pmol/L and suppressed TSH. Her TSH Receptor antibody showed elevated levels, and the initial CXR revealed cardiomegaly. She was started with oral carbimazole 30 mg daily, oral propranolol 20 mg 4 times a day, Lugol's iodine 4 drops 4 times a day, and intravenous hydrocortisone 50 mg q 6 hourly. Two anti-failure medications were used to treat her heart failure. Her symptoms improved, and she was discharged with oral carbimazole and oral propranolol.

CONCLUSION

It is important to plan an early definitive therapy in this case to prevent future cardiac decompensation during relapse. Medical practitioners need to be aware of the rare presentations of Graves' disease to avoid delayed diagnosis and treatment.

EP_P026

MATERNAL PREGNANCY LUTEOMA: A RARE CAUSE OF VIRILISATION IN A FEMALE NEWBORN AND MOTHER

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INTRODUCTION/BACKGROUND

Virilisation of a female newborn is commonly attributed to congenital adrenal hyperplasia but there are rarer causes that can be maternal in origin. Luteomas, a rare, benign androgen-producing ovarian tumour arising during pregnancy can result in both maternal and fetal virilization.

CASE

We describe a case of a newborn with ambiguous genitalia. This baby was born at 36 weeks via caesarean section for poor progress, weighing 2.8 kilograms at birth. Examination at birth revealed a prominent clitorophallic structure, fused labioscrotal folds but no palpable gonads. Otherwise, on general examination, there were no dysmorphic features or hyperpigmentation and serum electrolytes were normal with no hypoglycaemic episodes. On further assessment, 17 Hydroxyprogesterone (17-OHP) level was not elevated; karyotyping and radiological findings were consistent with a female gender. In hindsight, the mother recollected having signs of virilization, i.e., acneiform eruption on her upper chest and back, hirsutism, and deepening voice since the second trimester. Bilateral unhealthy, friable ovarian tumours were revealed intra-operatively which ruptured on handling. As the nature of the tumours was suspicious of malignancy, bilateral oophorectomy was done. Maternal beta human chorionic gonadotrophin (b-HCG) and alpha-fetoprotein (AFP) levels were elevated. The histopathological examination of the ovarian mass confirmed the diagnosis of pregnancy luteoma.

CONCLUSION

This case attests to the fact that rare causes of virilisation in a female baby cannot be overlooked. We thus need to be vigilant and have a high index of suspicion of maternal pregnancy luteomas as a possible cause of virilisation in a female baby.

EP_P027

PAEDIATRIC GRAVES' DISEASE AND DEFINITIVE TREATMENT

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INTRODUCTION

Paediatric Graves' disease (GD) is managed by antithyroid drugs (ATD), radioactive iodine (RAI) or thyroid surgery. This study aimed to describe the characteristics and outcomes of paediatric patients who received definitive therapy.

METHODOLOGY

Children and adolescents diagnosed with GD from 2012 to 2024 at the University Malaya Medical Centre were included in this retrospective review.

RESULT

A total of 37 patients were referred and diagnosed with GD; majority (78.4%) were female. Definitive therapy was given to 48%: 5 (35%) had total thyroidectomy and 9 (64%) received RAI. They had an average of four relapses during the disease. On average, the patients received ATD for 4.37 ± 2.28 years prior to the definitive treatment. The main factor in determining the choice of treatment was the size of the goitre. The mean goitre size for the RAI group was 21.68 ± 7.9 g, compared to 76.7 ± 22.88 g for the thyroidectomy group. Mean age in the RAI group was 15.53 ± 1.23 years. The youngest patient was 8 years old. Mean RAI dose was 9.3 ± 0.66 mCi. Six patients achieved hypothyroidism within 2.17 ± 2.44 months, while 1 patient achieved hypothyroidism 8 months post-RAI. Three had relapses post-RAI. Two patients required a second RAI one year later and achieved hypothyroidism within 2 to 4 weeks. Those who required a second RAI were given lower RAI doses initially (mean 5.6 ± 2.2 mCi). The mean age of patients who underwent total