Adult E-Poster

she was referred to an endocrinologist. Further evaluation included a morning serum cortisol level at 9 am, which was normal, ruling out adrenal insufficiency. However, serum aldosterone was low with inappropriately low renin levels despite elevated potassium. Mild metabolic acidosis was present. These findings strongly suggested a diagnosis of HH. The patient was managed through dietary potassium restriction, discontinuation of NSAIDs, initiation of fludrocortisone for potassium excretion, and sodium bicarbonate to correct the metabolic acidosis with a close watch on renal function and potassium levels. Within two weeks, her potassium levels normalized and remained stable thereafter. Hyperkalaemia was ultimately attributed to HH, likely caused by a combination of chronic diabetes with CKD and the use of NSAIDs, all leading to juxtaglomerular apparatus dysfunction.

CONCLUSION

This case highlights the importance of considering HH in persons with diabetes or CKD with unexplained hyperkalaemia despite a normal or mildly impaired renal function and initiating the appropriate management to prevent potentially life-threatening arrhythmias.

EP_A020

THYROTOXICOSIS WITH DISCORDANT THYROID FUNCTION TESTS: A RARE PITUITARY TUMOR PRESENTING WITH THYROTOXIC CARDIOMYOPATHY

https://doi.org/10.15605/jafes.040.S1.028

Siti Nabihah Mohamed Hatta,[1] Husna Rosleli,[1] Jo-An Ng,[2] Ooi Chuan Ng,[1] Vickneswaran A/L Maramuthu[1]

[1]Medical Department, Hospital Sultan Abdul Aziz Shah (HSAAS) Universiti Putra Malaysia, Serdang, Malaysia
[2]MAHSA University, Petaling Jaya, Malaysia

INTRODUCTION

Thyrotoxicosis can lead to life-threatening complications, including thyroid storm and thyrotoxic cardiomyopathy. Discordant thyroid function tests (TFTs) in severe thyrotoxicosis raise suspicion for atypical causes such as assay interference, pituitary pathology, or ectopic thyrotropin (TSH) secretion.

CASE

A 29-year-old male presented with a two-week history of cough, dyspnea, and palpitations. On admission, he was hemodynamically stable but had bibasal fine crepitations, bilateral pedal edema and signs of thyrotoxicosis (agitation, fine tremors, and hyperreflexia). Cardiac monitoring revealed atrial fibrillation with a heart rate >150 bpm. Thyroid function tests showed discordant TSH 14.92 Miu/L, T4 65.9 pmol/L and T3 13.47 pmol/L levels. He was treated as a case of thyroid storm with thyrotoxic cardiomyopathy.

Echocardiography confirmed heart failure with reduced ejection fraction (20%) and pulmonary artery systolic pressure of 48 mm Hg. Further workup ruled out Group 2, 3, 4 Pulmonary Hypertension (PH) and no invasive right heart catheterization was done. Assay interference was excluded, thyroid autoantibodies were negative and other pituitary hormones were normal. Pituitary MRI showed a large pituitary mass, raising suspicion for the presence of a TSH-secreting pituitary adenoma.

He is currently managed with the anti-thyroid drug methimazole, anti-heart failure medications and anticoagulation by a multidisciplinary team.

TSH-secreting pituitary adenomas (TSHomas) are rare, causing autonomous TSH secretion unresponsive to negative feedback. Unlike resistance to thyroid hormone (RTH), TSHomas typically present with overt hyperthyroidism and tumor-related symptoms (visual defects, headaches, anterior pituitary dysfunction). Atrial fibrillation and heart failure are rare in TSHomas but were prominent in this case. Transsphenoidal surgery is the preferred treatment, resulting to thyroid function normalization in 80% of cases. However, TSHomas often exhibit aggressive invasion, affecting surgical success. If surgery fails, somatostatin analogs (SSAs) can normalize TSH and reduce tumor size.

CONCLUSION

This case highlights the need to consider causes of atypical thyrotoxicosis when TFTs are discordant. Early recognition and a multidisciplinary approach are crucial for managing thyrotoxic cardiomyopathy and its underlying etiology.

EP_A021

ADULT LANGERHANS CELL HISTIOCYTOSIS WITH MULTISYSTEM INVOLVEMENT

https://doi.org/10.15605/jafes.040.S1.029

Wei Wei Ng[1] and Norasyikin A. Wahab[2]

[1]Hospital Putrajaya, Putrajaya, Malaysia
[2]Faculty of Medicine, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

INTRODUCTION/BACKGROUND

Langerhans cell histiocytosis (LCH) is a rare, heterogenous disease with a wide range of manifestations, from unifocal lesions to multisystem involvement. Commonly affected