RESULTS
Responses were obtained from 33 endocrinologists. The majority (81%) used reference limits given rather than a fixed cut-off of 700 m IU/L and 70% used a sex-specific range. More than half (69%) favoured that the laboratory should screen for macroprolactin in all samples with high prolactin. On report format, 61.5% preferred the use of post-PEG monomeric reference ranges and 100% required the laboratory to indicate the presence of macroprolactin.

CONCLUSION
The laboratory working group will consider the responses from endocrinologists in preparing the consensus recommendations on reporting macroprolactin and the reference intervals.

EP_A122

UNVEILING PITUITARY PARADOX: OCTREOTIDE LONG-ACTING RELEASE (LAR) INDUCED APOPLEXY IN POST-OPERATIVE RESIDUAL MACROADENOMA

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INTRODUCTION/BACKGROUND
The development of a somatostatin analogue (SSA) has revolutionized the treatment of acromegaly. Octreotide LAR is a long-acting release formulation of SSA, often used as an alternative when surgery is not possible in patients with acromegaly or as an adjuvant therapy in post-operative patients with residual pituitary adenoma. Pituitary apoplexy, characterized by infarction or bleeding of the pituitary gland, is a rare condition.

CASE
An 18-year-old male with a clinical and biochemical diagnosis of acromegaly underwent transsphenoidal surgery in November 2021 with incomplete tumour resection, complicated by pituitary apoplexy after administration of octreotide LAR.

Post-operatively, he had residual pituitary adenoma with optic chiasm compression and persistent elevations of insulin-like growth factor 1 (IGF-1) (1.7x > upper limit of normal) and growth hormone (GH) level (10x > normal limit). After extensive discussion, the patient was started on medical treatment, cabergoline 0.5 mg twice weekly, but failed to achieve biochemical control despite continued use for 9 months. Subsequently, octreotide LAR 30 mg monthly was started, aiming to achieve better biochemical control and shrink the tumour size while awaiting stereotactic radiosurgery.

Unfortunately, 6 weeks after the first injection of octreotide LAR, he developed a sudden severe headache and visual disturbance, presenting clinically with bitemporal hemianopia, subsequently diagnosed with pituitary apoplexy on cranial MRI. Octreotide LAR was discontinued. Patient underwent repeated transsphenoidal surgery, which was uncomplicated, albeit with pre-existing central hypothyroidism and hypocortisolism.

CONCLUSION
Pituitary apoplexy is one of the rare complications of SSA. However, clinicians need to maintain a high level of suspicion for this complication if the patient presents with sudden headache with or without neuro-ophthalmic signs after receiving SSA, given its significant morbidity and potential fatality.

EP_A123

A RARE CASE OF ECTOPIC GIANT PROLACTINOMA MIMICKING CLIVAL CHORDOMA

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INTRODUCTION/BACKGROUND
Ectopic pituitary adenomas are extremely rare tumours which develop outside the sella turcica. The most common locations are the sphenoid sinus, clivus, suprasellar space, nasopharynx and cavernous sinus. Due to their rarity, these tumours are frequently misdiagnosed as other skull lesions such as chordoma, chondrosarcoma, meningioma or astrocytoma. We present a case of ectopic giant prolactinoma mimicking as clival chordoma.

CASE
A 38-year-old nulliparous female presented with oligomenorrhoea since the age of 20 and secondary amenorrhea at the age of 38 associated with galactorrhoea. Otherwise, she denied headache, symptoms of increased ICP or blurring of vision. There were no other symptoms to suggest pituitary hyper- or hypofunction. Her initial hormonal work-up showed hyperprolactinemia (>8000 ng/mL) with hypogonadotropic hypogonadism. MRI of the brain was signed out as clival chordoma measuring 2.3 x 3.6 x 4.1 cm displacing the pituitary gland and

infundibulum. She underwent a biopsy of the lesion and the HPE confirmed pituitary lactotroph adenoma. She was started on cabergoline and her prolactin levels reduced significantly.

CONCLUSION

Ectopic pituitary adenomas occurring in the clivus are very rare. The main differential diagnosis to be considered is chordoma. Other than radiological imaging, additional endocrinological workup may be useful as well to establish the diagnosis. Biopsy of the lesion should be performed whenever the diagnosis is in doubt, as medical treatment with cabergoline often yields favourable outcomes in cases of ectopic prolactinoma which leads to a reduction in tumour size and prolactin level.

EP_A124

BATTLING THE UNCOMMON: A CASE REPORT ON ECTOPIC ACTH SYNDROME FROM PANCREATIC NEUROENDOCRINE TUMOUR WITH LIVER METASTASES

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INTRODUCTION/BACKGROUND

Pancreatic neuroendocrine tumours (pNETs) are rare malignancies originating from the islet cells of the pancreas, comprising only 1%-2% of pancreatic tumours. Among functional pNETs, insulinoma and gastrinoma are the most common, while ACTH-secreting tumours are very rare. Ectopic ACTH syndrome (EAS) caused by pNETs is particularly aggressive, often presenting with metastatic disease, primarily to the liver.

CASE

We present a case of a 25-year-old male who presented acutely with upper gastrointestinal bleeding. Clinical examination revealed features consistent with Cushing's syndrome, and further investigations identified an ACTH-secreting neuroendocrine pancreatic tumour with liver metastasis. The disease was complicated by extensive inferior vena cava thrombosis and concurrent thrombocytopenia, necessitating the insertion of an IVC filter. The patient underwent distal pancreatectomy, splenectomy and wedge resection of the stomach. Hypercortisolism was controlled with steroidogenesis inhibitors, including metyrapone, ketoconazole and the newer agent, osilodrostat. Post-operatively, he underwent a Ga-68 Dotatate scan which showed evidence of somatostatin-receptor avid metastatic disease in the liver and he was started on a somatostatin analogue.

pNETs typically localized in the head and body of the pancreas with an average size of 4.6 cm (2.5–7 cm) and the source of ectopic ACTH secretion may remain hidden for several years. In our case, the pancreatic lesion measured 11 cm which was larger than the average size. Despite the challenges posed by the tumour's size and complications such as IVC thrombosis, the multidisciplinary approach involving endocrinologists, surgeons and radiologists allowed for effective management. Surgical intervention was complemented by medical therapies such as metyrapone, ketoconazole, lanreotide and eventually osilodrostat to control hypercortisolism. Osilodrostat demonstrated good efficacy in reducing cortisol levels in our patient.

CONCLUSION

This case highlights the aggressive nature of EAS-pNETs and the challenges in the management, particularly when presenting with advanced metastatic disease. The use of osilodrostat represents a promising advancement in the management of EAS.

EP_A125

CUSHING'S DISEASE AND THROMBOSIS: A CLINICAL PERSPECTIVE

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INTRODUCTION/BACKGROUND

Cushing's disease is the most common cause of endogenous Cushing's syndrome, which is caused by an adrenocorticotropin (ACTH) -secreting pituitary tumour. It poses a myriad of complications due to the state of excess cortisol levels, including thrombosis. It is interesting that thrombotic risk due to the hypercoagulable state in Cushing's disease is higher after pituitary surgery when cortisol levels are diminished.

We present a case of a female with recurrent Cushing's disease who developed extensive thrombotic complications post-successful transsphenoidal surgery (TSS) to highlight the importance of anticoagulation therapy in mitigating the risk of thrombosis.