CONCLUSION
This case highlights the need for a high index of clinical suspicion for the presence of parathyroid carcinoma pre-operatively in patients who exhibit severe hypercalcemia, markedly raised PTH and bone manifestations so that en bloc-resection of the parathyroid with ipsilateral partial thyroidectomy and central node dissection can be planned prior to surgery.

EP_A005

THYMIC HYPERPLASIA IN GRAVES' DISEASE: A DIAGNOSTIC AND MANAGEMENT CHALLENGE

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INTRODUCTION/BACKGROUND
Thymic hyperplasia is a recognized but frequently underappreciated entity associated with Graves' disease (GD). It is often misinterpreted as a mediastinal mass, potentially leading to unwarranted biopsies or surgical intervention. The underlying pathophysiological mechanisms remain poorly understood. Spontaneous regression of the mediastinal mass following euthyroidism with effective thyrotoxicosis treatment supports a benign etiology. Here, we present a case of a young female with GD and an incidentally discovered anterior mediastinal mass, highlighting the diagnostic complexities that necessitated a multidisciplinary approach.

CASE
A 21-year-old female presenting with a large goiter, a thyrotoxic state (FT4 >100 pmol/L, TSH 0.01 mU/ml and anti-TSH receptor Ab >40 IU/L) with no thyroid ophthalmopathy was diagnosed with GD. Despite medical management, adequate control of her thyroid hormone levels proved to be challenging, prompting a surgical consultation for a potential thyroidectomy. To assess the extent of the goiter, computed tomography (CT) imaging was performed, revealing a grossly enlarged thyroid gland with mild tracheal narrowing and a well-defined, solid, enhancing 5.6 cm × 6.4 cm × 4.3 cm anterior mediastinal mass.

Given the initial concern for an ectopic thyroid gland or malignancy, performing an invasive biopsy was considered. However, a multidisciplinary team consisting of experts from endocrinology, surgery, respiratory medicine, radiology, and nuclear medicine reviewed the findings and concluded that the mass was most consistent with thymic hyperplasia. Considering the high surgical risk, a conservative approach was pursued, with the patient undergoing radioiodine therapy for thyrotoxicosis and serial imaging to monitor the mediastinal mass. Long-term outcomes are yet to be seen.

CONCLUSION
This case underscores the diagnostic challenges posed by thymic hyperplasia in patients with GD and the potential for misdiagnosis as a mediastinal pathology. Awareness of this association is crucial in order to avoid unnecessary surgical interventions. A multidisciplinary approach is essential for accurate diagnosis and optimal management, promoting a conservative therapeutic strategy when appropriate.

EP_A006

GRANULOMATOUS DISEASE-INDUCED SEVERE HYPERCALCEMIA

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INTRODUCTION/BACKGROUND
Hypercalcemia is commonly seen in granulomatous disease especially in sarcoidosis in around 40-50% cases; however, lower rates of association have been reported in tuberculosis. The etiology is due to the production of extrarenal 1-alpha-hydroxylase enzymes by activated macrophages seen in the granulomas. This will then lead to inappropriately elevated 1,25-dihydroxyvitamin D causing dysregulation of calcium metabolism.

CASE
A patient with a known case of disseminated tuberculosis (TB) was admitted to critical care with an initial impression of cerebral toxoplasmosis. Throughout his admission, blood parameters were closely monitored which revealed moderate to severe hypercalcemia ranging from 2.8-4.0 mmol/L with clinical features of nephrogenic diabetes insipidus (polyuria of 5440 ml urine output per day, hypernatremia ranging 147-157 mmol/L (135-145 mmol/L) and low urine osmolality 143 mOsm/kg). However, despite treatment with hydration, severe hypercalcemia resulted in the atypical presence of J-wave or Osborn wave on electrocardiogram (ECG). Hypothermia has been ruled out as his body temperature ranges from 36.7-37 °C. There is no interruption in his TB medications and iatrogenic

causes have also been excluded. Intact parathyroid hormone (iPTH) yielded a low result of 1.61 pmol/L (1.95-8.49 pmol/L). Overall features point to non-iPTH dependent hypercalcemia. Corticosteroid therapy with IV hydrocortisone 50 mg TDS together with subcutaneous calcitonin 100 iU TDS were initiated. Bisphosphonate therapy consisting of one dose of intravenous zoledronic acid 4 mg was added to the therapeutic regimen the next day. After 3 days of treatment, hypercalcemia resolved with corrected calcium ranging from 1.7-2.3 mmol/L. The patient unfortunately succumbed to overwhelming sepsis with multiorgan involvement.

CONCLUSION

Granuloma-induced-hypercalcemia remains a diagnostic challenge in persons with TB due to its uncommon occurrence. However, there must be a high index of suspicion to facilitate early intervention with calcium lowering drugs to avoid morbidity and mortality in such patients.

EP_A007

BEYOND THE SORE THROAT: UNVEILING THE THYROID'S HIDDEN TURMOIL

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INTRODUCTION

Subacute thyroiditis (SAT) is an inflammatory thyroid disorder often presenting with anterior neck pain and transient thyroid dysfunction. This case highlights the diagnostic challenges and evolving thyroid function tests (TFT) in a patient initially referred for prolonged throat pain.

CASE

A 50-year-old female presented with anterior neck pain persisting for two weeks, initially treated with antibiotics for suspected infection. She had no dysphagia, odynophagia, or overt hyperthyroid symptoms but reported a significant weight loss of 6 kg over a year, early satiety, and loss of appetite. Examination revealed tenderness over the thyroid gland with no palpable goiter or lymphadenopathy. Initial TFT showed suppressed TSH <0.01 mIU/L with elevated free T4 of 56.4 pmol/L.

Inflammatory markers were raised, with an ESR of 77 mm/hr and CRP of 71.5 mg/L, supporting an inflammatory process. Tumor markers, including CEA, AFP, CA-125, CA 15-3, and CA 19-9, were not elevated, reducing the suspicion for the presence of malignancy.

Follow-up TFT showed a rapid transition from hyperthyroidism (TSH <0.01, T4 56.4) to euthyroidism (TSH 1.39, T4 8.6), and subsequently, hypothyroidism (TSH 9.9, T4 7.1). The dynamic TFT pattern, absence of thyroid autoantibodies, and recent upper respiratory symptoms supported the diagnosis of subacute thyroiditis.

The patient was started on L-thyroxine 50 mcg OD due to hypothyroid progression, with plans for TFT reassessment in 4 weeks. Referral to gastroenterology for early satiety was deferred, considering the likelihood of thyroid-related symptoms.

CONCLUSION

This case underscores the importance of recognizing evolving TFT trends in subacute thyroiditis in order to avoid unnecessary interventions. A systematic approach to thyroid dysfunction in medical care is crucial for timely diagnosis and management, bridging the gap between knowledge and clinical practice.

EP_A008

POST-COVID-19 CHRONIC FATIGUE SYNDROME WITH ACUTE PANCREATITIS AND TRANSIENT HYPERZINCEMIA

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INTRODUCTION/BACKGROUND

Chronic fatigue syndrome (CFS) often follows viral infections, including COVID-19. Long COVID is increasingly recognized as a cause of post-viral fatigue. While rare, hyperzincaemia has been linked to acute pancreatitis. This case explores the interplay between post-viral fatigue, metabolic disturbances, autonomic dysfunction, and transient hyperzincaemia in acute pancreatitis.

CASE

A 61-year-old male with hypertension, benign prostatic hyperplasia, hepatosteatosis, and gallstone-induced acute pancreatitis presented with persistent fatigue