hyperparathyroidism often remits but bone disease progresses. Bisphosphonate therapy such as pamidronic acid has been described in those with recurrent fractures in later life.

EP_P005

CASE REPORT: VAN WYK-GRUMBACH SYNDROME: HYPOTHYROIDISM PRESENTING AS PRECOCIOUS PUBERTY

https://doi.org/10.15605/jafes.038.S2.134

Hazirah Ahmad
Hospital Sultanah Bahiyah, Malaysia

INTRODUCTION/BACKGROUND
Acquired causes of hypothyroidism such as Hashimoto's thyroiditis is mostly insidious and often goes undetected, unless there is concomitant thyroid gland enlargement or profound hypothyroid symptoms. Precocious puberty in girls is a rare cause of acquired hypothyroidism.

CASE
We report an 8 year-3-month-old female of Chinese-Indian descent, who presented with precocious puberty (bilateral breast budding, axillary hair, and pubic hair) about 6 months prior, with the mother's concern of poor learning in school. There were no other symptoms of puberty such as vaginal discharge or growth acceleration. She was adopted at 6 months old, thus, there is uncertainty about her biological family history. Her height was at the 25th centile and weight at 75th centile. She had a single café-au-lait spot at the right thigh, with Tanner stage 2 breasts, axillary hair, and pubic hair. She also had mild scoliosis with no other skeletal deformities. She had no thyroid gland enlargement but her facial expression was dull. Her blood investigations revealed pre-pubertal levels of gonadotrophins with undetectable estradiol, normal prolactin and negative b-HCG screen. Her thyroid function revealed markedly increased TSH (>100mIU/L) with severely low fT4 (<5.4 pmol/L). Her thyroid peroxidase antibody (anti-TPO) level was 131 IU/ml (<35). Ultrasound of the thyroid showed features in keeping with autoimmune thyroiditis with incidental thyroglossal duct cyst. Upon further questioning, the mother did recall prominent neck swelling since the past 2 years. Following L-thyroxine initiation, her thyroid function normalized and she showed significant improvement in height (she grew 10 cm/year) with progression of puberty. Her last bone age was 10 years old (CA: 9 year and 6 months).

CONCLUSION
Van Wyk-Grumbach syndrome is a relatively uncommon cause of pseudo-precocious puberty that often skips detection. Thyroid assessment is recommended in a girl presenting with precocious puberty, even in the absence of goiter. Timely diagnosis and treatment with L-thyroxine normalizes thyroid function and significantly improves linear growth.

EP_P006

CASE REPORT: EXOGENOUS CUSHING SYNDROME IN A GROWING CHILD FOLLOWING CHRONIC TOPICAL STEROIDS FOR FAMILIAL PSORIASIS

https://doi.org/10.15605/jafes.038.S2.135

Tsae Yun Tan
Hospital Sultanah Bahiyah, Malaysia

INTRODUCTION/BACKGROUND
Cushing syndrome is relatively uncommon in young children but exogenous Cushing syndrome is increasingly seen due to both prescribed and surreptitious intake of steroids.

CASE
We report a 6 year-10-month-old female, referred from Dermatology for obesity. She had itchy and scaly red plaques about 1 year prior. Both her mother and elder sister had been diagnosed with psoriasis and treated elsewhere. Even without a doctor's advice, she was given over-the-counter topical betamethasone dipropionate by her mother 1 year before consult. The mother applied the steroid generously over the child's whole body including the face and inguinal region twice a day for every flare, which usually occurred around 2 episodes every month. Since then, her daughter gained weight and stopped growing. She had florid Cushingoid features with emotional lability (easily tearing), truncal obesity, thick violaceous purple striae over the trunk, neck, upper, and lower limbs, and extensive erythematous scaly psoriatic plaques (BSA~80%). She was hypertensive with blood pressures ranging from 130-150/88-100 mmHg. She did not have proximal muscle weakness. Her eye assessment was negative for glaucoma or cataract, or hypertensive retinopathy changes. She had a pre-pubertal Tanner stage with no virilisation or hirsutism. She had persistently suppressed 8am cortisol level (<27.6 nmol/L) and low ACTH level (1.10 pmol/L, reference range 1.6-13.9) with normal 17OHP and DHEAS screen. She had borderline HbA1c (5.7%), dyslipidaemia, and non-alcoholic fatty liver disease based on an abdominal ultrasound. Her topical steroids for psoriasis were stepped down and she was initiated on steroid-sparing UV