stranded DNA and extractable nuclear antibodies were otherwise negative. He was discharged well on warfarin, hydrocortisone and fludrocortisone.

CONCLUSION

Adrenal insufficiency is a rare manifestation of APLS. This case highlights the importance of maintaining a high index of suspicion for APLS in patients presenting with bilateral adrenal haemorrhage and thrombotic events. Failure to diagnose or treat this condition promptly may lead to significant morbidity and mortality.

EP_A018

CLINICAL CONUNDRUM OF STEROID RESISTANT TESTICULAR ADRENAL REST TUMOURS (TARTS): CASE SERIES

https://doi.org/10.15605/jafes.039.S1.029

Mohd Fyzal Bahrudin, Abdul Rahim Mohd Othman, Noor Rafhati Adyani Abdullah
Endocrine Unit, Hospital Sultanah Bahiyah, Kedah, Malaysia

INTRODUCTION/BACKGROUND

Testicular adrenal rest tumours (TARTs) are benign intratesticular masses that occur in male patients with congenital adrenal hyperplasia (CAH), with more than 90% of cases caused by a deficiency of 21-α-hydroxylase. The presence of TART is an important complication leading to irreversible gonadal dysfunction and infertility. TARTs appear to be associated with poor hormonal control with concomitant elevated ACTH. The current mainstay of therapy is intensified glucocorticoid therapy. We describe two challenging cases of steroid-resistant TARTs.

CASE

Case 1 is a 25-year-old male with classical CAH diagnosed at 7 weeks of life. At age 12, he was diagnosed with TARTs. With a 17-OHP elevated to >60.6 nmol/L, his glucocorticoid dose was intensified with dexamethasone 0.5 mg ON for 5 years together with fludrocortisone. The latest 17-OHP was 436.7 nmol/L (1-10), ACTH 80.6 pmol/L (1.6-13.9), Direct renin >550 mU/L (5.3-99.1) and testosterone 21.64 nmol/L (0.58 - 31.28). Testicular ultrasonography demonstrated unresolved TARTs 1.0 x 1.1 x 1.4 cm (right) and 1.3 x 1.2 x 2.3 cm (left). Dexamethasone was subsequently switched to prednisolone 2.5 mg BD together with a referral to the urology team for consideration of testicular-sparing surgery or semen cryopreservation.

Case 2 is a 20-year-old male with classical CAH diagnosed as a one-month-old infant and diagnosed with TARTs at age 13 years. Apart from fludrocortisone, his glucocorticoid therapy was intensified with dexamethasone 2.5 mg ON (tapering dose) for 5 years with his latest 17-OHP 116.4 nmol/L, testosterone 23.06 nmol/L, ACTH 128.9 pmol/L and Renin 47.2 mU/L. Testicular ultrasonography revealed increased size of TARTs 2.0 x 1.9 x 3.3 cm (right) and 1.7 x 1.5 x 2.9 cm (left). His case was complicated by exogenous Cushing syndrome secondary to dexamethasone. Dexamethasone was switched to prednisolone 2.5 mg BD with a referral to the urology team for co-management.

CONCLUSION

Intensified glucocorticoid therapy has led to tumour size reduction and improved testicular function in only a subset of patients. However, this approach potentially leads to serious side effects. Further research should aim to identify pharmacological alternatives that can effectively prevent the development of TARTs and treat existing TARTs to improve fertility outcomes.

EP_A019

MANAGING STEROIDS IN A FEMALE WITH NCCAH COMPLICATED WITH COVID-19 IN PREGNANCY

https://doi.org/10.15605/jafes.039.S1.030

Norisha Nandini
Penang General Hospital, Malaysia

INTRODUCTION

We report a case of a female with Non-Classical Congenital Adrenal Hyperplasia (NCCAH) which was complicated by COVID-19 during her pregnancy. This is the second such case to be reported so far; the first being in Italy in 2020. The role of steroid management throughout her pregnancy is highlighted.

CASE

This is a case of a 28-year-old female diagnosed with NCCAH since age 21 and maintained on oral prednisolone 7.5 mg OD pre-pregnancy. At the 20th week of gestation, she was switched to oral hydrocortisone 10 mg BD as she developed mild Cushingoid features. Consequently, she presented at 30 weeks of gestation to the ED with symptoms of breathlessness, dehydration and compensated shock and was diagnosed with COVID-19 Category 5. She received fluid boluses and low-dose inotrope and was placed under ICU care due to worsening hypoxia. She was initiated on maintenance fluids and Remdesivir for COVID-19 and intravenous hydrocortisone 100 mg bolus with maintenance of 50 mg QID to prevent an adrenal crisis. In the ICU, her condition stabilized with inotropic and oxygen support weaned off. Her intravenous hydrocortisone was maintained at 50 mg QID. Throughout her stay, no foetal compromise was observed. She was discharged

well on day 5 of illness with a supraphysiological dose of hydrocortisone 20 mg/10 mg. Further steroid adjustments were planned at the outpatient clinic on follow-up.

CONCLUSION

Managing acute COVID-19 infection during late pregnancy, especially with an underlying adrenal condition, poses significant challenges due to therapeutic uncertainties. A multidisciplinary team and close ICU monitoring were vital for ensuring a successful outcome for both mother and child. Steroid management in NCCAH patients, particularly during pregnancy, is critical. Early treatment with appropriate antivirals and steroids can mitigate illness progression and severity, reducing morbidity and mortality associated with COVID-19.

EP_A020

SPECTRUM OF ADRENAL INFECTIONS – FROM SOFT TO HARD: CASES OF ADRENAL ABSCESS AND CALCIFICATION

https://doi.org/10.15605/jafes.039.S1.031

Muhammad Habib Nasution Zulpan Nasution,[1] Abdullah Shamshir Abd Mokti,[1] Khaulah Karimah Azni,[2] Nor Fauziah Muhamad Handar,[2] Masni Mohamad[1]

[1]*Endocrine Unit, Institut Endokrin, Hospital Putrajaya, Malaysia*
[2]*Radiology Department, Hospital Putrajaya, Malaysia*

INTRODUCTION

Adrenal infections can present in a spectrum from adrenalitis to abscess and calcification. It may either affect the adrenals unilaterally or bilaterally. We present two cases of adrenal infections: a unilateral adrenal abscess following ERCP and a bilateral adrenal calcification due to Histoplasmosis.

CASE

The first case is a 54-year-old male, with a history of alcoholism and diabetes, who presented with abdominal pain. Initial CT-abdomen showed chronic pancreatitis with a right adrenal lesion measuring 4.8 cm. ERCP done showed pancreatitis with infected pseudocyst. However, he presented back 2 months later with fever, abdominal pain and constitutional symptoms. CT-abdomen revealed a small liver abscess and a right adrenal abscess measuring 9 cm with an average HU of 61. He was treated with antibiotics for 8 weeks and underwent abscess drainage. The hormonal work-up was within normal range with adrenal insufficiency ruled out. All bacterial, tuberculous and fungal work-up were negative. A repeat CT of the abdomen after 4 months showed a residual adrenal abscess measuring 4.8 cm and a right adrenalectomy was scheduled.

The second case is a 45-year-old male, a smoker with hypertension, who presented with constitutional symptoms, skin darkening, fever and features of adrenal crisis. Steroids and antibiotics were started. CT of the abdomen showed enlarged and calcified bilateral adrenals measuring 5 cm. Primary adrenal insufficiency was confirmed biochemically. CT-guided biopsy showed fibrous and necrotic tissue and PAS, GMS and Ziehl-Nielsen stains were negative. Adrenal tissue PCR was positive for *Histoplama capsulatum* and a diagnosis of adrenal histoplasmosis was made. The patient underwent a two-week treatment with Amphotericin B and continued with oral Itraconazole-planned for 1 year. He showed improved general health and increased weight. Repeat CT of the adrenals after 3 months showed no significant change.

CONCLUSION

Adrenal infections have various presentations and can affect both immunocompetent and immunocompromised patients. Treatment of the underlying organism with antimicrobial therapies and steroid replacement is key to avoiding significant morbidity and mortality.

EP_A021

CARNEY COMPLEX: THE CASE OF A RARE ENDOCRINE SYNDROME

https://doi.org/10.15605/jafes.039.S1.032

Wei Wei Ng and Shanty Velaiutham
Hospital Pulau Pinang, Malaysia

INTRODUCTION/BACKGROUND

Carney complex (CNC) is a rare multiple endocrine neoplasia characterized by spotty skin pigmentation, myxomas and endocrine overactivity. We report a case of a young female with multiple typical manifestations of CNC over the past 12 years, including bilateral primary pigmented nodular adrenocortical disease, bilateral breast ductal adenoma, cardiac myxoma and thyroid nodule.

CASE

This female first presented at age 28 for secondary amenorrhea, weight gain and uncontrolled hypertension. She had pigmentation over her lips and features of Cushing syndrome, such as facial plethora, purple striae and proximal myopathy. She had a right breast fibroadenoma at age 17 and young-onset hypertension at age 25 on past medical history. There were no familial diseases noted. The initial work-up was suggestive of ACTH-independent Cushing syndrome. The adrenal CT showed a 2.3 x 1.2 cm right adrenal adenoma and a normal left adrenal gland. She underwent a right adrenalectomy with a tissue histopathology suggestive of pigmented nodular adrenal-