

goitre and fine tremors. Ultrasonography of the neck was done with the impression of subacute thyroiditis. These findings fulfilled the Japanese Thyroid Association (JTA) criteria for subacute thyroiditis. A Tc-99m Pertechnetate also confirmed the findings of thyroiditis. The patient was commenced on oral prednisolone 25 mg daily (0.5 kg/BW/day) with a tapering regimen over 2 weeks. He also received oral celecoxib 200 mg daily for 5 days and oral propranolol 20 mg daily. He gradually improved upon the 2-week clinic review and all medications were discontinued. Upon re-evaluation at 3 months, thyroid function tests normalized, and the thyroid ultrasound displayed the resolution of thyroiditis characteristics, accompanied by amelioration of all symptoms.

CONCLUSION

Subacute thyroiditis is an inflammatory thyroid condition characterized distinctly by painful enlargement of the thyroid. Transient hyperthyroidism is a hallmark of subacute thyroiditis where the inflamed thyroid gland releases unregulated excessive thyroid hormone into the bloodstream, leading to thyrotoxicosis symptoms. In this case, we treated our patient with a short-term 2-week combination of steroids + NSAIDs which showed non-inferior efficacy to the traditional long-term steroids (4-8 weeks).

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HUMAN CHORIONIC GONADOTROPHIN (HCG) AND HYPERTHYROIDISM: RARE BUT PARALLEL CAUSE

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INTRODUCTION/BACKGROUND

Choriocarcinoma is a hCG-producing malignancy, with the beta subunit being structurally similar to TSH, allowing it to bind to TSH receptors on thyroid follicular cells and at high levels to elicit biochemical hyperthyroidism.

CASE

We report a case of choriocarcinoma-induced hyperthyroidism in a 29-year-old female. She was initially admitted for breathing difficulties and was found to have a posterior mediastinal mass, which was later histologically confirmed to be choriocarcinoma with B-HCG levels of 466,511 that peaked to 825,316. Thyroid functions measured shows TSH of 32.07, T4 of 0.009 with negative thyroid antibodies (Anti Thyroid Peroxidase <9, Anti Thyroglobulin 11.9). Ultrasonography showed bilateral thyroid nodules, ACTR TR3 (1.5 cm), however, staging CT did not pick

up an overt goitre. Patient was started on carbimazole and planned for chemotherapy with thyroid function monitoring.

CONCLUSION

TSH and Beta-HCG are highly homologous and can cross-link to produce elevated thyroid hormone levels. The prevalence of hyperthyroidism in choriocarcinoma is not known; however, prolonged exposure to high HCG levels is required for it to occur. It is generally accepted that 25,000 IU/L of HCG is equivalent to 1 mU/L of TSH activity, with suggestions to measure thyroid function in patients with HCG >50,000 IU/L. Patients with symptomatic hyperthyroidism are treated with antithyroid drugs and the primary choriocarcinoma is treated with chemotherapy. Reduction or normalisation of the beta hCG levels quickly induces euthyroidism. Beta-HCG-induced hyperthyroidism is rare; however, with high levels found in choriocarcinoma, suspicion of concurrent hyperthyroidism should be raised. Patients with HCG-secreting tumours should be evaluated for hyperthyroidism and may benefit from treatment until the underlying cause is treated.

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DOUBLE WHAMMY: CIRCULATORY COLLAPSE AND LIVER DYSFUNCTION IN THYROID STORM

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INTRODUCTION/BACKGROUND

Liver dysfunction is not an uncommon association in patients presenting with thyroid storm and could limit the treatment armamentarium. Circulatory collapse precipitated by the use of long-acting non-cardioselective beta-blockers in certain groups of patients can complicate the course of the disease.

CASE

We report three cases of thyroid storm with circulatory collapse and ischemic hepatitis complicating the use of beta-blockers and thionamides. All were females in their 40's. Two presented with rapid atrial fibrillation (ventricular rate 158- 196 per minute) and biventricular failure, and one with acute pulmonary oedema. All developed hypotension required inotropic support; two after beta-blocker and one after intubation. Their free T4 was 53.6 pmol/L to 74.3 pmol/L, Burch-Wartofsky scores were 60-95. All received ventilatory support and were treated for