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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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

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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-

cortical hyperplasia. She was then subjected to a left adrenalectomy as she remained hypercortisolemic after the initial surgery. She went into remission after the bilateral adrenalectomy. At age 29, a surveillance scan showed a left solitary thyroid nodule and multiple bilateral breast lumps with a tissue biopsy suggestive of ductal adenoma. Excision of atrial myxoma was done at age 33 following the detection of cardiac myxoma from an echocardiogram when she complained of palpitations. Unfortunately, she was diagnosed with left breast carcinoma at age 38, requiring a left mastectomy. A recent tissue biopsy of a right breast lump showed intraductal papilloma.

CONCLUSION

The diagnosis of CNC is often delayed owing to its rarity and complexity. Clinical and biochemical screening are the gold standard for the diagnosis of CNC. This patient requires a lifelong follow-up for the recurrence of cardiac myxoma and other associated manifestations of CNC.

EP_A022

ASSESSING THE POTENTIAL OF DULAGLUTIDE IN DE-INTENSIFICATION OF BACKGROUND ORAL GLUCOSE-LOWERING DRUG (OGLD) AND INSULIN THERAPY IN MALAYSIANS WITH TYPE 2 DIABETES MELLITUS

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Zanariah Hussein,[1] Foo Siew Hui,[2] Low Yen Nee,[2] Noor Lita Adam[3]
[1]*Hospital Putrajaya, Malaysia*
[2]*Hospital Selayang, Malaysia*
[3]*Hospital Tuanku Ja'afar Seremban, Malaysia*

INTRODUCTION/BACKGROUND

Many Malaysian T2DM patients are on multiple glucose-lowering drugs (i.e. ≥2 OGLDs ± insulin). Dulaglutide, a once-weekly GLP-1RA, has been shown to significantly lower HbA1c levels in T2DM patients. However, there is a lack of real-world data to show the reduction of background treatment after patients start dulaglutide.

METHODOLOGY

This study aims to assess the potential of dulaglutide in de-intensifying background OGLDs and total daily dose (TDD) of insulin in T2DM patients in a real-world clinical setting. This is a retrospective study of 45 T2DM patients who initiated dulaglutide in 3 Ministry of Health (MOH) hospital-based endocrinologist-led diabetes clinics conducted in Hospital Putrajaya, Hospital Selayang and Hospital Tuanku Ja'afar. The primary outcome was a change in OGLDs and insulin therapy at 6 and 12 months of dulaglutide therapy.

RESULTS

At baseline, 91% (n = 41) of patients were on ≥2 OGLDs, while 82% (n = 37) were on insulin therapy with a mean baseline TDD of 64 units. After 6 months of dulaglutide therapy, 18% (n = 8) of the patients had at least one of their OGLD doses reduced, 38% (n = 17) of patients were able to stop one OGLD, and 4% (n = 2) of patients were even able to stop two OGLDs. At 12 months, 22% (n = 10) of patients had at least one of their OGLD doses reduced, 40% (n = 18) of patients were able to stop one OGLD, 9% (n = 4) of patients were able to stop two OGLDs from baseline, 56% (n = 25) of insulin-treated patients on dulaglutide had a TDD reduction of 23 units (-36%) at 6 months and 19 units (-30%) at 12 months.

CONCLUSION

Dulaglutide, with its once-weekly dosing, can effectively simplify patients' diabetes treatment by allowing the reduction of OGLDs and TDD of insulin. This de-intensification of medication could reduce the medication burden on patients and lessen the total drug cost for T2DM patients.

EP_A023

ASSESSING THE REAL-WORLD EFFICACY OF DULAGLUTIDE IN MALAYSIAN MOH PATIENTS WITH TYPE 2 DIABETES MELLITUS

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Zanariah Hussein,[1] Foo Siew Hui,[2] Low Yen Nee,[2] Subashini Rajoo,[3] Noor Lita Adam[4]
[1]*Hospital Putrajaya, Malaysia*
[2]*Hospital Selayan, Malaysia*
[3]*Hospital Kuala Lumpur, Malaysia*
[4]*Hospital Tuanku Ja'afar Seremban, Malaysia*

INTRODUCTION/BACKGROUND

An estimated 70% of Type 2 Diabetes Mellitus (T2DM) patients treated in Ministry of Health (MOH) hospital-based diabetes clinics are still unable to achieve HbA1c targets despite combination glucose-lowering drugs. Moreover, more than 80% of these patients are overweight or obese. In Malaysia, dulaglutide, a once-weekly GLP-1RA, was approved in 2018 for use in patients with T2DM. Accessibility to GLP-1RA therapy is much limited in MOH hospitals.

METHODOLOGY

This study aims to assess the glycaemic and weight-lowering efficacy of dulaglutide at 6 and 12 months in T2DM patients treated in a real-world clinical setting. We conducted a retrospective study of 69 T2DM patients who initiated dulaglutide in 4 MOH endocrinologist-led