CASE
A 70-year-old male was found to have a 15-cm right suprarenal mass when he underwent CT scan for the staging of nasopharyngeal carcinoma. He had no paroxysmal symptoms or hypertension. There were no features of Cushing syndrome. Endocrine evaluation showed no evidence of functioning pheochromocytoma or adrenocortical carcinoma. The patient underwent open adrenalectomy and tumour excision uneventfully. Pathology examination revealed a large ancient schwannoma consisting of spindle cells with nuclear and cytoplasmic S-100 positivity.

CONCLUSION
The pre-operative diagnosis of retroperitoneal schwannoma remains challenging despite the advances in imaging modalities. Th definitive diagnosis relies on biopsy or resection.

EP_A007

THE FAST AND FURIOUS CUSHING'S SYNDROME

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INTRODUCTION
Ritonavir is a commonly prescribed protease inhibitor for human immune deficiency (HIV) treatment. It is a potent inhibitor of hepatic cytochrome P450 (CYP450) enzyme. Interaction between ritonavir and corticosteroids induces iatrogenic Cushing's Syndrome. We share a case of an acute onset of Cushing's Syndrome in a young female with HIV.

CASE
A 25-year-old female with stable retroviral disease on ritonavir along with tenofovir, emtricitabine and atazanavir developed Cushing's syndrome within 2 weeks of receiving injectable hydrocortisone from a general practitioner's clinic for skin itchiness. Facial swelling, hirsutism, abdominal striae, body acne, weight gain and proximal myopathy were noted. Early morning cortisol was 28 nmol/L and the 24-hour urine-free cortisol was 45 nmol/day. She was diagnosed with iatrogenic Cushing's syndrome with suppression of the hypothalamic-pituitary adrenal (HPA) axis secondary to drug interaction between ritonavir and intravenous hydrocortisone. She was started on oral hydrocortisone 20 mg in the morning and 10 mg in the evening. Throughout her hospitalization and upon discharge, she remained clinically well. She is planning for a Synacthen test on an outpatient basis to reassess her HPA axis.

CONCLUSION
Drug interaction between ritonavir and corticosteroids may result in increased levels of plasma corticosteroids, potentiated by the CYP450 metabolism which prolongs the half-life of hydrocortisone, that can lead to Cushing's syndrome. This highlights the importance of a thorough review of the patient's medications to prevent drug-to-drug interaction. If corticosteroid administration cannot be avoided, the patient needs to be monitored for symptoms of Cushing's syndrome.

EP_A008

A CASE OF CLINICALLY AND BIOCHEMICALLY SILENT GIANT PHEOCHROMOCYTOMA

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INTRODUCTION/BACKGROUND
With the widespread use of computed imaging and genetic testing, up to 60% of pheochromocytomas are diagnosed in the presymptomatic stage, particularly when the lesion is smaller than 3 cm. We report a rare case of clinically and biochemically silent giant pheochromocytoma.

CASE
A 44-year-old Malay male with a two-year history of hypertension was initially admitted to the surgical team for gallbladder empyema. However, abdominal CT showed a lobulated, heterogeneously enhancing mass with an area of necrosis at the right peritoneal region measuring 11 x 13.5 x 15.2 cm. Subsequent ultrasound-guided biopsy of the mass revealed pheochromocytoma. He was then referred to the Endocrine team for further management. No paroxysmal symptoms were reported by the patient and his blood pressure was well-controlled on a single antihypertensive. Laboratory workup including 24-hour urine catecholamines and 24-hour urine metanephrine were not elevated. Thus, 68Ga/Dotatate scan was performed, which demonstrated evidence of somatostatin receptor avid malignancy in the abdominal mass with no evidence of regional or distant metastasis. Following the scan, serum chromogranin A (CgA) was sent and was found to be elevated (2682.4 ng/ml, normal range: 27-94 ng/ml). After adequate alpha- and beta-blockade, he successfully underwent right adrenalectomy with complete removal of the mass with no complications intra- and postoperatively. The HPE of the mass reported the presence of a well-circumscribed tumour focally encapsulated by a thin fibrous capsule, with the absence of necrosis and invasion