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

https://doi.org/10.15605/jafes.040.S1.033

Fitri Mat Dait,[1] Siti Sanaa Wan Azman,[1] Masliza Hanuni Mohd Ali,[1] Dr Nurul Ashikin Adnan,[2] Dr Wan Muhammad Nazief Wan Hassan,[3] Dr Nurul Atiah Mohd Ali[4]

[1]Endocrine Unit, Medical Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia
[2]Infectious Disease Unit,Medical Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia
[3]Radiology Department, Hospital Pulau Pinang, Malaysia
[4]Pathology Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia

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

https://doi.org/10.15605/jafes.040.S1.034

Sim Yin Ng and Ken Seng Chiew

Department of Internal Medicine, Hospital Sultan Ismail, Johor Bahru, Malaysia

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

refractory despite 3 days of intravenous potassium infusion. Stool studies excluded infective causes, and 24-hour urine 5-HIAA was normal. Trial of subcutaneous octreotide, titrated up to 100 mcg, led to resolution of symptoms and hypokalaemia within a day.

His fasting serum VIP levels sent prior to initiation of therapy were elevated at 211 pg/ml (normal range <86 pg/mL). Gallium-68 DOTATATE showed somatostatin-avid disease at the pancreatic head, multiple abdominopelvic lymph nodes and both liver lobes.

Our multidisciplinary team meeting determined that curative surgery was not feasible due to extensive metastases and vascular involvement. The patient remains well and asymptomatic on octreotide long-acting release during subsequent follow-ups.

CONCLUSION

This case highlights an unusual case of VIPoma, which presented with cholestatic jaundice prior to diarrhea. Strong multidisciplinary collaboration is crucial to optimize outcomes.

EP_A027

DOEGE-POTTER SYNDROME ARISING FROM AGGRESSIVE RECURRENT FIBROUS TUMOUR OF THE LUNG: A CASE REPORT

https://doi.org/10.15605/jafes.040.S1.035

Nurain Azmi, Masliza Hanuni Mohd Ali, Siti Sanaa Wan Azman

Endocrine Unit, Medical Department, Hospital Sultanah Nur Zahirah

INTRODUCTION

Doege-Potter Syndrome (DPS) is a rare paraneoplastic syndrome characterized by hypoinsulinemic hypoglycaemia. It typically arises in patients with mesenchymal tumours, particularly fibrous tumours of the lung. DPS is secondary to ectopic secretion of high-molecular-weight insulin-like growth factor (IGF)-2 that induces hypoglycemia.

CASE

We report a 56-year-old male with an underlying solitary fibrous lung tumour that was resected in 2013, which recurred in 2023 and was deemed unresectable. He was to undergo chemotherapy. However, while waiting, he presented neuroglycopenia with a capillary blood glucose of 1.9 mmol/L, reversed with glucose administration. Imaging studies revealed a large pleural-based lesion on the left with an interval increment in size, with its largest diameter at 20.6 cm and worsening mass effect. Histopathology report from CT-guided biopsy confirmed diagnosis of recurrent fibrous tumour with no malignant features. Renal and liver profiles were normal, and HbA1c was 4.3%. Paired random blood glucose was 2.8 mmol/L, with suppressed C-peptide and insulin levels of 31.81 pmol/L (NR 366.66-1466.65) and <1.39 pmol/L (NR 17.8-173), respectively. Serum IGF-1 was normal at 166.2 ng/ml (NR 54.3-194.2). Serum IGF-2 was 479 ng/ml (NR 333-967), with an IGF-2:IGF-1 ratio of 3, supporting the diagnosis of IGF-2-mediated hypoglycemia. We started him with oral prednisolone 0.5 mg/kg/day, and the hypoglycaemia improved. Unfortunately, he succumbed to respiratory failure due to advanced tumour progression. Given the clinical findings and available biochemical markers, this case is consistent with a diagnosis of non-islet cell tumour hypoglycaemia (NICTH).

CONCLUSION

This case emphasizes the association between solitary fibrous tumours of the lung and DPS, highlighting the potential for recurrence of the tumour and persistent paraneoplastic effects. Early recognition and appropriate management of DPS are crucial in improving patient outcomes, such as the commencement of corticosteroids, while awaiting definitive treatment.

EP_A028

ELDERLY WITH ABSOLUTE INSULIN DEFICIENCY IN A SENIOR CARE FACILITY: A TAILORED APPROACH

https://doi.org/10.15605/jafes.040.S1.036

Suprhamanyam Evali,[1] Davyina Divasyini Dorett,[1] Anilah Abdul Rahim,[2] Ijaz Hallaj Rahmatullah[2]

[1]*Internal Medicine Unit, Hospital Kuala Kangsar, Perak, Malaysia*

[2]*Endocrinology Unit, Hospital Raja Permaisuri Bainun, Ipoh, Perak, Malaysia*

INTRODUCTION

Managing diabetes in elderly insulin-deficient patients poses significant challenges, particularly when social support is limited.

CASE

We present an elderly female with recurrent diabetic ketoacidosis (DKA) and frequent hypoglycemic episodes. Despite various insulin regimens, she experienced unpredictable glycemic fluctuations, complicated by hypoglycemia unawareness.