(TFT), with elevated free-T4 (range: 24.3-34.3 pmol/L) and non-suppressed thyroid stimulating hormone (TSH) (range: 1.19-4.07 mIU/L), similar across different laboratory platforms. Serum alpha-subunit of TSH was 0.6 IU/L, with TSH molar ratio of 3.1. Morning cortisol level was normal (598 nmol/L). Other pituitary hormones were appropriate for age and postmenopausal status. Whole body CT-scan was negative for malignancy, but incidentally showed a sellar mass. MRI confirmed a sellar mass measuring 1.1 x 2.1 x 2.1 cm, with suprasellar and cavernous extension, and chiasmal compression, with no features of apoplexy. Posterior pituitary T1 bright spot was present and displaced posteriorly.

Her hyponatremia improved with fluid restriction and rescue doses of tolvaptan. The sellar tumour was resected trans-sphenoidally. Histopathological examination confirmed a diagnosis of pituitary adenoma, which stained negative for ACTH, GH and PRL. TSH-staining was unavailable. Postoperatively, her TFT and sodium levels normalized.

CONCLUSION

Hyponatremia is a rare presentation for pituitary adenomas, especially in the absence of hypocortisolism or hypothyroidism. SIAD has been reported in non-functioning pituitary adenomas, pituitary apoplexy and central hypothyroidism and hypocortisolism. This is postulated to be due to exaggerated arginine-vasopressin (AVP) secretion due to local mass effect.

EP_A049

GIANT PITUITARY MACROADENOMA MASKED BY BILATERAL RETINAL DETACHMENT

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INTRODUCTION/BACKGROUND

Pituitary adenomas are benign tumours that encompass 10-20% of intracranial neoplasms. About 25-35% are clinically non-functioning pituitary adenomas (NFPA). Giant pituitary adenomas (diameter ≥4 cm) comprise approximately 5% of all pituitary tumours and usually present with mass effects on the neighbouring structures causing visual impairments, headaches and cranial nerve dysfunction. We present a case of giant pituitary macroadenoma with late presentation, being masked by bilateral retinal detachment.

CASE

A 39-year-old male with past history of bilateral retinal detachment following motor vehicle accident presented with progressive deteriorating vision for the past 3 years. This was initially attributed to retinal detachment/retinal scar. He then had frequent falls and headaches for the past 2 months. Cranial MRI showed a large pituitary adenoma measuring 6.3 x 5.7 x 5.9 cm with compression to the frontal and parietal lobes, optic chiasm and lateral ventricles bilaterally. He underwent two debulking surgeries. Post-surgery imaging showed minimal changes in tumour size. Histopathology examination showed pituitary adenoma with low ki67. Clinically and biochemically, he had panhypopituitarism with thyroid stimulating hormone (TSH), adrenocorticotropic hormone (ACTH) and gonadotrophins insufficiency. He is now on thyroxine, hydrocortisone and testosterone replacement. A multidisciplinary team meeting discussion concluded that a third debulking surgery by a high-volume surgeon followed by radiotherapy is the best option for the patient.

CONCLUSION

This is a case of NFPA complicated by progressive visual impairment which was masked by bilateral retinal detachment. We highlight the difficulty of detecting NFPA early in this patient in view of his visual history.

EP_A050

RESOLUTION OF CYSTIC MACROPROLACTINOMA WITH DOPAMINE AGONIST THERAPY

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INTRODUCTION/BACKGROUND

Cystic prolactinomas are prolactinomas that harbor cystic regions, usually occupying ≥50% of the tumour volume. It is hypothesized that dopamine agonists are ineffective in reducing cystic tumour mass due to the absence of dopamine receptors in the cystic portion of the tumour. We present a case of a patient with a cystic prolactinoma for which the cyst disappears following treatment with dopamine agonist.

CASE

A 23-year-old Malay female first presented with secondary amenorrhoea. She attained menarche at 15 years of age and had regular menses since then until 2019. She is otherwise

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 ^{68}Gallium-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.

EP_A052

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).