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^2. She was treated for polycystic ovarian syndrome (PCOS) by the Gynaecology team. Ovarian ultrasound showed no cysts. The hormonal profile revealed an elevated

testosterone level of 5.74 nmol/L (NR: <1.67). Other blood investigations were normal. Further investigation for the hyperandrogenism from possible androgen-producing tumour was postponed till post-delivery. However, during the 6-month follow-up post-delivery, she had regularised menses and reduced facial hair, which minimised regular shaving. Her repeat testosterone level taken 4 months post-delivery was 0.49 nmol/L.

CONCLUSION

Elevated testosterone during pregnancy is a normal physiological response vital for maintaining pregnancy and initiation of parturition. It is caused by the increased production and reduced clearance of testosterone. Excess testosterone during pregnancy does not cause clinical hyperandrogenism as a result of increased SHBG, which binds the androgens, and placental aromatase, which converts excess testosterone to estradiol. However, PCOS can result in a diminished protective effect of the placenta aromatase, resulting in clinical hyperandrogenism during pregnancy. Our patient had a pre-pregnancy PCOS diagnosis, which worsened her hyperandrogenism intrapartum. This condition was similar to a few published case reports. The resolution of PCOS symptoms post-delivery can transiently happen due to the stabilisation of hormones postpartum; unfortunately, PCOS symptoms may recur later on.

EP_A061

WHEN THE THYROID AND STOMACH COLLIDE: APS TYPE 3B BEHIND CARDIAC SYMPTOMS

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INTRODUCTION/BACKGROUND

Autoimmune Polyglandular Syndromes (APS) are a group of disorders characterised by the simultaneous or sequential occurrence of multiple autoimmune-mediated diseases affecting endocrine glands. Pernicious anaemia is commonly part of this broader spectrum of autoimmune conditions.

CASE

We report the case of a 65-year-old male with a seven-year history of megaloblastic anaemia treated with cyanocobalamin, who presented with severe anaemia-induced non-ST-elevation myocardial infarction (NSTEMI) that manifested as chest pain, reduced exercise tolerance and profound fatigue. Initial investigations revealed pancytopenia, with a haemoglobin level of 5.0 g/dL, elevated mean corpuscular volume (142.2 fL), platelet count of 26 × 10^9/L, white cell count of 0.9 × 10^9/L, and significantly elevated troponin I levels (initially 2069 ng/L and rising to over 25,000 ng/L). Iron studies showed low serum iron (9.3 µmol/L), marginally elevated ferritin (325.3 ng/mL) and reduced total iron-binding capacity (40.84 µmol/L). Vitamin assays confirmed severe vitamin B12 deficiency (59 pmol/L) with elevated folate (49.2 nmol/L). Given the profound B12 deficiency, immunological testing revealed the presence of anti-parietal cell antibodies and elevated intrinsic factor IgG, which confirmed the diagnosis of pernicious anaemia. Given the clinical features suggestive of hypothyroidism, thyroid function testing was performed, revealing a free T4 of 4.3 pmol/L, TSH of 108.96 mIU/L and anti-thyroid peroxidase antibodies >600 IU/mL, consistent with Hashimoto's thyroiditis. Levothyroxine and cyanocobalamin replacement therapy were initiated subsequently. These findings led to a diagnosis of APS type 3b, characterised by the coexistence of pernicious anaemia and Hashimoto's thyroiditis.

CONCLUSION

Hashimoto's thyroiditis (HT) and autoimmune gastritis (AIG) often coexist. Studies have shown that HT is present in 10–40% of patients with gastric disorders, and about 40% of those with AIG also have HT. This case emphasizes the need to screen for coexisting autoimmune conditions.

EP_A062

OVARIAN OVERDRIVE: FUNCTIONING GONADOTROPH ADENOMA LEADING TO SPONTANEOUS OVARIAN HYPERSTIMULATION

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INTRODUCTION/BACKGROUND

Functioning gonadotroph adenomas (FGAs) are rare pituitary tumours characterised by the hypersecretion of biologically active gonadotrophs. We report a case of a 22-year-old Malay female diagnosed with FGA with ovarian hyperstimulation syndrome (OHSS), highlighting her clinical presentation, management, and post-operative outcomes.

CASE

The patient first presented at age 19 with acute abdominal pain and irregular menstruation. An abdominal ultrasound