

Adult E-Poster

to avoid unnecessary investigations and treatments. The somatostatin test can be useful and practical in differentiating TSHoma from resistance to thyroid hormone.

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LATENT AUTOIMMUNE DIABETES IN YOUTH PRESENTING AS YOUNG-ONSET TYPE 2 DIABETES: A CASE REPORT

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INTRODUCTION/BACKGROUND

Latent autoimmune diabetes forms a continuous age-related spectrum from LADY to LADA, where LADY exhibits greater autoimmunity. Latent autoimmune diabetes in youth (LADY) is diagnosed in individuals aged 15 to 29 years. A high prevalence of LADY is observed among youth with the T2DM phenotype. The TCF7L2 rs12255372 polymorphism is linked to an increased risk of developing T2DM at a young age and is associated with lower levels of GADA in individuals with either T2DM or latent autoimmune diabetes.

CASE

A 28-year-old female with no history of T2DM was admitted to the emergency room due to altered mental status. She had experienced a weight loss of approximately 10 kg and frequent nocturnal urination; however, she had never consulted a physician. Both her parents and her sister have a known history of T2DM. A physical examination revealed excess body weight and acanthosis nigricans. Laboratory results indicated elevated glucose levels, a high A1C level, a normal fasting C-peptide, negative ketones in the urine and a high HOMA-IR score. Following the patient's clinical improvement, we transitioned from insulin to oral hypoglycemic drugs. After several weeks, we identified a positive anti-GAD result and the TCF7L2 gene polymorphism, rs12255372 (G/T).

CONCLUSION

The clinical diagnosis of latent autoimmune diabetes (LAD) can be quite challenging. Young individuals exhibiting a T2DM phenotype should undergo assessment for pancreatic islet cell autoantibodies. Common TCF7L2 gene polymorphisms are linked to T2DM and latent autoimmune diabetes but not type 1 diabetes.

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SUSPECTED LEFT ADRENOCORTICAL CARCINOMA LATER DIAGNOSED AS EXTRA-ADRENAL COMBINED SCHWANNOMA AND GANGLIONEUROMA

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INTRODUCTION/BACKGROUND

Ganglioneuromas and schwannomas are both rare benign tumours. They arise from different types of nerve cells: ganglioneuromas from autonomic ganglion cells and schwannomas from nerve sheath cells (Schwann cells). A combined adrenal ganglioneuroma and schwannoma is extremely rare, representing 1.4% of adrenal incidentalomas.

CASE

We present a 41-year-old male with an underlying left ureteric calculus who was referred for left adrenal incidentaloma from CT urography (CTU). He had no history of paroxysms of headache, sweating or palpitations. There were no symptoms to suggest Cushing's or underlying malignancy. On examination, he was normotensive and there were no discriminatory features of Cushing's. Laboratory evaluation showed normal potassium (4.3 mmol/L), and the overnight dexamethasone test (ODST) was appropriately suppressed (12 nmol/L). 24-hour urine metanephrine was within normal range. Testosterone and DHEAS were within the normal range with 19 nmol/L and 3.830 umol/L levels, respectively. Initial CTU reported a left adrenal mass measuring 4.0 x 3.1 x 3.8 cm. The adrenal CT demonstrated a left adrenal mass measuring 4.1 x 3.2 x 4.0 cm, with a 39 Hounsfield unit, an absolute washout of 28% and a relative washout of 16%. These findings indicate an indeterminate adrenal mass with a differential of adrenocortical carcinoma or pheochromocytoma. He underwent a left adrenalectomy and was discharged well. Histopathological examination showed an encapsulated biphasic tumour. There were Verocay bodies, and the neoplastic cells were narrow, elongated and wavy with tapered ends, interspersed with collagen fibres, which are distinct characteristics of schwannomas. At the periphery of the tumour, a separate proliferation of spindle cells