was administered, followed by oral isavuconazole and itraconazole. Computed tomography (CT) scan demonstrated enlarged bilateral adrenal glands with the right side measuring 4.9 x 2.6 x 6.8 cm, and the medial limb of the left adrenal gland measuring 4.3 x 2.5 cm. The lateral limb of the left adrenal gland was 3.6 x 2.1 cm. Ten weeks after antifungal therapy was started, CT scan revealed a smaller left adrenal lesion, but the right adrenal lesion remains unchanged. Short synacthen test showed PAI with peak cortisol 246 nmol/L, ACTH 20.3 pmol/L (1.6-13.9). He is awaiting adrenal biopsy pending urinary metanephrines. Glucocorticoid replacement was initiated. Antifungal therapy would be continued for no less than one year.

CONCLUSION

Adrenal histoplasmosis is common and histopathological analysis is crucial in managing such cases. It is important to be vigilant about infections like histoplasmosis as a potential cause of PAI. Delay in treatment could result in life-threatening consequences.

EP_A011

MALIGNANT PARAGANGLIOMA IN AN ADOLESCENT

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INTRODUCTION/BACKGROUND

Pheochromocytomas (PCC) and paragangliomas (PGL) (PPGL) are rare neuroendocrine tumours occurring in children and adolescents. Nevertheless, they are the most common endocrine tumours in the paediatric population and account for 0.5–1% of paediatric hypertensive cases. We describe a 16-year-old female with malignant paraganglioma.

CASE

A previously healthy 16-year-old female presented with a one-month history of intermittent headaches associated with palpitations and presyncopal attacks. The first blood pressure reading revealed that she was hypertensive, with a BP of 159/116. She had no chest pain, shortness of breath, diaphoresis, abdominal pain, or diarrhoea. There is no family history of hypertension in the young or endocrine disorder. The patient is lean with a BMI of 14.2 kg/m^2. No goitre, cushingoid or acromegalic features were present. The hormonal workup done was consistent with phaeochromocytoma (normetanephrine: 55.30 umol/day) (35.5 X ULN)). Other forms of work-up for secondary hypertension were unremarkable. Adrenal CT imaging revealed an enhancing mass at the left pararenal space measuring 4.1 x 4.7 x 4.7 cm with local infiltration to the tail and body of the pancreas complicated by a left renal infarct. Therefore, she was diagnosed with left paraganglioma with local infiltration. Preoperatively, she was started on oral prazosin 1 mg, 6 hourly and oral bisoprolol 2.5 mg daily and successfully underwent open resection of the left paraganglioma. Unfortunately, she remained hypertensive post-surgery, indicating a possible malignant paraganglioma. Thus, she was restarted on antihypertensive medications. Gallium-DOTATE scan and genetic testing have been arranged to aid further management.

CONCLUSION

Diagnosis of pheochromocytoma and paraganglioma is paramount during the evaluation of secondary hypertension in the paediatric population. Although they are uncommon, possible curative surgery can be offered. All children should be subjected to genetic testing given the high rate of inheritance of these tumours. Subsequently, all patients with genetic mutations ought to be under lifelong surveillance in view of the risk of recurrence and malignancy.

EP_A012

A RARE CASE OF UNILATERAL ADRENAL LYMPHOMA WITH LYMPHADENOPATHY

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INTRODUCTION/BACKGROUND

Adrenal lymphoma is an extremely rare and highly invasive malignant disease. We report a rare case of unilateral adrenal lymphoma with lymphadenopathy.

CASE

A 68-year-old male presented with abdominal discomfort, polyuria and weight loss of 15 kg over 6 months. Physical examination revealed a thin elderly man with fullness over the left lumbar and inguinal lymph nodes. Laboratory tests showed markedly elevated lactate dehydrogenase (LDH) levels of >690 UI/L (<248) and hypercalcemia. A computed tomography (CT) scan revealed a large left adrenal mass (11.6 x 8.3 x 9.6 cm) with multiple matted abdominal lymph nodes, raising a suspicion of adrenal malignancy. Following this, hormonal profile was done which showed normal cortisol and catecholamines. An ultrasound-guided trucut biopsy of the right inguinal lymph nodes was performed. The microscopic examination showed a malignant tumour composed of mononuclear cells with pleomorphic nuclei with high mitotic figures. On immunohistochemistry, the tumour cells were positive for vimentin, CD20, CD10,