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Refractory Thyrotoxicosis – Challenges in Management

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INTRODUCTION

Refractory Graves thyrotoxicosis is a rare condition in which hyperthyroidism fails to respond to the conventional thionamides. Patient with severe hyperthyroidism or allergy to thionamide may benefit from alternative medical therapies namely radioactive iodine therapy, glucocorticoids, cholestyramine or lithium. Thyroidectomy is the definitive treatment for Graves thyrotoxicosis that is recommended when medical therapies have failed or are contraindicated.

The medical records of the patient were traced and reviewed.

CASE

Here we report a 14-year-old girl who was diagnosed with Graves' disease a year ago. She had thyrotoxic symptoms with positive thyroid autoantibodies. She was initially started on carbimazole and developed agranulocytosis from it. She had cushingoid syndrome with myopathy from steroid, gastrointestinal side effects from cholestyramine and severe lithium toxicity requiring hemodialysis. She developed severe myopathy compromising her airway and requires mechanical ventilation and needed prolonged intubation. She was initially planned for radioactive iodine therapy but remained clinically and biochemically hyperthyroid despite trial of 4 cycles of plasmapheresis. The only therapy that managed to control her hyperthyroidism temporarily was Lugol's iodine. Thus the initial plan for radioactive iodine treatment was not feasible. In general, we would usually aim for patient to be in euthyroid state prior to surgery to minimize potential peri-operative complications. A short course of Lugol's iodine was reinitiated and she was referred for inpatient thyroidectomy. She successfully underwent thyroidectomy without any peri-operative complications and is currently in euthyroid.

CONCLUSION

In conclusion, inpatient thyroidectomy should be considered in patient with refractory Graves thyrotoxicosis that is resistant to conventional therapies to prevent secondary complications.

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Ampullary Hyperplasia in a Patient with Poorly Controlled Acromegaly: A Case Report

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INTRODUCTION

The complexity of acromegaly management increases exponentially when a patient is still uncontrolled after undergoing primary pituitary surgery, pituitary radiotherapy and concomitant somatostatin analogue treatment. Poorly controlled disease has definite increased risk of malignancy.

CASE

A 60-year-old lady with acromegaly and concomitant diabetes and hypertension had undergone transsphenoidal pituitary surgery in 2011. Post-operatively, somatostatin analogue (octreotide) was started since she had residual tumour and elevated IGF-1 levels. Despite this her IGF-1 levels remained elevated. Conventional pituitary radiotherapy was opted partly due to her fear of second surgery in 2016. Unfortunately, her disease remained active, evidenced with persistently elevated IGF-1 levels, poorly controlled diabetes and hypertension and frequent headaches.

In December 2018, she developed symptoms of obstructive jaundice and subsequent ERCP revealed presence of ampullary tumour with choledocho-doudenal fistula and grossly dilated common bile duct with no filling defects. Tumour marker CA19-9 was markedly elevated. HPE of tumour biopsy revealed high-grade glandular dysplasia. Acromegaly patients have increased risk of developing colonic polyps and malignancy but association of acromegaly and biliary duct tumour has not been established and rarely reported. Though in uncontrolled disease, elevated levels of IGF-1 promotes angiogenesis and malignancy.

CONCLUSION

This case illustrates a rare finding of obstructive jaundice and ampullary tumour in poorly controlled acromegaly. This patient would require Whipple's procedure for the tumour but optimisation for surgery would be extremely difficult. This include controlling her diabetes, hypertension and growth hormone excess. In this reassessment for pituitary surgery would be vital.