Adult E-Poster

EP_A030

HYPERTHYROIDISM WITH SEVERE TRANSAMINITIS IN A PREGNANT FEMALE WITH A TOXIC NODULE

https://doi.org/10.15605/jafes.040.S1.038

Thaalitha Naidu,[1] Siti Sanaa Wan Azman,[2] Masliza Hanuni Mohd Ali,[2] Syuhada Dan Adnan[3]

[1]Medical Department, Hospital Kemaman, Terengganu, Malaysia
[2]Endocrinology Unit, Medical Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia
[3]Gastroenterology and Hepatology Unit, Medical Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia

INTRODUCTION/BACKGROUND.

Hyperthyroidism occurs in 0.1–0.4% of pregnancies, mostly due to Graves' disease. Other causes include toxic adenoma, multinodular goitre and trophoblastic tumours.

CASE

A 27-year-old primigravida at 9 weeks presented with vomiting, epigastric discomfort, anorexia, palpitations and weight loss of 8 kg in one month. Family history was significant for thyroid malignancy. On examination, she was alert but dehydrated, icteric and tachycardic (HR 120 bpm), spiking fever (38°C) with tremors present. No goitre or thyroid eye signs noted. Systemic findings were unremarkable. Investigations revealed TWC: 13 x10⁹/L, Urea: 8 mmol/L, Sodium: 119 mmol/L, TB: 31.5 µmol/L, ALP: 74 U/L, ALT: 943 U/L and AST: 630 U/L. ECG showed sinus tachycardia. She was managed symptomatically with anti-emetics and intravenous fluids. However, her liver function worsened; TB: 56 µmol/L, ALP: 69 U/L, ALT: 1583 U/L and AST: 530 U/L. TFT revealed thyrotoxicosis with Free T4 >100 pmol/L and TSH 0.012 mIU/L. Neck ultrasonography showed a homogenous, non-enlarged thyroid gland with a TIRADS 5 thyroid nodule on the right. Normal vascularity was seen within the gland. Hepatic ultrasonography was unremarkable. She was initiated on oral propranolol 60 mg TDS and Lugol's iodine 10 drops TDS for five days. Thyroid autoantibodies, viral hepatitis panel and other second-line investigations for transaminitis were negative. As results improved, she was discharged with tapered Lugol's iodine (5 drops TDS for 5 days) and continued on propranolol. After two weeks, both liver and thyroid function normalised. Fine-needle aspiration cytology of the thyroid nodule revealed atypia of undetermined significance, Bethesda Category III. Postpartum hemi- or total thyroidectomy has been planned as she remains well with a stable pregnancy.

CONCLUSION

Significant transaminitis in early pregnancy mandates a broad differential, including thyroid dysfunction, as early recognition ensures favourable maternal and fetal outcomes. In selected cases, short-term iodine and beta-blockade offer a safe, effective bridge to definitive management.

EP_A031

FLORID ERUPTIVE XANTHOMAS IN A FAMILIAL HYPERTRIGLYCERIDEMIA PATIENT

https://doi.org/10.15605/jafes.040.S1.039

Thaalitha Naidu,[1] Siti Sanaa Wan Azman,[2] Masliza Hanuni Mohd Ali[2]

[1]Medical Department, Hospital Kemaman, Terengganu, Malaysia
[2]Endocrinology Unit, Medical Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia

INTRODUCTION/BACKGROUND

Eruptive xanthomas can be an early indicator of lipid disorders, occurring in approximately 8.5% of patients with severe hypertriglyceridemia.

CASE

A 27-year-old Malay male, with a history of Type 2 Diabetes Mellitus and Dyslipidemia since age 19, presented for treatment after being lost to follow-up. He reported osmotic symptoms, weight loss and recurrent severe epigastric pain radiating to the back. He is a teetotaler, heavy smoker (13 pack-years), with poor dietary habits and frequent high-fat, high-carbohydrate meals. Family history includes diabetes and dyslipidemia in both parents.

On examination, BMI was 27 kg/m², waist circumference 80 cm and blood pressure 144/91 mm Hg. Crops of 2–5 mm yellow nodules were present over the elbows, buttocks, knees, lateral malleolus, and interphalangeal joints, along with yellowish papules over palms and back, suggestive of eruptive xanthomas. There was no arcus senilis or xanthelasma. Other systemic examinations were unremarkable. Fundoscopy showed no lipemia retinalis or diabetic retinopathy.

Investigations revealed markedly elevated Total Cholesterol (TC) 15.89 mmol/L, Triglycerides (68.44 mmol/L), low HDL (0.61 mmol/L), with invalid LDL values. HbA1c was 10.7%, with mild transaminitis, proteinuria and CKD stage 2 (eGFR 61 mL/min/1.73 m²). Amylase, TSH and other biochemical tests were normal. ECG and echocardiogram were normal. Abdominal imaging revealed fatty liver without chronic pancreatitis.