

He was started on a thionamide with close monitoring of blood counts. However, the thionamide was withheld in view of his reducing absolute neutrophil count. He was then treated with steroids, lithium and cholestyramine with no improvement in his thyroid function tests.

Hence, he was eventually given radioactive iodine. Graves' disease with myelodysplastic syndrome proves to be challenging for endocrinologists to treat. The probable underlying pathophysiology is that high blood levels of thyroid hormones can be toxic to bone marrow cells leading to an increase in functional activity of reticuloendothelial cells, causing insufficient hematopoietic cells. In one study, free T3 and T4 were noted to be higher with lower TSH in patients with myelodysplastic syndrome. In view of the difficulty of treating hyperthyroidism with anti-thyroid drugs, our patient was treated with radioiodine ablation.

CONCLUSION

In conclusion, managing Graves' disease in individuals with myelodysplastic syndrome requires detailed evaluation and monitoring.

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MANAGING THYROTOXIC ATRIAL FIBRILLATION IN A BIOCHEMICALLY EUTHYROID PATIENT

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Hazwani I, Ng Ooi Chuan, Raja Abdul Wafy RMR
Department of Medicine, Faculty of Medicine and Health Sciences, University Putra Malaysia.

INTRODUCTION/BACKGROUND

Hyperthyroidism induces cardiovascular changes like increased heart rate and atrial automaticity, leading to conditions such as atrial fibrillation and heart failure, contributing to higher mortality rates. Despite achieving euthyroidism with treatment, cardiovascular manifestations may persist, necessitating further investigation into factors associated with persistent atrial fibrillation to guide appropriate anticoagulation therapy.

CASE 1

A 66-year-old Malay male with high blood pressure, dyslipidaemia, and thyrotoxic atrial fibrillation (TAF) due to Graves' disease of 5 years duration. He had two failed radioactive iodine treatments and thyroid surgery. He had periodic palpitations, dyspnoea, and left chest pain. His ECG revealed rapid atrial fibrillation. He has uncontrolled elevated blood pressure. The thyroid function tests were normal (T4 = 14.21, TSH = 4.78). He was eventually referred to the cardiology team who recommended cardiac ablation.

CASE 2

A 34-year-old female with Graves' disease and atrial fibrillation (AF) despite taking bisoprolol, went to the emergency department due to frequent palpitations and dizziness. She did not have chest pain. Her ECG showed atrial fibrillation. She had normal thyroid function tests (T4 = 15.21, TSH = 3.56) with elevated troponin levels. She was treated for symptomatic AF. She was subsequently referred to cardiology for cardiac ablation.

CONCLUSION

Thyroid hormones affect cardiovascular function, predisposing hyperthyroid individuals to atrial fibrillation even after achieving euthyroidism. The thromboembolic risk in TAF is reduced by oral anticoagulants. Treatment for TAF involves antithyroid medications to restore euthyroidism together with rate and rhythm regulation. Wong et al., found an unexpected relationship between decreased free thyroxine levels and chronic atrial fibrillation. TAF has a high thromboembolic risk even after euthyroidism, requiring anticoagulants and ongoing monitoring to prevent recurrence. Sometimes ablation is recommended, especially for persistent AF. In conclusion, hyperthyroidism-related AF therapy requires collaboration between endocrine and cardiovascular specialists. Prompt diagnosis and personalised treatment can improve the prognosis and reduce complications.

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A RARE CASE OF FUNCTIONAL METASTATIC FOLLICULAR THYROID CARCINOMA WITH EGGSHELL CALCIFICATION

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Yong Siang NG and Chin Voon Tong
Hospital Putrajaya, Malaysia

INTRODUCTION/BACKGROUND

Only a few cases of follicular thyroid carcinoma (FTC) with eggshell (or rim-like peripheral) calcification have been reported. Here, we report a rare case of functional metastatic FTC with eggshell calcification.

CASE

A 57-year-old female presented with progressive neck enlargement, dysphagia, and weight loss of 10 kg over 2 months. She also had a hoarse voice. On examination, she appeared thyrotoxic. She had a palpable 3 x 4 cm mass over the left neck, which was hard in consistency and immobile. Biochemically, she was hyperthyroid with suppressed TSH and high free T4 of 67.9 pmol/L (7.9-14.4). Her chest radiograph showed an eggshell calcification over the neck