resolution of seizure and recovery of consciousness. This allowed a safe window for urgent thyroidectomy four days after plasmapheresis and an uneventful surgery.

CONCLUSION

This case highlights the complexities in the management of thyroid storm, and the risk of relapse despite initial biochemical and clinical improvement. A sufficient course of plasmapheresis is essential to allow for urgent thyroidectomy.

EP_A088

ATRIAL FLUTTER IN HYPERTHYROIDISM: ACHIEVING EARLY RHYTHM CONTROL

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M. Razi Zulkufli,[1] H.K.R. Subbarao,[1] Mohd Syafiq MS,[1] Salbiah S,[1] Rafizi Mohamed Rus[2]
[1]94 Hospital Angkatan Tentera, Kem Terendak Malacca, Malaysia
[2]Hospital Angkatan Tentera Tuanku Mizan, Kuala Lumpur, Malaysia

INTRODUCTION

Atrial arrhythmia is a common manifestation of cardiac complications of hyperthyroidism. However, most literature focus on the incidence and management of atrial fibrillation rather than atrial flutter. It also suggests postponement of cardioversion until the fourth month of maintaining a euthyroid state, as more than half of cases revert spontaneously to sinus rhythm and atrial fibrillation may recur with thyrotoxicosis. Here we present a case of atrial flutter with early rhythm control with electrical cardioversion without subsequent recurrence.

CASE

A 29-year-old male presented with a two-day history of fever and recurrent episodes of palpitations. Upon arrival, findings showed BP 110/70, temperature 38°C, and typical counterclockwise atrial flutter with variable block and HR 130 bpm on ECG. Results revealed low TSH (<0.01 mIU/L) and elevated FT4 (90 pmol/L). He was treated as Graves' thyrotoxicosis precipitated by viral fever. Treatment included carbimazole 30 mg OD, rate control with propanolol 40 mg TDS and supportive care. Echocardiogram showed EF 44% with dilated RA, RV and LA. In view of evidence of cardiomyopathy, trans-oesophageal echocardiogram and elective cardioversion was performed a week after discharge. Rhythm was successfully cardioverted back to sinus rhythm. He remains in sinus rhythm with improvement in cardiac function four weeks after cardioversion.

CONCLUSION

In general, the management of atrial flutter is slightly different from atrial fibrillation, as the former may be treated with immediate rhythm control using electrical cardioversion. Despite the thyrotoxic state, earlier rhythm control is better for cases of atrial flutter in order to prevent development or worsening of thyrotoxic cardiomyopathy.

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PERSISTENT VOMITING AS THE PRESENTATION OF THYROTOXICOSIS: A CASE REPORT

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Chee Keong Seow and Chin Voon Tong
Hospital Melaka, Malaysia

INTRODUCTION

Thyrotoxicosis may have many different presentations at diagnosis. We present a case of thyrotoxicosis with the presentation of only recurrent vomiting in pregnancy.

CASE

The patient's medical records were traced and reviewed.

A 41-year-old Malay female, G4P2 with one miscarriage, with underlying type 2 DM initially presented during pregnancy with recurrent admissions for vomiting since the first trimester. She was admitted and treated for hyperemesis gravidarum and urinary tract infection at 12 and 14 weeks gestation. She was readmitted at 28 weeks for recurrent vomiting and reduced oral intake one week prior to admission. She denied having conventional symptoms of thyrotoxicosis. She did not have any family history of thyroid disorder. Examination findings revealed a small goitre with no fine tremors or thyroid eye signs, BP within normal range and HR 100 to 107. Clinically, she had mild dehydration. Multiple investigations including serum calcium, ketone, amylase and brain MRI to look for the cause of persistent vomiting were normal. During her third admission, thyroid tests were done for evaluation of tachycardia. Results showed elevated FT4 (66 pmol/L), suppressed TSH (0.01mIU/L), negative thyroid antibodies and no significant abnormality on neck ultrasonography. She was started on oral carbimazole 20 mg OD and oral propranolol 20 mg BD. Vomiting was resolved thereafter. She delivered via emergency lower caesarean section at 31 weeks for abnormal cardiotocography and foetal intrauterine growth restriction.

CONCLUSION

Recurrent vomiting in pregnancy is a rare presentation for thyrotoxicosis. This should not be missed in clinical practice to prevent adverse maternal and foetal outcomes.