

## Adult E-Poster

bronchoscopy were performed, and tumour fluid for cytology was negative for malignant cells. MRI of the neck revealed an ectopic lingual thyroid with nodular goitre and haemorrhagic cystic component causing oropharyngeal luminal narrowing, with absence of orthotopic thyroid gland. She is clinically euthyroid but biochemically subclinical hypothyroidism (TSH 11.87 uIU/mL, FT4 13.07 pmol/L). Anti-TPO antibodies were negative; a neck ultrasound showed no normal thyroid tissue in the anterior neck. Thyroxine hormone replacement commenced, and her TFT levels normalized 4 months later. Repeat neck CT showed no reduction in the size of the lingual thyroid. However, she declined surgical intervention.

### CONCLUSION

Lingual thyroid is extremely rare but remains an important differential for patients presenting with a mass at the tongue base. Treatment with thyroxine should be initiated to prevent hypothyroidism and progressive growth of the ectopic tissue. Surgical intervention is indicated when the patient presents with severe respiratory tract obstruction, limited size-reduction despite thyroxine replacement or malignancy.

## EP\_A059

### TRANSIENT REMISSION OF ACROMEGALY FOLLOWING PITUITARY APOPLEXY AND EARLY RELAPSE: A CASE REPORT

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### INTRODUCTION/BACKGROUND

Acromegaly is caused by excessive growth hormone (GH) secretion and secondary elevation of insulin-like growth factor-1 (IGF-1). Elevated serum IGF-1 level is a useful screening tool for acromegaly. However, IGF-1 levels may appear normal in conditions such as liver disease, malnutrition, uncontrolled diabetes mellitus and pituitary apoplexy. When serum IGF-1 levels are normal, it is easy to miss the diagnosis of acromegaly without a high index of suspicion and/or a GH suppression test. We report a case of an acromegaly patient with pituitary apoplexy and initially normal IGF-1 level.

### CASE

A 24-year-old young female presented initially with severe headache, blurring of vision, vomiting and sudden onset of reduced consciousness. Brain CT showed intratumoral haemorrhage of sellar and suprasellar mass causing

cerebral oedema and mass effect, suggestive of pituitary apoplexy. Emergency craniectomy and tumour excision were performed, and HPE revealed a pituitary adenoma. Hormonal workup prior to surgery showed central hypothyroidism with hyperprolactinemia, likely caused by stalk effect. Other parameters were unremarkable, including normal IGF-1. Postoperatively, she developed panhypopituitarism, bilateral eye blindness and scar epilepsy. IGF-1 was rechecked 6 months postoperatively for spade-like hands, but the result was not found. It was only after four years, following family concerns about gradual acral enlargement, that her post-op IGF-1 was found markedly elevated. GH suppression test subsequently confirmed acromegaly. She was offered repeat surgery due to the persistent sellar mass from MRI surveillance. However, the patient was not keen and medical therapy with a somatostatin receptor ligand was initiated, with referral to oncology for radiotherapy.

### CONCLUSION

Transient remission of acromegaly after pituitary apoplexy can occur. However, a high index of suspicion of relapse is crucial especially in those patients with acromegaloid features. Hence, repeating IGF-1 testing or GH suppression test is advisable if the diagnosis is uncertain.

## EP\_A060

### HAIRY PREGNANCY: A RARE CASE OF GESTATIONAL HYPERANDROGENISM

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### INTRODUCTION/BACKGROUND

The role of testosterone in pregnancy is usually overlooked. Studies have shown that pregnancy can result in physiological elevation of testosterone, as high as 2 to 3 times the upper limit of normal, but this does not result in the virilisation of the mother. We present a rare case of virilisation during pregnancy with a complete resolution of symptoms post-delivery.

### CASE

This is the case of a 27-year-old female referred for increased hair on her limbs and face, requiring her to shave every 1-2 weeks (Ferriman-Gallway 5). In history, she has had irregular menses starting at 18 years old. She is obese, with a pre-pregnancy weight of 84 kg and a BMI of 35 kg/m<sup>2</sup>. She was treated for polycystic ovarian syndrome (PCOS) by the Gynaecology team. Ovarian ultrasound showed no cysts. The hormonal profile revealed an elevated