CASE

A 78-year-old female with poorly-controlled diabetes mellitus presented with recurrent episodes of generalized weakness, lethargy and gastrointestinal symptoms since March 2024. She had undergone a total thyroidectomy in 2009 for multinodular goiter and neck surgery in 2022 for extensive neck abscess. Her calcium was normal in 2019 but no other postoperative monitoring was done.

She was admitted in March, May, and September 2024 with increasing myalgia, breathlessness, elevated creatine kinase (CK) (500 to 3000 U/L) and progressive renal dysfunction [creatinine: 93 mmol/L (March), 175 mmol/L (May), 422 mmol/L(September)]. Thyroid function tests were normal. Urinalysis showed proteinuria and hematuria. Extensive investigations for autoimmune myositis and renal failure were unremarkable, resulting in a presumed diagnosis of diabetic nephropathy.

In September, amid worsening renal function and persistent CK elevation, severe hypocalcemia (1.30 mmol/L*) was finally recognized. Retrospectively, hypocalcemia (1.47 mmol/L) was first detected in May 2024, treated with intravenous calcium bolus, but not investigated. Immediate calcium infusion with oral calcium and calcitriol supplementation led to a significant CK reduction from 1233 U/L to 286 U/L, creatinine level decreased from 422 mmol/L to 315 mmol/L, with marked improvement of her symptoms and she was discharged without residual weakness. Subsequent follow-up showed further improvement in creatinine to 187 mmol/L and a stabilized CK level (235 U/L). Ultimately, hypoparathyroidism was confirmed to have an undetectable iPTH level.

CONCLUSION

This case highlights the importance of recognizing delayed hypoparathyroidism and its presentation with severe rhabdomyolysis. Unawareness of this complication and a low index of suspicion can lead to prolonged misdiagnosis and exacerbate complications. Prompt recognition and treatment are crucial.

EP_A105

BLINDED BY METASTASIS: A RARE CASE OF RENAL CELL CARCINOMA IN THE PITUITARY

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INTRODUCTION/BACKGROUND

Renal cell carcinoma (RCC) is the most common primary kidney tumor, accounting for 1-3% of adult malignancies. Metastasis of RCC to the pituitary gland is extremely rare, with only a few reported cases. The time interval from primary tumor diagnosis to pituitary metastasis ranges from 3 months to 27 years, with a median interval of 1 year. Surgical resection is the treatment of choice in cases where vision deteriorates due to optic nerve compression. Adjuvant therapies may also be used, including radiotherapy, chemotherapy, immunotherapy, or targeted therapy. Here, we report a case of RCC metastasis to the pituitary presenting with impaired vision.

CASE

A 62-year-old healthy male presented with progressive blurring of vision in both eyes, where the left eye was completely blind, and the right eye had tunnel vision. Constitutional symptoms occurred four months after undergoing right nephrectomy for RCC stage III. Magnetic resonance imaging revealed an enlarged sella with a solid lesion extending into the suprasellar region, compressing the bilateral optic chiasm and abutting both anterior cerebral arteries. He underwent transsphenoidal surgery, but the procedure was incomplete due to significant bleeding from the vascularized tumor. Two months later, a second decompression surgery was performed to preserve both the optic nerve and chiasm. Postoperatively, he developed panhypopituitarism and required hormone replacement therapy with thyroxine and hydrocortisone. Histopathology examination confirmed metastasis of clear cell renal carcinoma. Hence, radiotherapy and the tyrosine kinase inhibitor (TKI) Pazopanib were used as adjuvant therapies. Following treatment, the patient's vision remained stable, with neither improvement nor further deterioration.

Adult E-Poster

CONCLUSION
This case underscores the rarity of pituitary metastases from renal cell carcinoma and emphasizes the need for clinicians to consider this complication among patients with unexplained neurological symptoms. A multidisciplinary treatment approach with radiotherapy and TKI has potential benefits in challenging cases with incomplete surgical resection.

EP_A106

A RARE ENCOUNTER: UNVEILING THE CLINICAL SPECTRUM OF SUBACUTE THYROIDITIS

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INTRODUCTION/BACKGROUND
Subacute thyroiditis (SAT) is a rare, self-limiting inflammatory thyroid disease. It usually presents with neck pain, transient thyrotoxicosis and systemic dysfunction. It predominantly affects women aged 20-50 years and is commonly associated with viral infections or autoimmune responses. We report an unusual case of SAT with atypical presentation, highlighting its diagnostic challenges and management.

CASE
A 38-year-old female presented with fever and painless anterior neck swelling with significant weight loss of 9 kg for two weeks, preceded by left otalgia for one week. She denied any significant past medical history, was not taking any medications and reported no family history of thyroid diseases. On examination, the patient was calm, and except for a high-grade fever, there were no other signs of sepsis. She had a palpable, non-tender, diffuse goiter without thyroid eye signs or fine tremors.

Laboratory investigations showed low thyroid-stimulating hormone (TSH) at 0.05 mIU/L, with elevated free T4 (51.6 pmol/L) and free T3 (14.1 pmol/L), yielding a T3/T4 ratio of <0.3. C-reactive protein (CRP) was markedly elevated at 162 mg/L, though white cell count remained normal. Anti-thyroid antibodies were negative. Thyroid ultrasound revealed a multinodular goiter (TIRADS 3), while thyroid scintigraphy demonstrated low uptake, confirming SAT. These findings indicated the hyperthyroid phase of SAT.

Based on clinical symptoms, laboratory results, and imaging findings, a diagnosis of subacute thyroiditis was made. The patient was treated with corticosteroids to reduce inflammation alongside symptomatic treatment. The patient responded well, with resolution of symptoms within four weeks. Follow-up thyroid function tests normalized after two months, with no recurrence of symptoms or persistence of hyper/hypothyroidism was noted.

CONCLUSION
This case emphasizes that SAT should be considered in patients presenting with fever and elevated free T4 who lack typical thyrotoxic features, especially following a recent infection. The painless goiter and significantly elevated free T4 in this case represented atypical features that could have easily led to misdiagnosis.

EP_A107

INDIVIDUALIZED MANAGEMENT STRATEGIES FOR VERY SEVERE HYPERTRIGLYCERIDEMIA: A CASE SERIES

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INTRODUCTION/BACKGROUND
Very severe hypertriglyceridemia (HTG) is defined by the Endocrine Society as a serum triglyceride concentration ≥22.6 mmol/L. Management typically involves dietary modification, pharmacotherapy such as fibrates combined with statins, insulin therapy, and plasmapheresis in select cases. We report two cases of non-familial very severe HTG secondary to poorly controlled type 2 diabetes mellitus, each managed using different therapeutic strategies.

CASE
Case 1: A 23-year-old female with type 2 diabetes mellitus and class I obesity (BMI 29.3 kg/m^2) presented with diabetic ketoacidosis and acute pancreatitis. She had a history of poor adherence to insulin therapy. Her serum triglyceride level was markedly elevated at 64 mmol/L. She was treated with a fixed-rate intravenous insulin infusion (0.1 units/kg/hour) and kept on nothing per orem, resulting in a significant reduction of triglyceride levels to 2.5 mmol/L within three days.

Case 2: An 83-year-old female with type 2 diabetes mellitus, stage 4 chronic kidney disease, hypertension, neurocognitive disorder and osteoporosis who was incidentally found to have severe HTG (25.6 mmol/L) during routine screening. Despite being asymptomatic, she was started on a variable-rate intravenous insulin infusion to reduce the