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.

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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.