hypoglycemia, particularly when occurring nocturnally. IGF-2 overproduction, typically by large mesenchymal or epithelial tumours, is the underlying reason behind these events. Although surgical resection of the tumour remains the definitive treatment, glucocorticoids and frequent glucose supplementation are used in conservative management.

EP_A083

MEN TYPE 2B SYNDROME IN A NORMOTENSIVE YOUNG FEMALE WITH INCIDENTALLY DISCOVERED PHAEOCHROMOCYTOMA

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INTRODUCTION/BACKGROUND
Phaeochromocytomas (PC) account for up to 5-25% of adrenal incidentalomas. Some PC patients, especially those with an adrenal incidentaloma, are asymptomatic and have normal blood pressure. The frequency of incidentally discovered normotensive phaeochromocytomas is increasing owing to better accessibility of imaging procedures. These tumours may be linked to certain genetic syndromes, such as Multiple Endocrine Neoplasia (MEN) type 2B, a rare condition caused by the RET proto-oncogene mutation, and includes a range of clinical manifestations such as phaeochromocytomas, medullary thyroid carcinoma and mucosal neuromas.

CASE
A 34-year-old female who had undergone total thyroidectomy for medullary thyroid carcinoma (MTC) was referred for an incidental right adrenal mass from CT staging. She had no paroxysms of headache or palpitations, no family history of MTC, pheochromocytoma and MEN-related diseases. She was normotensive. Physical examinations revealed mucosal neuromas on the tongue, buccal mucosa, lips, and eyelids. No marfanoid habitus present. Laboratory results showed normal serum calcium (2.57 mmol/L), but a 24-hour urine metanephrine was four times the upper limit of normal, along with borderline elevation of normetanephrines. The adrenal CT revealed an indeterminate right adrenal mass measuring 2 x 2 x 3 cm with peripheral calcifications suggesting pheochromocytoma. Left lymph node and carotid sheath biopsy were reported as features consistent with ganglioneuroma. The patient is scheduled for a right retroperitoneoscopic adrenalectomy. The unifying clinical presentations are consistent with MEN 2B Syndrome. However, genetic panel testing was not done due to financial constraints.

CONCLUSION
This case underscores the importance of considering genetic syndromes, such as MEN type 2B, in patients with incidental findings of pheochromocytomas, even when the patient is normotensive. Early diagnosis and genetic testing can help guide management, including surveillance for other tumours associated with MEN type 2B and early intervention. Further research is needed to explore the clinical presentation of pheochromocytomas in normotensive patients.

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PSEUDOACROMEGALY IN A PATIENT WITH PACHYDERMOPERIOSTOSIS

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INTRODUCTION/BACKGROUND
Patients who are clinically suspected of acromegaly are usually referred to an endocrinologist. Biochemical evaluation is necessary to confirm the presence of an abnormality in the growth hormone (GH) axis. There are some conditions with physical features mimicking acromegaly in the absence of GH excess. Given the heterogeneity of conditions that can cause pseudoacromegaly, this posed a diagnostic challenge.

CASE
A 32-year-old male was referred to the Endocrine clinic for evaluation of suspected acromegaly. He had an incidental finding of pancytopenia and chronic excessive sweating when he presented to his General Practitioner. Following this, he was diagnosed with myelofibrosis by a haematologist. He reported having large hands and feet since his teens. He was also referred to a dermatologist for generalised skin thickening and itchiness and treated for photodermatitis.

Clinically, he has clubbing of the fingers of his hands and feet and furrowing of skin on his forehead but no other phenotypical features of acromegaly. Biochemically, IGF-1 and GH levels were normal.