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

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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

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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-