decreased to 2.44 mmol/L after six doses of calcitonin. Eventually, she delivered vaginally at 38 weeks with no complications; the neonate weighed 2.58 kg.

A 33-year-old primigravida developed hypertension at 22 weeks, progressing to preeclampsia with pulmonary oedema and blurred vision at 27 weeks, requiring emergency caesarean section. The neonate weighed 980 g; placental histology showed vascular malperfusion and retroplacental haematoma. Hypertension persisted post-delivery. Retrospectively, there was an unrecognised hypercalcaemia detected from 26 weeks gestation. Postpartum laboratory showed calcium 3.04 mmol/L, phosphate 0.67 mmol/L and intact PTH 20.3 pmol/L. Ultrasound and Tc-99m Sestamibi confirmed a left inferior parathyroid adenoma. She underwent a left parathyroidectomy, and she was immediately weaned off antihypertensives.

CONCLUSION

PHPT in pregnancy poses significant maternal and foetal risks. Medical therapy options are limited during pregnancy. Early recognition and tailored management are crucial to minimise maternal and foetal complications.

EP_A092

WHEN THE CURE BITES BACK: A CASE REPORT ON CARBIMAZOLE-INDUCED MYOSITIS

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INTRODUCTION/BACKGROUND

Musculoskeletal complaints, including myositis, are common in thyroid disorders. However, it is a rare and non-classical side effect of antithyroid drugs.

CASE

A 35-year-old male with Graves' disease was admitted for symptomatic thyrotoxicosis despite treatment with high-dose carbimazole, lithium and dexamethasone for direct observed therapy (DOTS). On examination, he exhibited signs of thyrotoxicosis, including tremors, sweaty palms, proptosis and a large goitre. Thyroid function tests revealed overt thyrotoxicosis (TSH <0.001 mIU/L, T4 122.5 pmol/L). He responded well to DOTS on the same treatment, with T4 decreasing to 27 pmol/L by Day 10 of admission. However, he developed severe proximal muscle aches on day 10. Laboratory investigation revealed an elevated creatinine kinase (CK) level of 5662 IU/L. A diagnosis of carbimazole-induced myositis was made, prompting the discontinuation of carbimazole and initiation of intravenous hydration and cholestyramine while continuing lithium and steroids. The myositis improved, but there was a rebound in his thyrotoxicosis (T4 52pmol/L), prompting a trial of propylthiouracil, which led to a flare of the myositis (CK 1328 IU/). He was planned for urgent total thyroidectomy then and was started on Lugol's iodine.

Myalgia and elevated CK levels are rare but recognised manifestations of hyperthyroidism. These can be due to direct effects of thyrotoxicosis on skeletal muscle, thyrotoxic hypokalemic periodic paralysis and drug-induced myositis by carbimazole and propylthiouracil. The pathophysiology of drug-induced myositis may be due to the abrupt decrease in circulating thyroid hormones, leading to a relative hypothyroid state in the peripheral tissues and resulting in myositis. Thioamides may also have a direct toxic effect on myocytes and trigger a local immune response at myocytes, leading to myositis.

CONCLUSION

This case highlights myositis as a rare side effect of anti-thyroid drugs and can cause significant morbidity. Early recognition and close monitoring are essential for managing this condition.

EP_A093

A RARE CASE OF HYPONATREMIA AS A LEADING SIGN OF EMPTY SELLA SYNDROME

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INTRODUCTION/BACKGROUND

Hyponatremia is a common electrolyte disturbance that can be life-threatening. Careful evaluation of hyponatremia may reveal significant underlying conditions and may lead to the diagnosis of a rare multiple hormone deficiency, with detrimental consequences for the patient if left untreated. We present an interesting case of a patient who presented with symptoms of chronic hyponatremia, and the results of the examination led us to the discovery of partial empty sella syndrome as the aetiology.

CASE

A 61-year-old female presented with a six-year history of general weakness, nausea, vomiting and cold intolerance.

She was diagnosed with hyponatremia and has routinely received sodium supplementation therapy. However, the patient's complaints have worsened over the past year. There is history of severe vaginal bleeding and shock during childbirth 22 years ago, which required a hysterectomy to be performed. Physical examination showed no abnormalities. Laboratory data showed severe hyponatremia with a serum sodium of 115 meq/L and low serum osmolality, but urine osmolality and urine sodium were elevated. Renal examination showed no abnormality. Thyroid function showed a low FT4 level at <0.4ng/dL (Reference Value [RV]: 0.7-1.48 ng/dL) and normal TSH at 1.882uIU/mL (RV: 0.35-4.94 uIU/mL). A low AM cortisol level of <1.0 mcg/dL (RV: 3.7 – 19.4 mcg/dL), normal adrenocorticotropic hormone (ACTH) level of 18.9pg/mL (RV: 7.2-63.3 pg/mL) suggested secondary adrenal insufficiency. She had low LH (6.6 mIU/mL), low FSH (11.7 mIU/mL) and low estradiol (5 pg/mL). The brain magnetic resonance imaging (MRI) confirmed the diagnosis of partial empty sella. Treatment with steroids and levothyroxine led to symptoms and laboratory resolution in a few months.

CONCLUSION

Empty sella syndrome is a rare pituitary condition that can be primary or secondary. It can potentially cause hypopituitarism that may be symptomatic or asymptomatic. This case emphasises the need for a comprehensive work-up of hyponatremia, awareness of secondary adrenal insufficiency, panhypopituitarism and recognition of the life-threatening potential of partial empty sella syndrome if left untreated.

EP_A094

AN UNUSUAL CASE PRESENTATION: MALIGNANT THYROID NODULE IN A PATIENT WITH LUNG ADENOCARCINOMA

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INTRODUCTION/BACKGROUND

Lung adenocarcinoma is a prevalent subtype of lung cancer known for its capacity to metastasize to various organs. In patients diagnosed with this cancer, thyroid nodules pose diagnostic challenges, as they may indicate metastasis or represent distinct conditions such as multinodular goiter or other thyroid malignancies. Notably, lung adenocarcinoma has a higher tendency to metastasize to the thyroid, with an incidence rate of 1-3%.

CASE

A 53-year-old female, undergoing chemotherapy for lung adenocarcinoma, presented to the Internal Medicine Clinic at RSUP M. Djamil Padang with a secondary thyroid nodule suspected to be metastatic. Other differential diagnoses were primary thyroid tumor and subclinical hyperthyroidism. Her history included a neck mass, hoarseness, pain while swallowing, weight loss, fatigue, and tremors. Physical examination revealed multiple nodules in the anterior neck with defined borders that moved during swallowing. Thyroid ultrasound indicated bilateral multinodular goiter (TIRADS III) without lymph node enlargement. Scintigraphy showed a cold nodule. Fine needle aspiration biopsy (FNAB) confirmed thyroid carcinoma consistent with metastasis from lung adenocarcinoma. The management plan included continuing chemotherapy and oncology consultation.

CONCLUSION

This case highlights the critical importance of early detection and management of secondary cancers to enhance patient outcomes and emphasizes the need for clinician awareness of thyroid metastasis in lung cancer, particularly lung adenocarcinoma.

EP_A095

POSTMENOPAUSAL VIRILIZATION: THE TELLTALE SIGN OF A RARE OVARIAN TUMOR

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INTRODUCTION/BACKGROUND

Postmenopausal virilization describes the occurrence of male secondary characteristics in a postmenopausal woman, contributed by excess androgen that originating from either the ovaries or adrenal glands. Relative androgen excess could be due to menopausal transition or polycystic ovarian syndrome. However, with virilizing symptoms, further investigation is warranted to look for ovarian hyperthecosis or androgen-secreting ovarian or adrenal tumors. Sertoli-Leydig cell tumors are considered significantly rare, accounting for less than 1% of all primary ovarian tumors. Diagnosis of these rare tumors can be challenging.