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.

EP_A113

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-iodo-benzyl-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.

EP_A114

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.

One day PTA, due to poor oral intake, he did not take his replacement therapy tablets: hydrocortisone, L- thyroxine and desmopressin. Upon arrival, he was noted to be hypotensive with a blood pressure of 70/50 mmHg and a heart rate of 110 bpm. His O_2 saturation at room air was 80%. He appeared to be dehydrated with dry tongue. His GCS on arrival was E3V5M6. The abnormalities of his blood investigations were urea of 6.4 mmol/L, creatinine of 292 umol/L and sodium of 150 mmol/L. ECG showed sinus tachycardia with features of acute right ventricular strain pattern with S1Q3T3. Bedside echocardiogram showed features of acute PE with a dilated right ventricle and the presence of McConnell's' sign. A CTPA showed evidence of bilateral main pulmonary artery saddle embolism with RV thrombus. He was then referred to the National Heart Institute (IJN) for EKOS and catheter-guided thrombolysis where he was successfully treated.

CONCLUSION

The case illustrates the importance of severe hypernatremia and dehydration as predisposing factors for venous thromboembolism.

EP_A115

CENTRAL SEROUS CHORIORETINOPATHY (CSCR): AN UNCOMMON MANIFESTATION OF CUSHING'S SYNDROME

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INTRODUCTION/BACKGROUND

Central serous chorioretinopathy (CSCR) has been identified as a rare clinical presentation linked to elevated cortisol levels, both in overt Cushing's syndrome and in subclinical cases of hypercortisolism.

We report a case of Cushing's syndrome with uncommon presentation.

CASE

A 42- year-old female with pre-existing diabetes mellitus, hypertension and class III obesity came to the ophthalmology clinic for blurring of vision. Upon presentation, her blood pressure was 198/100 mm Hg and her blood glucose was 20 mmol/L. She was therefore admitted due to hypertensive emergency and uncontrolled diabetes mellitus. As the patient exhibited stigmata of Cushing's syndrome, further investigations revealed unsuppressed serum cortisol level after an overnight low dose (1mg) dexamethasone suppression test (ODST), elevated 24- hour urinary cortisol 1912 nmol/24hours, elevated plasma adrenocorticotrophic hormone (ACTH): 14.8 pmol/L, elevated serum dehydroepiandrosterone sulphate (DHEAS): >27 umol/L and elevated serum testosterone: 5.59 nmol/L. Eye assessment with fundoscopy and optical coherence tomography was suggestive of CSCR. Magnetic resonance imaging (MRI) revealed a left lateral pituitary microadenoma. She was treated with steroid-lowering therapy and scheduled for eye laser treatment by a retina surgeon.

CONCLUSION

When CSCR is diagnosed, it is important to consider a work-up for Cushing's syndrome due to the association between high cortisol levels and CSCR. Laser therapy is one of the treatment options for CSCR while addressing the underlying cause.

EP_A116

POSTERIOR STALK INTERRUPTION SYNDROME: A PECULIAR PRESENTATION OF AN UNCOMMON DISEASE

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INTRODUCTION/BACKGROUND

Posterior stalk interruption syndrome (PSIS) is a rare anatomical congenital anomaly that is characterised by a radiological triad of a thin or interrupted pituitary stalk, an absent or ectopic posterior lobe and anterior lobe hypoplasia or aplasia. Patients typically manifest with anterior pituitary hormone deficiencies at varying ages of presentation ranging from infancy to early adulthood.

CASE

We present a 15-year-old female who was initially referred for thrombocytopenia and hepatosplenomegaly. Further evaluation revealed that she also had short stature and primary amenorrhea. Antenatal history was unremarkable with no reported obstetrics complications. Clinical examination is consistent with Tanner Stage 1 with a height measuring below the third centile for her age.