diabetes insipidus, anterior pituitary hormone deficiency, and headache. Its presence should be suspected when a pituitary tumour involves the posterior pituitary, especially in an elderly patient.

EP_A054

METYRAPONE AS A BRIDGING THERAPY IN FLORID CUSHING'S DISEASE PATIENT PRIOR TO PITUITARY ADENOMECTOMY

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INTRODUCTION/BACKGROUND
Florid Cushing's disease gives rise to high morbidity and mortality due to its metabolic abnormalities and the risk of infection. Preoperative medical therapy with steroidogenesis inhibitors such as metyrapone, an 11β-hydroxylase inhibitor, may be considered if surgery is delayed or rapid reduction of cortisol is needed in patients with severe Cushing's who have potentially life-threatening metabolic, infectious or thromboembolic cardiovascular complications.

CASE
We describe a 31-year-old female who presented with lethargy and a short history of body acne, proximal muscle weakness, and hair loss for a month. She had missed her menses for two months. Upon examination, she was hypertensive (BP 190/112 mmHg), BMI was 26 kg/m^2. She had hirsutism, hyperpigmentation over her lips, knuckles, and nail folds, facial and body acnes, alopecia, proximal muscle weakness, acanthosis nigricans, dorsocervical and supraclavicular fat pads and purplish striae over her abdomen.

Initial blood results revealed severe hypokalaemia (1.9 mmol/l), metabolic alkalosis (HCO3 41.3 mmol/l), HbA1c 9.2% and transaminitis (ALT 324 U/L, AST 130 U/L) which precludes initiation of ketoconazole. ODST was not suppressed with a cortisol level of 1406 nmol/l, and HDDST showed 50% reduction of cortisol from baseline (baseline 1059 nmol/l, post 530 nmol/l). 24-hour urine cortisol was markedly elevated at 10,352 nmol/day. ACTH level was raised at 38.4 pmol/L. Pituitary MRI demonstrated a bulky left pituitary gland measuring 0.6 cm x 0.7 cm x 0.4 cm. CT TAP showed no evidence of a suspicious lesion/mass suggestive of ectopic Cushing's. She initially required high doses of basal-bolus insulin and potassium replacement together with four antihypertensives. We commenced her on Metyrapone 250 mg TDS and this was titrated to 500 mg TDS based on serial cortisol levels. We attained a cortisol level of 531 nmol/l with better control of her blood pressure and glucose level prior to pituitary adenomectomy with TSS.

CONCLUSION
This case illustrates the effectiveness of metyrapone in achieving normal biochemical clinical parameters pre-operatively before undergoing pituitary surgery.

EP_A055

UNCOMMON CAUSE OF SECONDARY EMPTY SELLA SYNDROME

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INTRODUCTION/BACKGROUND
The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic has led to detrimental outcomes worldwide, leading to millions of deaths. SARS-CoV-2 vaccines are a critical step for many countries in battling with this infection. Recently, there are increasing cases of endocrinopathy, including hypophysitis, associated with SARS-CoV-2 vaccination.

CASE
We describe a patient with hypophysitis as a sequalae of COVID-19 vaccination.

A 48-year-old male, with a history of pulmonary tuberculosis who completed treatment in 2016, presented with fever, chills, postural hypotension and left upper limb weakness. The symptoms appeared 2 weeks after his 1st dose of SARS-CoV-2 vaccination.

He was initially treated as acute disseminated encephalomyelitis (ADEM) and meningoencephalitis. During admission, he developed septic shock with multiorgan involvement. He remained hypotensive despite improvement of septic parameters. Hence, short synacthen test was done which revealed inadequate cortisol response.

Inpatient cerebrospinal fluid (CSF) investigations were normal. Cranial MRI showed asymmetrical white matter hyperdensities; possible aetiology included infectious and inflammatory causes. He was discharged well with oral hydrocortisone 10 mg bd.

Evaluation in an endocrine clinic showed that he had low cortisol with low ACTH levels. Moreover, insulin tolerance test done confirms inadequate ACTH and growth hormone response. Other anterior hormonal profile results were normal. In view of the evidence of hypothalamic-pituitary-adrenal (HPA) axis suppression, coupled with the pituitary MRI findings, the diagnosis of SARS-CoV-2 vaccination-induced hypophysitis was established.

CONCLUSION

SARS-CoV-2 vaccination-induced hypophysitis is a rare but significant adverse effect that needs to be recognised. Prompt diagnosis is crucial, as treatment with steroid is lifesaving. In light of our experience, diagnosis of hypophysitis should be considered when patients present with pituitary dysfunction with a history of recent COVID-19 vaccination.

EP_A056

USTEKINUMAB-INDUCED HYPOPHYSITIS IN CROHN'S DISEASE: A CASE REPORT

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INTRODUCTION/BACKGROUND

Ustekinumab is a monoclonal antibody targeting IL-2 and IL-23 that has been used to treat psoriasis and more recently, inflammatory bowel disease. With the increased use of immunotherapy, immune-related adverse events are being reported more frequently. Ustekinumab has been reported to cause hypophysitis in a patient with psoriasis.

CASE

We report a case of a 29-year-old female with difficult-to-treat Crohn's disease since 2008. She has received azathioprine, methotrexate, infliximab, and adalimumab without favorable response. She subsequently underwent a right hemicolectomy and terminal ileal resection in 2017. She had previously been on prednisolone in 2012. She was started on ustekinumab in May 2020 and showed good clinical response. Twenty-seven months after starting ustekinumab, on routine investigation, she had a fasting blood glucose of 1.9 mmol/L. There were also some home capillary glucose readings of <3.5 mmol/L. She reported no signs of hypoglycemia and denied taking other medications or traditional supplements. She had been off all steroids for more than 10 years. She was clinically euthyroid with no history of polyuria or visual field defects. She had transient oligomenorrhea due to significant weight loss in 2020. Her BMI was 16.2. She had no signs of Cushing's. Further workup revealed low cortisol level of 43 nmol/L with ACTH of 11 pg/ml. TFT was discordant with elevated FT4 of 34 pmol/L and normal TSH of 2.69 mIU/L, with no assay interference confirmed. Her prolactin level was normal at 374 mIU/L. Pituitary MRI showed loss of posterior pituitary bright spot, slightly thickened stalk with heterogeneity within the pituitary suggesting possible hypophysitis. She started hydrocortisone replacement and her hypoglycemia resolved. As she is currently responding well to the ustekinumab for her Crohn's, she will be monitored periodically for progression of her hypophysitis.

CONCLUSION

Patients treated with ustekinumab should be monitored periodically for autoimmune endocrinopathies such as hypophysitis and thyroiditis.

EP_A057

A RARE CASE OF MICROPROLACTINOMA AND GRANULOMATOUS MASTITIS

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INTRODUCTION/BACKGROUND

Idiopathic granulomatous mastitis (IGM) is a benign and rare chronic inflammatory disease of the breast. However, its clinical presentation can mimic a breast malignancy or abscess. The aetiology is often unknown but several predisposing factors were identified, including patients with autoimmune disorders, hyperprolactinemia secondary to pregnancy, lactation, dopamine antagonist usage or pituitary adenoma.

CASE

We report a rare case of IGM in a patient with hyperprolactinemia secondary to microprolactinoma.

A 45-year-old, para 2, premenopausal female presented to a surgical clinic with a 2-year history of intermittent bilateral galactorrhoea and right breast swelling with pus discharge. There was no menstrual irregularity. Ultrasound of the right breast demonstrated multiloculated hypoechoic collections with internal echogenicities. She was treated with antibiotics; however, there was no clinical