CASE
We report a case of long-standing acromegaly with persistent disease despite pituitary surgery, radiotherapy and Octreotide LAR treatment being switched to pasireotide treatment.

A 63-year-old female was diagnosed with acromegaly 12 years ago with an initial pituitary tumour size of 2.6 x 2.7 x 3.8 cm. She underwent initial transsphenoidal resection of the pituitary tumour but post-operatively she still had a residual tumour of 1.0 x 0.9 x 1.4cm. She received initial medical therapy (Octreotide LAR). However, due to persistent disease and residual tumour, she was then subjected to 11 cycles of radiotherapy. Despite radiotherapy, her serum IGF-1 levels remained elevated and she also developed uncontrolled diabetes. At this juncture, she also refused further pituitary surgery and refused an MRI scan due to claustrophobia. Over the next few years, she would be maintained on Octreotide LAR 40 mg. Her IGF-1 levels would fluctuate slightly but never achieved control. Pasireotide treatment was subsequently started for the patient 1 year ago. After initiation of pasireotide, she had shown significant improvement of serum IGF-1 levels from 628.5 ng/ml to 203.4 ng/ml after 4 months of treatment. She also finally agreed to a repeat MRI pituitary which showed minimal residual tumour.

CONCLUSION
This case demonstrated the difficulty in achieving remission in an acromegaly patient despite surgery and radiotherapy. Despite long standing acromegaly disease and long duration of Octreotide LAR treatment, initiation of pasireotide has benefit to bring patient into biochemical and symptom control.

EP_A060

ATYPICAL PRESENTATION OF FUNCTIONING MALIGNANT METASTATIC PARAGANGLIOMA WITH RECURRENT MYASTHENIA CRISIS

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INTRODUCTION/BACKGROUND
The crude prevalence of paraganglioma is 2 per 100,000 persons/year. Roughly 10% of paragangliomas are malignant, resulting in a rare occurrence of 90-95 cases per 400 million people. The usual symptom of paraganglioma is related to catecholamine hypersecretion. However, we report an intra-abdominal paraganglioma presenting as recurrent myasthenia crisis without symptoms of catecholamine hypersecretion.

CASE
We report a case of a 34-year-old female who presented with abdominal pain. On work-up, CT scan revealed a 20-cm intraabdominal mass. Inguinal lymph nodes biopsy revealed reactive tissue. She was then lost to follow-up. She had recurrent admission for myasthenia crisis after 6 months of initial presentation. She received regular plasma exchange during the crisis to which she responded well. Further work-up of the abdominal mass revealed a functioning abdominal paraganglioma. Throughout her hospitalization, patient was normotensive with no symptoms to suggest paroxysm.

CT of the thorax-abdomen-pelvis revealed a 27-cm intra-abdominal multilobulated mass encasing major abdominal vessels and causing mass effect to adjacent organs. There was also compression fracture with lytic lesions of L3 and L4 vertebra. No mediastinal mass was seen. 24-hr urine metanephrines (umol/day): normetanephrine 21.9 (0.0-2.13), metanephrine 200.0 (0.0-1.62), 3-methoxytyramine 251.40 (0.10–1.79). Cervical lymph nodes tissue-biopsy revealed histological features and immunohistochemistry staining in favour of paraganglioma with necrosis and high mitotic figures.

A multi-disciplinary-team discussion was done with surgical, oncology and radio-nuclear for direction of therapy. Unfortunately, debulking surgery was not feasible

in view of the large functioning mass encasing major vessels. Chemo- and radio-nuclear therapy is not suitable in view of baseline ECOG-4. Decision for best supportive care was made with family members.

CONCLUSION
Due to its low prevalence, there is a low index of suspicion when it comes to diagnosing paraganglioma. Adding atypical presentation to this, this may lead to delay diagnosis and treatment. Early diagnosis is utmost important in a case of malignant paraganglioma since the treatment is by surgical removal.

EP_A061

APOPLEXY IN MICROPROLACTINOMA

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INTRODUCTION/BACKGROUND
Pituitary adenoma apoplexy is uncommon and often occurs spontaneously as a result of infarction, haemorrhage or a combination of both. Pituitary apoplexy is potentially life threatening and has long term consequences resulting in permanent hormonal deficiencies. It is often associated with pituitary macroadenoma and occurrence with pituitary microadenoma is rare.

CASE
We report a case of micro-prolactinoma with pituitary apoplexy on follow-up pituitary MRI.

A 29-year-old female who presented with secondary oligomenorrhea in December 2021 was subsequently diagnosed with micro-prolactinoma. Cabergoline therapy was initiated promptly. However, her serial prolactin level while on treatment would fluctuate between normal range and up to three times the upper limit. During her initial few months of treatment, she would develop intermittent headache which subsequently subsided. A repeat pituitary MRI was initially planned due to this complaint to exclude pituitary apoplexy, but MRI was postponed due to patient's claustrophobia. The repeat pituitary MRI was only performed in early 2023 revealing the presence of pituitary apoplexy with intratumoral haemorrhage. At the same time, she would also be diagnosed with hypocortisolism and hypothyroidism. Hydrocortisone and thyroxine replacement therapy were initiated and cabergoline therapy was stopped. During her follow-up she did not exhibit overt symptoms of hypocortisolism,hypothyroidism, or visual field defects.

CONCLUSION
This case illustrated that pituitary apoplexy could present in pituitary microadenoma and may present with subtle symptoms. Without a high index of suspicion, pituitary apoplexy can be overlooked leading to delay or missing diagnosis. Pituitary apoplexy requires prompt diagnosis with imaging and treatment can improve the clinical outcomes of patients.

EP_A062

A RARE CASE OF TOTAL LEFT ANTERIOR CIRCULATION INFARCT (TACI) SECONDARY TO THYROTROPINOMA (TSHoma) TREATED WITH OCTREOTIDE MEDICAL THERAPY

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INTRODUCTION/BACKGROUND
TSHoma is a rare cause of functioning pituitary adenoma. Patients with TSHoma have a biochemical derangement of elevated free thyroid hormones with unsuppressed TSH. They are usually misdiagnosed and treated for primary hyperthyroidism at the initial diagnosis. Most common symptoms upon presentations are hyperthyroidism, goitre and visual field defects. We reported an asymptomatic middle-aged female who presented acutely with left TACI secondary to atrial fibrillation due to a large functioning TSHoma.

CASE
A 53-year-old female, with no known medical diseases, presented with sudden-onset aphasia and right-sided body weakness. She presented to the emergency department with hypertension and tachycardia and ECG showed fast atrial fibrillation. Thyroid function test (TFT) showed that patient had a discordant hyperthyroid result [FT4 51.1 pmol/L (reference range 7.9-14.4) and TSH 4.825 mU/L (reference range 0.34-5.60)]. Repeated TFT on another platform had similar results. MRI of the brain revealed a heterogeneous mass occupying the sellar region with suprasellar extension 1.8 x 2.6 x 3.7 cm (AP x W x CC). TRH stimulation testing confirmed a functioning TSHoma and the patient was started on IM Octreotide LAR with rapid improvement of the TFT and resolution of the atrial fibrillation within 2 months. As this patient was not fit for surgical operation during the acute presentation, she was treated with medical therapy of Octreoride LAR and the patient achieved good improvement in 6 months' time where she was able to function independently. A repeat MRI after 6 months showed a smaller sellar mass (1.6 x 2.3 x 3.5 cm).