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

risk of pancreatitis. Her triglyceride levels decreased to 16.8 mmol/L but then plateaued. Insulin was discontinued, and a low-carbohydrate, low-fat diet with intermittent fasting (from lunch until the next day's breakfast) was initiated. This led to a reduction in her triglyceride level to 9.01 mmol/L within three days.

Both patients were discharged with premixed insulin, rosuvastatin, omega-3 fatty acid supplementation and additional fenofibrate for Case 1 only, as Case 2 has CKD stage 4.

CONCLUSION

These cases highlight the importance of individualized treatment strategies in managing very severe non-familial HTG. While insulin infusion and dietary interventions were effective in both patients, the choice of therapy should be guided by clinical context.

EP_A108

INTERPRETING THYROID HORMONE LEVELS IN A PATIENT WITH GRAVES' DISEASE ON ENOXAPARIN

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INTRODUCTION/BACKGROUND

Enoxaparin, a low molecular-weight heparin, can interfere with free T4 measurements by displacing thyroid hormones from their binding proteins, potentially giving rise to misleading results. Diagnosis becomes particularly challenging in Graves' disease when this interference occurs, as fluctuating thyroid function caused by shifting TSH receptor antibodies is rare in this condition.

CASE

We report a 38-year-old Malay female who was diagnosed with Grave's disease in May 2024 and treated with carbimazole. Five months later, she was readmitted for dyspnea and hypoxia and diagnosed with a severe pulmonary embolism. Treatment included thrombolysis with alteplase, followed by anticoagulation therapy using enoxaparin.

Upon admission, her anti-thyroid therapy was withheld due to subclinical hypothyroidism, as evidenced by a slightly low free T4 (12.8 pmol/L) and elevated TSH (6.65 iU/L). During her prolonged hospital stay, reassessment revealed discordant thyroid hormone levels, with both free T4 and TSH being elevated, coinciding with the development of hypothyroid symptoms. Assay interference was ruled out through thyroid function tests performed in other laboratories. While anti-TSH receptor antibody was positive, anti-thyroid peroxidase antibody was normal. A multidisciplinary discussion between physicians and biochemical pathologists concluded that the discordant thyroid function test results were likely due to enoxaparin-induced interference (falsely elevated free T4) in the context of her underlying hypothyroid state (elevated TSH). Oral levothyroxine was initiated. Subsequently, her pulmonary embolism treatment was switched to oral rivaroxaban, and further thyroid function tests showed normal free T4 and TSH levels, corresponding to a clinically euthyroid state.

CONCLUSION

This case emphasizes that when managing Graves' disease with low molecular-weight heparin, clinicians should be aware of potential laboratory interference when interpreting discordant thyroid function test results.

EP_A109

ACARBOSE: AN UNEXPECTED ALLY IN MANAGING REACTIVE HYPOGLYCEMIA IN PREGNANCY

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INTRODUCTION/BACKGROUND

Reactive hypoglycemia, or postprandial hypoglycemia, which can occur during pregnancy due to physiological changes such as altered insulin sensitivity and heightened metabolic needs, presents unique management considerations. Acarbose, an alpha-glucosidase inhibitor, offers a potential therapeutic strategy by slowing the digestion and absorption of carbohydrates, thereby helping to regulate postprandial glucose levels and prevent hypoglycemic episodes in pregnant women.

CASE

We present the case of a 25-year-old pregnant female diagnosed with overt diabetes mellitus at 10 weeks of gestation via oral glucose tolerance test (OGTT). Initially she was started with insulin and metformin, however despite dietary adjustments and titration of medications, she experienced recurrent hypoglycemic episodes. These episodes occurred 1-2 hours after meals and were refractory to conventional management. Acarbose was then initiated