essential in accurately determining tumor origin, thus guiding optimal management strategies. Adrenal rests have been described within the retroperitoneum, broad ligament, testis, ovaries and inguinal region. Due to limited data, the management of ectopic ACC is generally considered similar to that of eutopic tumors. Complete surgical resection is still the mainstay of treatment for both eutopic and ectopic ACC. Long-term follow-up and close monitoring are imperative given the risk of recurrence.

CONCLUSION

This case underscores the importance of maintaining a high index of suspicion, as many ectopic adrenocortical rests are under-recognized due to their small size and low clinical relevance. Awareness of ectopic adrenal rests is crucial to correctly identify sources of adrenocortical hormone production, avoid misinterpretations in the diagnostic workup of intraabdominal masses, and to evaluate for possible malignant transformation.

EP_A018

SUCCESSFUL THYROIDECTOMY IN SEVERE GRAVES' DISEASE: A MODIFIED BLOCK-AND-REPLACE APPROACH

https://doi.org/10.15605/jafes.040.S1.026

Nursafinas Rofii[1,2] and Ooi Chuan Ng[2]
[1]Hospital Sultan Abdul Aziz Shah, Universiti Putra Malaysia, Serdang, Malaysia
[2]Univerisiti Putra Malaysia, Serdang, Selangor, Malaysia

INTRODUCTION/BACKGROUND

Graves' disease is the most common cause of autoimmune hyperthyroidism. In severe cases, thyroidectomy is required. The block-and-replace regimen helps achieve euthyroidism preoperatively, but perioperative thyroid instability remains a challenge, particularly in urgent surgical settings.

CASE

A 20-year-old Malay female with severe plaque psoriasis developed a painful goiter and severe thyrotoxicosis following Guselkumab treatment, necessitating carbimazole 30 mg daily. She was initially scheduled for radioactive iodine (RAI) therapy; however, two weeks after her fourth Guselkumab dose, just before her planned RAI, she had thyroid storm. Emergency management included Lugol's iodine, high-dose propylthiouracil, corticosteroids, and cholestyramine. Due to recent iodine exposure, RAI was no longer a viable option, necessitating an alternative definitive treatment approach.

Methimazole was increased from 20 mg to 25 mg twice daily, successfully lowering free T4 from 27 to 17 pmol/L. However, on the day before her scheduled thyroidectomy, severe hypothyroidism (TSH <0.01 mIU/L, T4 <5 pmol/L) was noted. To rapidly restore euthyroidism, she received a total of 300 mcg of levothyroxine overnight while continuing methimazole. This intervention raised her T4 to 8.3 pmol/L, ensuring safe surgical conditions while mitigating the risk of recurrent thyroid storm in this difficult-to-control case.

CONCLUSION

This case highlights the challenges of perioperative thyroid management in Graves' disease. High-dose levothyroxine while maintaining methimazole facilitated urgent surgical clearance, balancing the risks of hypothyroidism and thyroid storm. This modified block-and-replace approach may be considered in select cases requiring time-sensitive surgical intervention.

EP_A019

HYPORENINAEMIC HYPOALDOSTERONISM (HH) AS THE CAUSE OF UNEXPLAINED HYPERKALAEMIA

https://doi.org/10.15605/jafes.040.S1.027

Ashok Veerappan,[1] Nishkkriyaa Gopal,[1] Valliammai Valliyappan[2]
[1]Hospital Teluk Intan, Malaysia
[2]IMU University, Malaysia

INTRODUCTION

Hyporeninaemic hypoaldosteronism (HH) is a frequently overlooked cause of hyperkalaemia. In HH, juxtaglomerular apparatus dysfunction secondary to diabetes, chronic kidney disease and medications like NSAIDs, ACEI, and heparin leads to reduced renin secretion, thus decreasing aldosterone synthesis, resulting to impaired potassium excretion and H^+ secretion. Hyperkalaemia and metabolic acidosis ensue respectively with no adrenal insufficiency.

CASE

A 57-year-old female presented with persistent and asymptomatic hyperkalaemia for a year at primary care. Hemolysis was ruled out. Electrocardiogram findings remained normal throughout. She had type 2 diabetes mellitus for 15 years, hypertension and stage 2 chronic kidney disease (CKD) (eGFR ~62 mL/min/1.73 m^2) for 2 years. Diabetes was moderately controlled with metformin. Hypertension was treated with amlodipine. Additionally, she had been using NSAIDs intermittently for back pain over the last three years. Due to the presence of hyperkalaemia despite the fairly normal renal function,