4 days. She remained febrile despite 2 courses of intravenous (IV) amoxicillin-clavulanic acid and oral erythromycin. A chest radiograph at day 9 of illness showed collapsed consolidation of the left upper lobe of the lung.

She was noted to have hepatosplenomegaly on physical examination at day 12. Abdominal ultrasound revealed multiple well-defined splenic microabscesses. Routine blood and respiratory cultures were negative, but serum IgM titres for melioidosis were positive. She was treated with IV meropenem and oral trimethoprim-sulfamethoxazole.

Patient B is a 12-year-old female who presented with prolonged fever and newly diagnosed DKA (serum glucose: 30.3 mmol/L, serum ketone: 3.5 mmol/L venous pH: 7.24, HCO_3- : 12.6 mmol/L). Her fever persisted despite DKA resolution. She developed septic shock needing intensive care admission due to severe pneumonia with bilateral pleural effusion. CT thorax and abdomen showed consolidated changes in the lungs and multiple abscesses in the liver and spleen. Blood cultures grew *Burkholderia pseudomallei* which confirmed melioidosis infection. She was treated with 6 weeks of IV ceftazidime, meropenem and trimethoprim-sulfamethoxazole.

CONCLUSION

Prolonged fever in children presenting with DKA must be thoroughly investigated. Melioidosis is uncommon, however, it needs to be ruled out to ensure adequate treatment of patients with immunocompromised status.

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HASHIMOTO'S THYROIDITIS WITH SYSTEMIC INVOLVEMENT: A CASE REPORT

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INTRODUCTION/BACKGROUND

Hashimoto's thyroiditis is the most common cause of acquired primary hypothyroidism in children. It is an autoimmune disease involving cell and antibody-mediated immune processes, leading to progressive fibrosis. Severe hypothyroidism may have variable clinical manifestation mimicking other multiorgan dysfunction.

CASE

We report an 8-year-old male who presented to our centre with a 4-month history of intermittent facial and lower limb swelling associated with unintentional weight gain, cold intolerance, easy fatigability, and regression in school performance. There was no family history of thyroid disease or autoimmune disorder. He visited the healthcare clinic 2 weeks prior to presentation for an upper respiratory tract infection however hypothyroid symptoms were not addressed. He was a short male with weight of 29.7 kg (75^{th} centile) and height of 119 cm (10^{th} centile) with evidence of faltering growth and coarse facies. He has a diffuse goitre measuring 8 x 3 cm (length x width) associated with thyroid acropachy, bilateral pretibial myxoedema and bradyarrhythmia (mean heart rate 56/min). His biochemical results showed a markedly elevated TSH 2233 mIU/L with FT4 2pmol/L, anti TPO >1000 IU/ml and anti-TG antibody 53.7 IU/ml. He was started with oral levothyroxine 25 mcg daily (0.8 mcg/kg/day) and the dose was titrated up slowly to 50 mcg daily (1.7 mcg/kg/day) over 4 weeks. He received one stress dose of intravenous hydrocortisone 100 mg (100 mg/m^2/dose) on the day of admission due to hypotension upon starting thyroxine. His status of adrenal insufficiency has not been ruled out. There were no other complications of myxoedema coma.

CONCLUSION

We report a case of missed hypothyroidism despite frank symptoms and signs. This was the highest TSH reported in our centre and likely in Malaysia. Prolonged untreated Hashimoto's thyroiditis is associated with high morbidity and mortality risk. Initiating treatment must be done cautiously to prevent crisis and complications.