

CASE

A 45-year-old female was brought to the emergency department with breathlessness and pleuritic chest pain. She had a background history of diffuse large B-cell lymphoma of the thyroid gland stage 2Bx. She had achieved complete remission for the past year following thyroidectomy and a full course of chemotherapy in December 2022. Thyroxine replacement was only given for a month post-debulking thyroid surgery. She had hypotension (79/56 mm Hg), tachycardia (129 bpm) and muffled heart sounds. Chest X-ray showed globular enlargement of the cardiac silhouette with "water bottle" configuration and right pleural effusion. Echocardiogram demonstrated early diastolic right ventricular collapse with a large pericardial effusion. The heart was seen swinging within the effusion, suggestive of cardiac tamponade. Urgent pericardiocentesis drained 200 mL of exudative serous fluid. There was no growth on pericardial fluid culture, and cytology was negative for malignant cells. Tests showed severe hypothyroidism (TSH >51.6 m IU/L and fT4 <3.2 pmol/L). Intravenous levothyroxine 50 mcg was given for two days. This was converted to thyroxine 100 mcg orally daily, then increased to 200 mcg daily based on serial thyroid function tests. She was discharged well after eight days of hospitalization. Her latest tests showed improved TSH (24.07 m IU/L) and fT4 (14.03 pmol/L).

CONCLUSION

A high index of suspicion is important for timely diagnosis of cardiac tamponade due to severe hypothyroidism, followed by prompt intervention. While it is a treatable cause of cardiogenic shock, it may be fatal if left unrecognized.

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AUTOIMMUNE HEMOLYTIC ANAEMIA: A RARE MANIFESTATION OF GRAVES' DISEASE

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INTRODUCTION

Anemia is an atypical manifestation of Graves' Disease (GD). Autoimmune hemolytic anaemia (AIHA) is one of the rarest anemias seen in GD.

CASE

A 55-year-old female presented with failure symptoms and palpitations, with no other hyperthyroid symptoms. She was tachycardic (130 to 140 bpm) with an irregularly irregular heart rhythm. She had pallor, jaundice, thyromegaly

without bruit, fine crepitations on both lung fields and pedal edema. She had no murmur or hepatosplenomegaly. Chest radiograph showed congested lungs. Initial blood investigations showed normochromic normocytic anaemia (hemoglobin 6.7 g/dL), and normal WBC and platelet count. Hemolytic workup showed elevated indirect bilirubin (63 µmol/L), positive direct Coombs test, high reticulocyte count (10.8%), and RBC agglutination with few spherocytes on full blood picture. LDH was normal. She had elevated fT4 (58.5 pmol/L), low TSH (<0.005 m IU/L) and high levels of antithyroid peroxidase antibodies (84 IU/mL). She was not in thyroid storm. She was treated with carbimazole 30 mg OD and prednisolone 30 mg OD with respective tapering doses. She was well during our clinic review two weeks later. Hemoglobin (10.4 g/dL) and indirect bilirubin (28 µmol/L) improved without blood transfusion.

CONCLUSION

The presentations of Graves' disease may vary. While pernicious and iron deficiency are the common causes of anemia in GD, AIHA is rare. It is crucial to screen for thyroid disease in AIHA. The scarcity of pure AIHA manifestation in GD may potentially delay the diagnosis and lead to poor patient outcomes. AIHA in GD responds well to antithyroid and steroid.

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HAEMOPTYSIS AND HIDDEN THREATS: UNRAVELLING FOLLICULAR THYROID CANCER IN PREGNANCY

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INTRODUCTION

Haemoptysis in pregnancy is a rare but serious complication that demands prompt investigation and intervention. While pulmonary embolism is often considered, it is essential to explore other potential underlying pathologies such as lung cancer, bronchiectasis or infectious causes. In rare cases, metastatic differentiated thyroid cancer may present with haemoptysis as the primary symptom.

CASE

We describe a distinctive case involving a 30-year-old female in her 34th week of twin pregnancy. She had a history of left partial thyroidectomy four years prior for a large thyroid nodule. Histopathology showed papillary-like nuclear features in favour of adenomatous hyperplasia. Haemoptysis began at 20 weeks of pregnancy