normalization, particularly when urine osmolality is unexpectedly low. The patient's osmotic diuresis from hyperglycemia may have initially masked AVP-D, complicating the diagnosis.

This case highlights the need to differentiate AVP-D from osmotic diuresis in a patient with diabetes with persistent polyuria. Identifying the condition early and treating it with desmopressin, while optimizing blood sugar control, can help prevent future complications.

EP_A055

T3 THYROTOXICOSIS AS A PARANEOPLASTIC MANIFESTATION OF METASTATIC EXTRAGONADAL NONSEMINOMATOUS GERM CELL TUMOUR

https://doi.org/10.15605/jafes.040.S1.063

Mohd Idris Mohamad Diah,[1] Xin-Yi Ooi,[2] Hui Chin Wong,[2] Shamharini Nagaratnam,[1] Chin Voon Tong[1]

[1]*Department of Medicine, Endocrine Institute, Hospital Putrajaya, Putrajaya, Malaysia*

[2]*Endocrinology Unit, Department of Medicine, Hospital Tengku Ampuan Rahimah, Klang, Malaysia*

INTRODUCTION/BACKGROUND

Nonseminomatous germ cell tumours (NSGCTs) are rare malignancies that arise from gonadal or extragonadal sites and comprise various histological subtypes. In 90% of cases, β-human chorionic gonadotropin (β-hCG) is elevated, with extreme levels occasionally inducing thyrotoxicosis via TSH receptor cross-reactivity.

CASE

We report a case of metastatic extragonadal NSGCT presenting with T3 thyrotoxicosis. A 22-year-old Malay male with no prior medical history developed progressive abdominal pain, nausea, vomiting and a 20 kg weight loss over four months. On arrival at the emergency department, he was hypertensive (153/120 mm Hg) and tachycardic (132 bpm). Examination revealed a 3 × 3 cm left cervical lymph node but no signs of hyperthyroidism. Initial thyroid function tests showed suppressed TSH (0.017 mU/L), normal free T4 (20.82 pmol/L), and elevated T3 (6.6 mU/L), consistent with T3 thyrotoxicosis. He was initiated on carbimazole 20 mg OD. TSH receptor antibody was negative. He required intensive care admission for heart failure, where echocardiography revealed global hypokinesia with a left ventricular thrombus. Further evaluation with a contrast-enhanced CT scan of the neck, thorax, abdomen and pelvis showed extensive cervical, mediastinal and abdominal lymphadenopathy, as well as a large lobulated left suprarenal mass (6.7 × 6.5 × 6.4 cm) with necrosis. Workup for adrenal hyperfunction was negative, and a markedly elevated β-hCG (250,573.0 U/L) led to a revised diagnosis of metastatic extragonadal NSGCT with paraneoplastic thyrotoxicosis. A cervical lymph node biopsy confirmed the diagnosis. Antithyroid therapy was tapered to achieve normal T3 levels. He was then referred for chemotherapy. His thyroid function normalised following treatment and carbimazole was discontinued, coinciding with a decline in β-hCG levels.

CONCLUSION

This case highlights the importance of considering paraneoplastic thyrotoxicosis in patients with unexplained hyperthyroidism and systemic symptoms, particularly in the context of extreme β-hCG elevations. Early recognition and appropriate oncological management are crucial for optimising outcomes.

EP_A056

PRIMARY ADRENAL INSUFFICIENCY SECONDARY TO BILATERAL ADRENAL TUBERCULOSIS DURING ANTI-TUBERCULOSIS TREATMENT

https://doi.org/10.15605/jafes.040.S1.064

Mohd Idris Mohamad Diah, Jia Jun Khoo, Zi Yang Lian, Chin Voon Tong

Department of Medicine, Endocrine Institute, Hospital Putrajaya, Putrajaya, Malaysia

INTRODUCTION/BACKGROUND

Adrenal tuberculosis (TB) is a rare but serious form of extrapulmonary TB, accounting for 7% to 20% of primary adrenal insufficiency (PAI) cases worldwide. It typically results from haematogenous spread, leading to granulomatous inflammation, caseous necrosis and progressive adrenal destruction. Despite appropriate anti-TB therapy, PAI can develop weeks to months later due to ongoing adrenal damage.

CASE

A 68-year-old Malay male with type 2 diabetes mellitus, hypertension and ischaemic heart disease was recently diagnosed with miliary TB and had been on anti-TB treatment (EHRZ regimen) for 43 days. He presented with a two-day history of lethargy, poor oral intake and postural giddiness. Upon arrival, he appeared cachectic, with hyperpigmentation over the knuckles, a blood pressure of 88/71 mm Hg, and a heart rate of 99 bpm. Given his persistent hypotension despite fluid resuscitation, adrenal crisis was suspected, and intravenous hydrocortisone was