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).

CONCLUSION
TSHoma with acute stroke as an initial manifestation is uncommon. Interpretation of discordant TFT needs to be done and investigated carefully as TSHoma can be cured by surgical removal. In inoperable cases, medical therapy can control the disease well.

EP_A063

A CASE OF GIANT INVASIVE MACROPROLACTINOMA PRESENTING AS A NASOPHARYNGEAL MASS

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INTRODUCTION/BACKGROUND
Giant prolactinomas are rare and can invade the surrounding structure. Invasion tends to involve the suprasellar and cavernous sinus region with a minority invading the base of the skull.

CASE
We describe a rare presentation of giant invasive prolactinoma masquerading as nasopharyngeal tumour.

A 33-year-old female presented to the ENT clinic with nasal congestion, blocked ear, progressive right-sided hearing loss for 4 months and epistaxis and headache for 2 weeks. Nasopharyngeal scope showed a large mass protruding from the nasopharynx into the nasal cavity. Biopsy taken reported a neuroendocrine tumour with diffusely positive immunohistochemistry for synaptophysin, chromogranin and vimentin. Ki67 was 10%. MRI of the brain showed a large nasopharyngeal mass (7.1 x 9.8 x 6.3 cm) with complete obliteration of the nasopharynx and erosion of the sphenoid bone and clivus. There was also extensive multidirectional invasion of the surrounding tissue. The patient was referred to the neurosurgery and oncology team. Further history found that the patient had oligomenorrhea for many years and became amenorrhoeic past 2 years. She denied galactorrhoea. Visual field testing showed left inferior quadrantanopia. Prolactin level was 625,740 uIU/mL. She was then referred to our endocrine service. Thyroid function and 8 am cortisol were normal. Further histopathology staining showed positivity for prolactin and ACTH. She was initiated on cabergoline 0.5 mg 3x/week. She developed a CSF leak after 2 weeks; after tumour debulking and leak repair, cabergoline dose was titrated to 0.5 mg daily. Prolactin reduced to 160727 uIU/mL and the tumour size decreased to 6.0 x 8.3 x 6.0 cm. Multidisciplinary team discussion decided on a trial of higher dose cabergoline (5.5 mg/week) prior to consideration for radiotherapy; however, the patient developed another CSF leak 1 month after dose titration, requiring another repair.

CONCLUSION
Invasive giant prolactinoma may rarely present with skull base invasion and intranasal extension masquerading as nasopharyngeal tumor. Careful clinical evaluation is important to diagnose this rare presentation to allow timely and appropriate management.

EP_A064

TSHoma: A CASE OF MISTAKEN IDENTITY

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INTRODUCTION/BACKGROUND
TSH-secreting pituitary tumours are rare causes of hyperthyroidism. Its diagnosis is often delayed due to its uncommon presentation.

CASE
We report a case of TSHoma in a female initially mis-diagnosed as Graves' disease.

A 36-year-old female was diagnosed with Graves' disease by a general practitioner since 2016 following symptoms of palpitations and weight loss. There was no family history of thyroid disease. She was treated with carbimazole for 6 years before receiving radioactive iodine 15 mCi in May 2022. However, 5 months post RAI, her FT4 remained elevated, ranging from 34.1- 39.1 pmol/L (Normal: 12.3-20.2 pmol/L) with high TSH of 7.12-10.1 mIU/L (Normal: 0.3-3.94 mIU/L). She was restarted on carbimazole and referred to the endocrine unit. On retrospective review, prior to RAI, she had raised FT4 and TSH levels as well. She also reported intermittent headaches for ten years but no visual disturbances and menstrual irregularities. She was clinically euthyroid. Pulse rate was 70/min and regular without beta blocker. She had a small diffuse goitre but no thyroid eye signs, visual field was normal. Thyroid ultrasound showed diffuse thyroid gland enlargement. Additional testing showed no feature of assay interference. Sex-hormone binding globulin was elevated at 190 nmol/L (Normal: 30-90). Prolactin and cortisol were within normal range. MRI of the brain showed a heterogenous sellar-suprasellar mass measuring 2.0 x 2.5 x 2.4 cm. Six months post RAI she had normal FT4 and FT3 on carbimazole 5 mg daily, but TSH was elevated at 65.2 mIU/L. Carbimazole was