showed large bilateral multiloculated ovarian cysts, the largest cyst measuring 12 x 15 cm. She underwent laparotomy for left salpingo-oophorectomy and right ovarian cyst aspiration with histopathological examination (HPE) that ruled out ovarian malignancy.

Post-operatively, she remained amenorrheic with a thin endometrial wall despite progestin therapy. Follow-up scans showed persistent large ovarian cysts. Hormonal work-up revealed elevated estradiol (13422 pmol/L, NR 110-1468 pmol/L), unsuppressed FSH (31.8 IU/L, NR 3-8 IU/L) and raised prolactin (1551 mIU/L, NR 70-566 mIU/L) levels. She also had intermittent headaches but no visual disturbances, galactorrhea or hirsutism. MRI of the pituitary reported pituitary macroadenoma (1.8 x 2.6 x 2.9 cm) with suprasellar extension compressing onto the optic chiasm.

The patient successfully underwent transsphenoidal surgery (TSS) of the pituitary adenoma. Tissue HPE stained positive for synaptophysin (+), FSH (+) and LH (+), with a low Ki-67 index of 0.1%, confirming the diagnosis of FGA with stalk effect. Post-TSS, her gonadotropin level normalised, menstruation resumed and ovarian cyst size decreased. Follow-up MRI showed no residual tumour or recurrence.

CONCLUSION

FGAs are a rare differential diagnosis that needs to be considered in females presenting with spontaneous OHSS, accompanied by elevated serum estradiol and unsuppressed FSH. Early diagnosis and prompt transsphenoidal surgery can restore normal menstruation, improve fertility, and potentially avoid ovarian surgery.

EP_A063

UNMASKING SYNDROMIC HYPOPARATHYROIDISM IN PREGNANCY: A CASE OF BARAKAT SYNDROME

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INTRODUCTION/BACKGROUND

Hypoparathyroidism (HypoPT) is a rare endocrine disorder that presents unique challenges in pregnancy due to altered calcium homeostasis. While 75% of cases follow neck surgery, 25% arise from autoimmune, genetic or other causes. During pregnancy, elevated Parathyroid hormone-related peptide (PTHrP) suppresses PTH, while increased 1,25-(OH)2-D3 enhances calcium absorption, reducing maternal calcium requirements. Maintaining stable calcium levels is essential to prevent fetal hypocalcemia and secondary hyperparathyroidism.

CASE

A 24-year-old female at 37 weeks of gestation was incidentally found to have asymptomatic hypocalcemia. Two years earlier, during her first pregnancy, she experienced severe postpartum hypocalcemia accompanied by bilateral lower limb weakness. Investigations revealed a corrected calcium level of 1.65 mmol/L (reference range: 2.18–2.60), phosphate of 1.73 mmol/L (0.78–1.65), iPTH of 0.84 pmol/L (1.56–6.03) and a total 25-hydroxy vitamin D level of 28.88 nmol/L (≥75 nmol/L), leading to a diagnosis of vitamin D deficiency and HypoPT. Unfortunately, she was lost to follow-up. During her current pregnancy, blood tests showed a corrected calcium of 2.04 mmol/L, phosphate of 1.32 mmol/L and iPTH of 2.86 pmol/L. She remained clinically asymptomatic with no signs of hypocalcemia. The goal of management was to maintain calcium levels within the lower normal range until delivery. Further history revealed no prior neck surgery, but she had long-standing bilateral sensorineural hearing loss since childhood. Notably, her parents and siblings also had congenital deafness. Although rare, syndromic causes of HypoPT, such as Barakat syndrome (HDR syndrome), should be considered in patients with hearing impairment, renal disease, or congenital anomalies, especially with a strong family history.

CONCLUSION

This case highlights the importance of recognising syndromic HypoPT in pregnancy. Barakat syndrome, caused by GATA3 mutations, is characterised by HypoPT, deafness and renal disease, with the full triad in 62.3% of cases and HypoPT with deafness in 28.6%.

EP_A064

UNMASKING GASTRIC VOLVULUS IN THE SHADOW OF HYPOTHYROIDISM: A CASE OF ACUTE MESENTERO-AXIAL ROTATION

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INTRODUCTION

Gastric volvulus is a rare, life-threatening condition caused by an abnormal stomach rotation, potentially leading to obstruction and strangulation. The mesentero-axial type

is the most common, comprising about one-third of cases. This report discusses a case of acute mesentero-axial gastric volvulus likely caused by severe hypothyroidism.

CASE

A 77-year-old female with a history of degenerative spine disease, hypertension, hypothyroidism post-thyroidectomy and hyperlipidemia presented with a three-day history of abdominal pain, distension and vomiting. Clinically, her abdomen was distended and tender. Abdominal CT reported mesentero-axial gastric volvulus, and endoscopy showed a distended stomach with undigested food. Barium swallow revealed oesophageal motility disorders but no mass. Further tests showed elevated TSH levels (>51.9 mIU/L) and low free T4 (6.6 pmol/L), indicating severe hypothyroidism, likely due to missed levothyroxine (LT4) doses.

Due to her advanced age and initial presentation of sinus arrhythmia, the plan was to administer LT4 rectally with serial monitoring of TFT. The patient was prescribed a daily dose of 150 mcg (4 mcg/kg/day) of LT4, titrated up to 200 mcg daily (6 mcg/kg/day) and later switched to intravenous LT4 50 mcg daily before undergoing gastropexy. Following thyroid hormone replacement, her condition improved.

CONCLUSION

Severe hypothyroidism can impair gastrointestinal motility, and while gastrointestinal symptoms are common, gastric volvulus is rare. This case emphasises the importance of recognising thyroid dysfunction as a differential cause of gastric volvulus, particularly in patients with thyroid disorders. Early thyroid hormone replacement is essential to prevent recurrence and severe complications.

EP_A065

DEBILITATING NEUROGLYCOPENIA SECONDARY TO HIRATA DISEASE ACHIEVING REMISSION SPONTANEOUSLY

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INTRODUCTION/BACKGROUND

Insulin Autoimmune Syndrome (IAS), also known as Hirata's disease, is a rare cause of hyperinsulinaemic hypoglycaemia. It is characterised by spontaneous hypoglycemia associated with extremely high circulating insulin levels and positive anti-insulin antibodies. Hypoglycaemic episodes usually occur in the post-prandial state and are commonly associated with other autoimmune conditions, such as Graves' disease, systemic lupus erythematosus and rheumatoid arthritis.

CASE

We report a case of a 62-year-old male with a background history of hypertension and cerebrovascular accident who presented with reduced consciousness. His capillary blood glucose levels ranged from 1.7 to 2.2 mmol/L and hypoglycaemia symptoms resolved following intravenous dextrose administration. The patient denied any consumption of oral hypoglycemic agents, exogenous insulin or traditional medications. Hypoglycaemia episodes occurred in both fasting and postprandial states. There was no weight gain to suggest insulinoma, and there were no constitutional symptoms to suggest underlying malignancy. No associated autoimmune conditions were noted. Systemic examination was unremarkable. Laboratory results revealed random blood glucose levels of 1.7 mmol/l, with marked elevation of insulin level of >6944 pmol/l and C-peptide level of 3496 pmol/l. Renal and liver profile and septic parameters were all within normal range. Insulin autoantibody (IAA) titers were elevated at 175 IU/mL (positive >20 IU/mL). Sulfonylurea levels were undetectable, and tumour markers were within normal limits. Localisation studies with CT, MRI and endoscopic ultrasound of the pancreas showed a normal pancreaticobiliary system. He was initially managed with oral prednisolone 10 mg twice daily and responded well. The dose was tapered off over two months with no recurrent episodes of hypoglycaemia afterwards.

CONCLUSION

IAS should be considered in a patient with postprandial hypoglycaemia with marked elevation of insulin levels. The diagnosis can be confirmed by elevation of insulin autoantibody titres. Most cases are self-remitting but may be managed with low-carbohydrate meals, steroids and steroid-sparing immunosuppressants.