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.