a high index of suspicion for APS in individuals with a history of multiple autoimmune disorders, allowing for early screening and intervention to prevent complications. Comprehensive autoimmune surveillance and inter-disciplinary collaboration are essential for optimizing patient outcomes.

EP_A025

BILATERAL ADRENAL HISTOPLASMOSIS IN AN IMMUNOCOMPETENT ELDERLY PATIENT: A CASE REPORT

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INTRODUCTION

Histoplasmosis is a fungal infection caused by *Histoplasma capsulatum*, often acquired through inhalation of spores. Disseminated histoplasmosis with adrenal gland involvement is rare and may lead to adrenal insufficiency.

CASE

We report a case of a 70-year-old male, previously healthy, who presented with constitutional symptoms i.e. generalized lethargy, reduced appetite, and significant weight loss of 10 kilograms within 3 months. He was normotensive and no hyperpigmentation was noted. Tumor markers and viral screening were negative and HbA1c was 6.8%. There was no hyponatremia or hyperkalemia. Morning cortisol was 341 nmol/l. Computed tomography scan of the thorax, abdomen, and pelvis revealed bilateral mixed solid cystic adrenal masses and a wedge-shaped hypodense area in the spleen. Adrenal protocol of the CT showed bilateral adrenal masses measuring 5.3 x 3.7 x 3.8 cm on the right and 3.4 x 2.8 x 2.6 cm on the left. A CT-guided adrenal biopsy was performed and histopathological examination revealed highly fragmented tissue strips with huge areas of necrosis and hemorrhage composed of vague formation of epithelioid granuloma with numerous fungal spores. The fungi appearing intra-cytoplasmic in the H&E staining may suggest a histoplasmosis etiology. Synacthen test confirmed adrenal insufficiency with a peak cortisol level of 453 nmol/l. Intravenous amphotericin-B was given for two weeks followed by oral itraconazole 200 mg BD, alongside corticosteroid replacement for adrenal insufficiency. After 6 months, his condition improved significantly, and his adrenal size decreased on follow-up imaging with the largest diameter measuring 3.8 cm. We plan to complete itraconazole for a total of 12 months duration.

CONCLUSION

Bilateral adrenal histoplasmosis usually affects immunocompromised patients or those from endemic areas. This diagnosis should be taken into consideration in a patient presenting with bilateral adrenal masses. Diagnosis is often delayed due to nonspecific symptoms. Imaging, serology, and biopsy are essential for diagnosis. Prompt diagnosis and commencement of antifungal treatment are imperative to prevent adrenal crises.

EP_A026

SECRETIVE SECRETIONS, EXPLOSIVE EXCRETIONS: A RARE CASE OF VIPoma

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INTRODUCTION/BACKGROUND

Vasoactive Intestinal Peptide (VIP)-secreting neuroendocrine tumours (VIPomas) are rare, usually presenting with profuse watery diarrhea leading to severe electrolyte imbalances. Our patient's initial presentation with obstructive jaundice and portal vein thrombosis preceded the typical presentation, complicating early diagnosis.

CASE

A 34-year-old male presented in May 2024 with progressive jaundice, tea-colored urine and pale stools but no diarrhea. Investigations revealed markedly elevated direct hyperbilirubinemia (205 µmol/L), alkaline phosphatase (742 U/L) and gamma-glutamyl transferase (612 U/L), which was suggestive of biliary obstruction. CT scan identified a 4.2 cm pancreatic mass with hepatic metastases and portal vein thrombosis. EUS visualized a hypoechoic lesion at the head of the pancreas measuring 38 x 35 mm, causing upstream dilatation of the pancreatic and common bile duct. ERCP was done for sphincterectomy and stenting. Histopathology revealed a low-grade neuroendocrine neoplasm.

Six months later, the patient developed persistent watery diarrhea for two weeks, along with fatigue and weight loss. His severe hypokalemia (as low as 1.5 mmol/L) was