

## Adult E-Poster

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, hyperzincemia has been linked to acute pancreatitis. This case explores the interplay between post-viral fatigue, metabolic disturbances, autonomic dysfunction, and transient hyperzincemia in acute pancreatitis.

### CASE

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