3.1-6.8 pmol/L]). Her fT4 rebounded to 47.80 pmol/L (TSH<0.005 IU/L) after 6 weeks (or one month from the last dose of carbimazole). Carbimazole was reintroduced and continued up to her recent follow-up at 2 months post-discharge.

CONCLUSION

Hypothyroidism can occur with ATT for primary hyperthyroidism due to overdosage or increased individual sensitivity, but it is usually short-lived. Prolonged hypothyroidism shortly after presentation of thyroid storm is unusual. Possible explanations include the presence of TSH blocking or stimulating antibodies, sick euthyroid syndrome and the elusive "shock thyroid." A thyroid storm due to a thyrotoxic phase of thyroiditis is unlikely here due to the subsequent relapse of thyrotoxicosis. Careful clinical assessment and monitoring are essential to guide treatment direction.

EP_A079

UNMASKING MACRO-TSH: A CASE SERIES

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INTRODUCTION/BACKGROUND

Discrepancies between biochemical findings and clinical presentation—particularly isolated elevations in thyroid-stimulating hormone (TSH) with normal free thyroxine (FT4) and the absence of hypothyroid symptoms should prompt the consideration of assay interference. Macro-TSH is one of the important possible causes that should be considered. Failure to recognise macro-TSH can result in unnecessary investigations and inappropriate treatment. We describe two middle-aged male patients, both without a family history of thyroid disorders, who were referred for evaluation of discordant thyroid function tests.

CASE

Case 1. A 52-year-old male with long-standing Type 2 diabetes and chronic kidney disease Stage 3a was referred for an abnormal thyroid function test (TFT). His TSH was 7.83 uIU/L (0.35-4.94), while free T4 (FT4) was within the normal limit at 16.59 pmol/L (9-19.05). Polyethylene glycol (PEG) precipitation was 0.67 uIU/mL, with a recovery rate of 93% and a confirmed diagnosis of macro-TSH.

Case 2. A 29-year-old male had been treated for hypothyroidism with levothyroxine for 10 months following an initial TSH of 12.37 uIU/mL and free T4 of 13.27pmol/L. Despite adherence to treatment and titrating doses of thyroxine, his TSH persistently rose to 86.06 uIU/mL with free T4 of 11.64 pmol/L. He remained clinically euthyroid. PEG precipitation revealed pre-precipitation TSH of 76.46 uIU/mL with 84% recovery and post-precipitation TSH of 11.88 uIU/mL. These findings confirmed the presence of macro-TSH and led to the cessation of thyroxine treatment.

CONCLUSION

These cases underscore the importance of considering macro-TSH in patients with elevated TSH and normal FT4 who lack clinical symptoms of hypothyroidism. Failure to recognise this phenomenon may result in misdiagnosis and inappropriate treatment. PEG precipitation testing is a valuable tool in confirming macro-TSH and guiding appropriate clinical decision-making.

EP_A080

MUSCLE UNDER SIEGE: A CASE OF POST-BARIATRIC SURGERY RHABDOMYOLYSIS

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INTRODUCTION/BACKGROUND

Rhabdomyolysis after bariatric surgery is rare and under-recognised. It can lead to acute kidney impairment with an associated 25% risk of mortality. We report a patient with rhabdomyolysis after sleeve gastrectomy.

CASE

A 48-year-old male patient who has class III obesity (body mass index of 70 kg/m^2) was admitted for bariatric surgery. His medical history was significant for hypertension, gouty arthritis and moderate obstructive sleep apnea, with an American Society of Anesthesiologists (ASA) III physical status. He received 3 weeks of in-patient meal replacement therapy with a very low-calorie liquid diet and resistance exercise program before his operation. Intra-operatively, he was placed in a reverse Trendelenburg position. Initially, laparoscopic sleeve gastrectomy was planned, but a switch to open surgery was made due to technical difficulties. The total duration of surgery was 554 minutes. Post-operatively, the patient had a blister and grade II pressure injury at the left gluteus. He was oliguric (urine output less than 0.1 ml/kg/day) with elevated blood creatine kinase