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.

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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