

well with no galactorrhoea, headache or visual deficit. The hormonal evaluation revealed hyperprolactinemia (11,131 mIU/L) and hypogonadotropic hypogonadism (estradiol: 64.9 pmol/L, FSH: 7.2 mIU/L). Magnetic resonance imaging (MRI) demonstrated a cystic lesion occupying the pituitary fossa and extending into the suprasellar region; likely Rathke's cleft cyst with possible concomitant presence of pituitary adenoma. The lesion is abutting the optic chiasm with a height of 15.8 mm. She was treated with cabergoline 0.5mg twice per week. Her prolactin level normalized 3 months later with the resumption of a normal menstrual cycle. However, she defaulted to subsequent follow-up for 1 year before presenting to the endocrine clinic again for galactorrhoea and irregular menstruation. Prolactin level was 2,861 mIU/L. Cabergoline was re-initiated at 0.5 mg twice per week and her symptoms resolved 6 months later with the prolactin level of 311 mIU/L. Repeat MRI showed a right pituitary gland lesion measuring 0.4 x 0.3 x 0.3 cm with no cystic lesion identified.

CONCLUSION

Initial management strategies for cystic prolactinomas have been debated. In a recent review of cystic prolactinoma patients, 80% with compression of the optic chiasm evident on MRI (mostly without visual field defect) at presentation achieved resolution of chiasm compression with medical treatment. This case highlighted the effectiveness of cabergoline in treating cystic prolactinomas.

EP_A051

ENDOSCOPIC ULTRASOUND-GUIDED RADIOFREQUENCY ABLATION USED IN THE TREATMENT OF INSULINOMA

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INTRODUCTION/BACKGROUND

Surgical excision used to be the mainstay of curative treatment for insulinoma. In recent years, endoscopic ultrasound-guided radiofrequency ablation (EUS-guided RFA) has been used as a curative technique for insulinoma. Here, we report 2 cases of insulinoma with solitary lesions which showed clinical improvement following treatment with EUS-guided RFA.

CASE

The first case involved a 43-year-old Malay male, non-diabetic, who came with reduced consciousness during the fasting month of Ramadan. A low random blood sugar

of 1.4 mmol/L was accompanied by elevated insulin (8.3 mIU/L) and C-peptide (427 pmol/L). Contrast-enhanced CT showed a pancreatic lesion in the body measuring 1.4 x 1.6 cm. EUS confirmed the presence of a 1.5 cm hypoechoic lesion at the same location. He underwent 3 cycles of EUS-guided RFA without any complications. After the second cycle of RFA, diazoxide was discontinued and there was no recurrence of hypoglycaemia.

The second case involved a 59-year-old male who presented with recurrent episodes of giddiness and sweating for the past 1 year. Each episode resolved with food intake. A 72-hour prolonged fast revealed hyperinsulinaemic hypoglycaemia (RBS 2.3 mmol/L, elevated insulin 1064 pmol/L and elevated C-peptide 94.7 pmol/L). Insulin autoantibody was negative. Initial imaging with contrast-enhanced CT and ⁶⁸Gallium-DOTATATE scan failed to localize any pancreatic lesion. However, subsequent EUS detected a lesion at the pancreatic neck measuring 1.0 x 1.2 cm. Fine needle aspiration reported a pancreatic neuroendocrine tumour with positive staining for chromogranin and synaptophysin. He underwent 3 cycles of EUS-guided RFA without complications. His hypoglycaemia symptoms resolved after the 3rd cycle of RFA.

CONCLUSION

EUS-guided RFA can be a potential consideration in treating insulinoma with solitary lesions <2 cm with no evidence of metastasis. It is minimally invasive with low periprocedural complication risk. Longer follow-up is needed in both patients to assess long-term clinical effectiveness and recurrence.

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SUCCESSFUL RESOLUTION OF THYROID STORM FROM TSHoma WITH SOMATOSTATIN RECEPTOR LIGAND

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INTRODUCTION/BACKGROUND

Thyroid-stimulating hormone (TSH)-secreting pituitary adenomas (TSHomas) account for 2% of all pituitary adenomas. Symptoms of hyperthyroidism are common but thyroid storm is extremely rare. We report a case of TSHoma complicated by thyroid storm that was managed with somatostatin-receptor-ligand (SRL).