CONCLUSION
Glucocorticoid replacement may precipitate diabetes insipidus in the setting of adrenal insufficiency. Low cortisol levels will stimulate the release of antidiuretic hormone and increase water reabsorption in the kidney. This effect can be inhibited by exogenous steroids which may then rapidly unmask or worsen central DI.

EP_A129

SPONTANEOUS RHINORRHOEA SECONDARY TO NORMAL-PRESSURE PARTIAL EMPTY SELLA SYNDROME

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INTRODUCTION/BACKGROUND
Empty sella syndrome is a disorder where the sella turcica is partially or completely filled with cerebrospinal fluid (CSF), resulting in compression and displacement of the pituitary gland. Empty sella is frequently coupled with increased intracranial pressure which causes spontaneous CSF leaks. Some people may experience normal-pressure CSF leaks, which can be due to idiopathic or congenital abnormalities. Both high-pressure and normal-pressure CSF leaks are commonly seen in middle-aged obese women.

CASE
A 43-year-old obese female with a BMI of 34.9 kg/m^2 presented with a two-day history of headache and clear nasal discharge persisting for a month. She reported no weakness or visual disturbances. Upon examination, her blood pressure measured 142/70 mmHg, her Glasgow Coma Scale was intact, and her neurological assessment revealed no abnormalities. The ophthalmological evaluation showed no signs of papilledema. Subsequently, a lumbar puncture was performed, indicating a normal opening pressure of 12 cm H_2O. Brain MRI revealed a partially empty sella, while CT imaging of the paranasal sinuses aimed to identify the cause of the CSF leak, was suggestive of cribriform plate dehiscence. Evaluation of anterior pituitary hormones yielded results within normal ranges. The case was then referred to a neurosurgical team for further evaluation and potential surgical intervention.

The occurrence of a spontaneous cCSF leak frequently coincides with the radiographic discovery of an empty sella. Its clinical manifestation can vary, encompassing symptoms such as headaches, rhinorrhoea, visual impairments, and hormonal imbalances. Assessing pituitary hormone levels is crucial, with hormonal supplementation warranted when deficiencies are identified. Surgical intervention is essential in managing CSF leaks to mitigate potential complications like meningitis and brain abscesses.

CONCLUSION
A CSF leak is important to be recognised at the initial presentation, as surgical intervention is required to reduce the complication of infections.

EP_A130

IMMUNOLOGICAL CROSSFIRE: ENDOCRINOPATHIES IN THE AGE OF IMMUNE CHECKPOINT INHIBITORS

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INTRODUCTION/BACKGROUND
Pembrolizumab is a PD1 receptor inhibitor which is a type of immune checkpoint inhibitor (ICI) for cancer therapy. Immune-related adverse events (IRAE) are more commonly encountered with increased use.

CASE
A 52-year-old male with recurrent renal cell carcinoma developed endocrinopathies following pembrolizumab. After failure of first-line treatment, he received the first dose of pembrolizumab in November 2022.

Six weeks later, he was symptomatic of hyperthyroidism with corresponding biochemistry of TSH <0.01 m IU/L (reference interval 0.55 – 4.8), free T4 of 28.8 pmol/L (reference interval 11.5 – 22.7) and free T3 of 9.7 pmol/L (reference interval 3.5 – 5.5). Following treatment with low dose and tapering carbimazole for eight weeks, he quickly became hypothyroid. Biochemistry showed TSH of 87.3 m IU/L, fT4 of 2.9 pmol/L and fT3 of 1.3 pmol/L. Anti-thyroid peroxidase and anti-thyroglobulin antibodies were negative. Carbimazole was discontinued and levothyroxine 50 mcg daily were commenced. Pembrolizumab was continued.

Four months later, he presented with lethargy and postural symptoms. A random serum cortisol level was undetectable at <14 nmol/L (reference interval 145 – 619) and ACTH level was inappropriately normal at 6 pg/ml (reference interval 0 – 46). He denied any polyuria, polydipsia, or