of the vascular, adrenal capsular and periadrenal soft tissue, with a Ki-67 proliferative index of 1%. A repeat abdominal CT done two months post-operatively showed no evidence of local recurrence and a normal CgA level (85.8 ng/ml).

CONCLUSION
Surgery is the primary treatment for pheochromocytoma, and pre-operative alpha- and beta-blockade are essential regardless of tumour size and biochemical status. In patients without elevated levels of catecholamines, CgA is the alternative functional diagnostic and surveillance marker.

EP_A009

PHEOCHROMOCYTOMA: AN OVERLOOKED CONDITION IN HYPERTENSIVE DISORDER IN PREGNANCY

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INTRODUCTION/BACKGROUND
Pheochromocytoma is a rare tumour derived from chromaffin cells of the adrenal medulla or extra-adrenal paraganglia. It is a rare cause of secondary hypertension and is commonly overlooked in pregnancy due to limitations in investigation during pregnancy. It occurs in 0.1-1% of the hypertensive population and is even more rare in pregnancy.

CASE
A 33-year-old pregnant female with a parity of 8, diagnosed with chronic hypertension and with a history of severe preeclampsia in her previous pregnancy, presented again at 34 weeks of gestation with severe preeclampsia. Blood pressure was 179/124, and heart rate ranged from 100 to 120 bpm. Urinary examination revealed proteinuria. Despite treatment with conventional antihypertensives, her blood pressure remained uncontrolled. Thus, she was planning for emergency C-section. Intubation was done due to cardiorespiratory compromise, which was complicated by cardiac arrest. She was successfully resuscitated. Computed tomography (CT) of the adrenal glands showed a large, heterogeneously enhancing right adrenal lesion measuring 7.4 x 7 x 8 cm. Twenty-four-hour urinary catecholamine levels were elevated, with normetanephrine at 67.80 umol/day (0-2.13), metanephrine at 97.30 umol/day (0-1.62), and 3-methoxytyramine at 7.60 umol/day (0.1-1.79). The classical presentation of pheochromocytoma with paroxysmal hypertension, headaches, sweating, and palpitations may not be simultaneously present, especially during pregnancy. Labile BP and difficult to control hypertension should raise suspicion for pheochromocytoma, to prompt appropriate investigations that will facilitate an early diagnosis. Measurements of urinary or plasma catecholamines have reasonable sensitivity for detecting most pheochromocytomas, particularly in patients with sustained hypertension. Radioisotope scans, including iodine 131-labeled metaiodobenzylguanidine scanning, should be avoided during pregnancy due to foetal concerns and, if required, should be postponed until the postpartum period.

CONCLUSION
Pheochromocytoma in pregnancy is a life-threatening condition. Early suspicion and recognition are essential to prevent fetomaternal morbidity and mortality.

EP_A010

DISSEMINATED HISTOPLASMOSIS WITH BILATERAL ADRENAL INFILTRATION AND PRIMARY ADRENAL INSUFFICIENCY

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INTRODUCTION/BACKGROUND
Histoplasmosis is a fungal disease caused by *Histoplasma capsulatum* and characterized by two forms: pulmonary and disseminated histoplasmosis. In the latter form, adrenal infiltration is a common feature, resulting in detection of bilateral adrenal masses radiologically. Bilateral extensive destruction of the adrenal glands results in primary adrenal insufficiency (PAI), which occurs in 5–71% of adrenal histoplasmosis. We present a case of PAI with adrenal histoplasmosis.

CASE
A 71-year-old male, with underlying diabetes, hypertension, and pulmonary tuberculosis, presented with bloody diarrhea and thrombocytopenia. Multiple ulcers were observed over the dorsal surface of the tongue. The histopathological examination (HPE) of the tongue was consistent with histoplasmosis. Colonoscopy examination was unremarkable. The patient was referred to an infectious disease team and was prescribed a course of itraconazole for six weeks.

A year later, he had recurrent bloody diarrhea, and repeated colonoscopy revealed inflamed rectal mucosa. Histopathological examination revealed chronic proctitis with noncaseating granulomas that were consistent with fungal infection. Intravenous amphotericin B