prolactin (35.7 mIU/L) and low IGF-1 level of 11.9 ng/ml (69 -227 ng/ml) suggestive of growth hormone deficiency. Additionally, her vitamin D level was insufficient, 68.79 nmol/L. Short Synacthen test revealed adequate cortisol response. MRI of pituitary reported features of empty sella, confirming the diagnosis of primary ESS. She received hormonal replacement therapy, including estradiol, for pubertal induction. She was counselled for right total hip replacement, but she was not keen.

CONCLUSION

Panhypopituitarism observed in ESS affects bone remodeling, leading to early osteoporotic fracture. Treatment with hormonal replacement is essential to restore secondary sexual characteristics for psychosocial well-being as well as to improve bone health to reduce the risk of further fracture.

EP_A043

RACING HEART UNDER STORMY SKIES: A JOURNEY THROUGH AGRANULOCYTOSIS TO THYROID STORM

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INTRODUCTION/BACKGROUND

Thyroid storm is a rare but life-threatening exacerbation of thyrotoxicosis characterised by multi-system dysfunction. Its shared features with sepsis may pose a significant diagnostic challenge. We describe a patient with Graves' disease who developed carbimazole-induced agranulocytosis followed by thyroid storm necessitating therapeutic plasma exchange (TPE) and urgent thyroidectomy.

CASE

A 31-year-old female with newly diagnosed Graves' disease on carbimazole 40 mg daily presented with palpitations and right hypochondriac pain. Initial investigation showed elevated FT4 at 31 pmol/L (7.86-14.41 pmol/L), suppressed TSH at 0.03 uIU/mL (0.38-5.33 uIU/mL) with cholestatic transaminitis. On day 3 of admission, she developed agranulocytosis with an absolute neutrophil count (ANC) of 0.06 x 10^9/L, hence carbimazole was withheld. Granulocyte-colony stimulating factor was initiated along with a broad-spectrum antibiotic to cover for neutropenic sepsis. The ANC normalised after three days, but she developed spiking fever up to 40.8°C, associated with persistent vomiting followed by hypotension and tachycardia. Biochemical tests revealed rising FT4 to 44.5 pmol/L and hyperbilirubinemia. Initiation of glucocorticoids upon withholding carbimazole was delayed due to concern of sepsis. Diagnosis of thyroid storm was made and urgent TPE was initiated along with high-dose intravenous glucocorticoids and esmolol infusion. She showed immediate clinical improvement with defervescence and stabilization of hemodynamic parameters after the first cycle of TPE. Total thyroidectomy was performed after two cycles of TPE, and she was discharged well on day 30.

CONCLUSION

This case highlights the challenge of distinguishing thyroid storm from sepsis in the setting of carbimazole-induced agranulocytosis. It underscores the importance of prompt recognition and timely intervention of thyroid storms to prevent morbidity and mortality. Early initiation of TPE as bridging therapy before definitive therapy in the setting where antithyroid drug was contraindicated provided rapid control of thyrotoxicosis and was well tolerated.

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THROUGH THE EYES OF LUPUS: LIPAEMIA RETINALIS AS A RARE OCULAR MANIFESTATION OF HYPERTRIGLYCERIDEMIA

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INTRODUCTION/BACKGROUND

Lipaemia retinalis is a rare but striking ocular finding caused by extreme hypertriglyceridemia. It is typically associated with primary dyslipidemias but may also occur secondary to autoimmune disease such as systemic lupus erythematosus (SLE). We describe a case of newly diagnosed SLE with lupus nephritis, incidentally found to have lipaemia retinalis, leading to the diagnosis of severe hypertriglyceridemia.

METHODOLOGY

A 12-year-old female presented with two months of intermittent fever and constitutional symptoms. Investigations revealed normochromic normocytic anemia, raised inflammatory markers, positive ANA (speckled pattern) and anti-dsDNA with low complement levels. Proteinuria was present, and subsequent renal biopsy confirmed class III lupus nephritis. Fundoscopy revealed an incidental finding of lipaemia retinalis, and lipid profile showed severe