

The patient's initial presentation resulted in treatment for HHS. However, subsequent investigation uncovered the presence of CDI, which has been obscured by the diabetes mellitus. In younger patients who present with CDI, hypophysitis is typically the cause, reported to occur in up to 50% of patients. Treatment decisions should be guided by clinical evaluation and imaging, as patients with pituitary dysfunction but no mass effect and likely lymphocytic hypophysitis may be managed with medical therapy and close monitoring.

CONCLUSION

Clinicians should have a high index of suspicion of CDI among patients manifesting with possible HHS who do not improve despite adequate control of hyperglycemia.

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LOCAL EXPERIENCE WITH TARGETED RADIONUCLIDE THERAPY IN MALIGNANT PHEOCHROMOCYTOMA AND PARAGANGLIOMA

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INTRODUCTION/BACKGROUND

Targeted radionuclide therapy (TRT) is a promising therapeutic option for patients with malignant pheochromocytoma and paraganglioma (PPGL) but it is not widely available locally.

METHODOLOGY

We conducted a retrospective cohort study of patients with malignant PPGL from 2000 to 2023.

RESULTS

We report the experience of TRT among 15 patients with malignant PPGL (26% pheochromocytoma, 60% paraganglioma, 13% combined) under follow-up in a tertiary endocrine referral centre from 2000 to 2023. There was equal gender distribution with a median of 41 years at diagnosis. They had elevated 24-hr urine normetanephrine (100%), 3-methoxytyramine (53.3%) or urine metanephrine (27%). A total of 11 patients had multiple operations with residual primary and metastatic tumours, 2 had recurrence after initial complete resection and another 2 had unresectable primary tumour. The choice of TRT was based on avidity in functional imaging and consensus from multidisciplinary meetings. Ten patients had peptide receptor radionuclide

therapy (PRRT) and 5 patients had iodine 131-meto-iodobenzyl-guanidine (MIBG). A 177Lu-DOTATATE was used for PRRT with a mean dose of 201.23 mCi (7.47GBq/cycle). There was a reduction in both urine normetanephrine (93%) and requirements for antihypertensive medications (80%) after TRT. Using Response Evaluation Criteria in Solid Tumours (RECIST), disease control rate was 40% after 4 cycles of PRRT (n = 4) or MIBG (n = 2). Among patients with disease progression, a subsequent plan was additional TRT cycles up to a total of 6 cycles (n=3), chemotherapy (n=2), or watchful waiting (n = 1). One patient with SDHB mutation, who had multimodal therapies including multiple surgeries, chemoembolization, PRRT and chemotherapy with temozolamide, succumbed to her progressive disease 20 years after diagnosis. With regards to toxicities using Common Terminology Criteria for Adverse Events (CTCAE), there were grade I hypotension post PRRT (n = 1), grade I leucopenia (n = 1) and grade I-II renal impairment (n = 3).

CONCLUSION

TRT is well tolerated and worthy of extensive research to explore full potential in the treatment of advanced or non-resectable PPGL.

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HYPERNATREMIC DEHYDRATION AND ACUTE MASSIVE PULMONARY EMBOLISM: COINCIDENCE OR TRUE RISK FACTOR

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INTRODUCTION/BACKGROUND

Diabetes Insipidus (DI) is a common complication after extensive transcranial surgery for craniopharyngioma. DI mainly causes impairment of the sense of thirst and vasopressin (AVP) secretion. This puts the patient at risk of severe dehydration and hypernatremia. Venous thromboembolism is one of the potentially fatal complications which can occur due to severe dehydration and hypernatremia.

CASE

We report a 22-year-old Malay male, college student, with underlying panhypopituitarism and chronic diabetes insipidus post-removal of craniopharyngioma at the age of 8 years with acute massive bilateral pulmonary embolism (PE). He presented to our Emergency Department with acute onset of shortness of breath and chest pain for a day. Although feeling unwell, he was still able to ambulate and attend school.