

CONCLUSION

A mixed cortical and medullary adrenal neoplasm is extremely rare. Therefore, knowledge about long-term clinical course and prognosis is limited. Long-term follow-up is recommended to assess the recurrence in the contralateral adrenal gland.

EP_A016**A SINGLE METASTATIC LARGE ADRENAL MASS MIMICKING ADRENOCORTICAL CELL CARCINOMA**

<https://doi.org/10.15605/jafes.039.S1.027>

Wan Mohd Hafez WH,¹ Masliza Hanuni MA,¹ Siti Sanaa WA,¹ Hussain Mohamad,² Nor Hisham Muda²

¹Endocrinology Unit, Medical Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia

²Breast and Endocrine Surgery Unit, Department of Surgery, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia

INTRODUCTION

Invasive breast ductal carcinoma commonly metastasizes to the lungs, liver, bones and brain. Solitary adrenal metastasis from invasive ductal carcinoma is extremely rare. Hence, a single large adrenal metastasis can mimic a primary adrenal tumour such as adrenocortical carcinoma. We report a case of a rare single metastatic large adrenal mass from invasive ductal carcinoma mimicking adrenocortical carcinoma.

CASE

A 49-year-old female, with a known case of invasive ductal carcinoma of the right breast underwent right mastectomy and axillary clearance and completed 6 cycles of systemic chemotherapy and 15 cycles of radiotherapy. The FDG-PET scan surveillance post-treatment showed FDG-avid left adrenal mass suggestive of metastasis or primary malignancy with no other solid organ or bone metastasis. Subsequent computed tomography (CT) scan also showed a large, irregular lobulated solid left adrenal mass measuring 7.3 x 4.8 x 5.4 cm. Plain HU was 30 HU and the calculated absolute washout was 55%. A large left adrenal mass with the absence of other solid organs and bone metastasis made adrenocortical carcinoma one of the possible aetiologies. Biochemical investigation to assess adrenal tumour functionality, namely, overnight dexamethasone suppression test (ODST), aldosterone renin ratio (ARR) and 24-hour urine metanephrines all yielded normal results. Left open adrenalectomy was performed and histopathological examination (HPE) confirmed left adrenal metastasis from the breast carcinoma.

CONCLUSION

Single large solitary adrenal metastasis from invasive breast ductal carcinoma is rare and can mimic adrenocortical carcinoma. Early recognition and adrenalectomy will probably lead to improved patient survival.

EP_A017**A RARE CASE OF ANTIPHOSPHOLIPID SYNDROME PRESENTING AS ADRENAL CRISIS AND BILATERAL ADRENAL HEMORRHAGE**

<https://doi.org/10.15605/jafes.039.S1.028>

Qingci Goh, Wan Mohd Hafez Wan Hamzah, Norlaila Mustafa, Norasyikin Wahab

Hospital Canselor Tuanku Muhriz UKM (HCTM), Malaysia

INTRODUCTION/BACKGROUND

Bilateral adrenal haemorrhage is a rare condition with potentially life-threatening consequences due to adrenal crisis. It can be the first presentation of antiphospholipid syndrome (APLS). We report a rare case of APLS presenting as an adrenal crisis and bilateral adrenal haemorrhage.

CASE

A 37-year-old male with a history of a motor vehicle accident 2 weeks ago presented with abdominal pain for 1 week, accompanied by nausea, vomiting, and lethargy. During the accident, where his motorbike skidded, he sustained an open fracture of the proximal phalanx of his little finger. Wound debridement was performed and a K-Wire was inserted. Clinical examination showed left-hand cellulitis, tenderness over the bilateral flank, and slightly low blood pressure (90/46 mmHg). Blood investigations revealed thrombocytopenia, hyponatremia, prolonged APTT that did not correct in the coagulation mixing study, and a low cortisol level (67 nmol/L). Abdominal CT scan revealed bilateral adrenal haemorrhage without any other solid organ and bowel injury. He was treated for acute adrenal crisis and subsequently started on hydrocortisone and fludrocortisone, resulting in significant clinical improvement. However, the left-hand cellulitis triggered digital artery thrombosis, leading to left-hand gangrene. Despite anticoagulation and ilioprost administration, he ended up with a left transradial amputation. Antiphospholipid syndrome was suspected in this patient based on the bilateral adrenal haemorrhage, digital artery thrombosis and abnormal coagulation profile. A full autoimmune work-up confirmed the presence of anticardiolipin, lupus anticoagulant, and anti-beta-2 glycoprotein. The anti-nuclear antibody was also positive 1:320, with a speckled pattern. C3, C4, anti-double