a baby girl was delivered with a birth weight of 3.37 kg, length of 51 cm and OFC of 33 cm. She was intubated with ETT size 3.0 and ventilated in NICU. Examination showed a diffuse neck swelling measuring 3 x 3 cm. Ultrasound and CT scan showed an enlarged right thyroid lobe 3.5 x 2.7 x 4.2 cm (AP x W x CC) and a left thyroid lobe 3.1 x 2.8 x 4.3 cm (AP x W x CC) with no cystic component or calcification. Thyroid lobes extended up to the angle of the mandible and inferiorly until thoracic inlet with the airway and esophagus almost circumferentially encased and airway patency only maintained by ETT. Cord TSH 25.12 m IU/L, fT4 10.0 pmol/L, while Day 5 TSH 37.41 m IU/L, 6.47 pmol/L. ATPO, ATG & TSH receptor antibodies were negative. Her thyroglobulin level was low at 0.6 ng/ml (intact thyroid, 3.5-77.0). Her mother also reported onset of goitre following 1st trimester. She complained of tiredness and started taking Himalaya salt. Urine iodine results for patient and mother results were 322.7 ug/L and 221.3 ug/L, respectively (250 - 499, sufficient for pregnant mother). She was treated with L-thyroxine at day 5 of life at 50 mcg daily (15 mcg/kg) with serial ultrasound neck and flexible endoscopic assessment. She was successfully extubated by day 26 and discharged after 1 month. On follow-up, her goitre remained small with normal development and hearing. Due to cost constraint, genetic test was not pursued.

CONCLUSION

Neonatal goitre with hypothyroidism may result from maternal ingestion of antithyroid drugs or goitrogens, transplacental transfer of antithyroid antibodies, or thyroid dyshormonogenesis. Low thyroglobulin level with raised TSH and low fT4 suggest thyroglobulin synthetic defect.

EP_P011

A BOY WITH UNTREATED PANHYPOPITUITARISM: CASE REPORT

https://doi.org/10.15605/jafes.039.S1.226

Sin Toun Loh,[1] Nithia Kamala,[1] Jayne Ong Ai Xin,[2] Nalini Selveindran,[2] Janet Yeow Hua Hong[2]

[1]*Department of Paediatrics, Hospital Miri, Malaysia*

[2]*Department of Paediatrics, Endocrine Unit, Hospital Putrajaya, Malaysia*

INTRODUCTION/BACKGROUND

Hypopituitarism in childhood is a complex disorder with diverse clinical presentation which can either be congenital or acquired. Hormonal deficits can evolve over time leading to a significant impact on a child's growth.

We describe a case of untreated panhypopituitarism presenting as an adrenal crisis managed in a district hospital.

CASE

A 13-year-old Indonesian male with a background of panhypopituitarism post mature teratoma resection in January 2020 presented an adrenal crisis after he defaulted treatment for 2 years. On presentation, he had hypoglycaemia with shock requiring extensive fluid resuscitation and double inotropic support. Examination revealed weight and height below 3rd centile, pre-pubertal with thin eyebrows and depressed tendon reflexes. Height velocity was 4.2 cm/year for past 2 years. His random cortisol was extremely low (<1.5 nmol/L) with hypothyroidism. Intravenous stress dose hydrocortisone was initiated and his hemodynamic status improved over time. Oral thyroxine supplement was restarted and he required regular dose of sublingual desmopressin for diabetes insipidus.

CONCLUSION

Untreated panhypopituitarism has been reported in adult as late as 45 years old with significant impairment in cardiac function, growth and regression of sexual characteristic. With appropriate hormonal replacement, growth can be optimized and lifetime expectancy can be improved without long term sequelae.

EP_P012

DELAYED PRESENTATION OF PITUITARY TUMOUR WITH HYPOPITUITARISM

https://doi.org/10.15605/jafes.039.S1.227

Parvina A/P Jayaraman, Hidayatil Alimi Keya Nordin, Noor Rafhati Adyani Abdullah

Endocrinology Unit, Medical Department, Hospital Sultanah Bahiyah, Malaysia

INTRODUCTION/BACKGROUND

Hypopituitarism is a relatively uncommon disorder in the paediatric population, and its prevalence in children is not yet well established. This condition can be caused by any disease that affects the pituitary gland, stalk or hypothalamus. We describe a patient who presented late with short stature and hypopituitarism.

CASE

A 16-year-old male presented with short stature and delayed puberty. He denied any headaches or visual problems. He was born full-term with a birth weight of 3.2 kg. Developmental milestones were normal. At presentation, his height was 139 cm and his weight was 35 kg (both below 3rd percentile). Midparental height was 167.5 cm. His Tanner stage was 1 and testicular volume was 2 ml bilaterally. His visual field assessment was unremarkable. Hormonal analysis demonstrated