and eGFR 37.6 mL/min. Thyroid function tests confirmed severe hypothyroidism with free T4 7.60 pmol/L (NR: 7.86-14.41), and TSH >49.40 mIU/L (NR: 0.38-5.33) with positive thyroid peroxidase antibody, confirming Hashimoto's thyroiditis. No other causes for rhabdomyolysis were identified and autoimmune hepatitis screening was negative. The patient was managed with aggressive intravenous hydration and levothyroxine replacement therapy, resulting in clinical and biochemical resolution.

CONCLUSION

This case underscores the importance of considering hypothyroidism in the differential diagnosis of unexplained rhabdomyolysis, especially in the absence of conventional triggers. Prompt recognition and early treatment are essential in preventing complications and ensuring optimal patient outcome.

EP_A136

MEMBRANOUS NEPHROPATHY IN A PATIENT WITH ELEVATED CARCINOEMBRYONIC ANTIGEN: AN UNUSUAL PRESENTATION OF MEDULLARY THYROID CARCINOMA

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INTRODUCTION/BACKGROUND

Membranous nephropathy is an important cause of nephrotic syndrome where immune complexes are deposited at the subepithelial space of the glomerular basement membrane. Membranous nephropathy is classified into primary and secondary causes, including infections, autoimmune, neoplasms, drugs or idiopathic. Medullary thyroid carcinoma (MTC) is a relatively rare malignant tumour subtype originating from the parafollicular cells of the thyroid gland, producing tumour markers such as calcitonin, carcinoembryonic antigen (CEA) and chromogranin A. The co-occurrence of membranous nephropathy with MTC is extremely uncommon, and such an association may reflect a paraneoplastic manifestation or an underlying monoclonal gammopathy.

CASE

We report the case of a 68-year-old woman who presented with progressive shortness of breath, bilateral lower limb edema, frothy urine, and periorbital puffiness. She denied orthopnea, paroxysmal nocturnal dyspnea, constitutional symptoms, or features suggestive of autoimmune disease. Initial workup revealed nephrotic-range proteinuria, and a renal biopsy demonstrated early membranous nephropathy. Notably, her CEA level was persistently elevated; however, upper and lower gastrointestinal endoscopies showed only benign findings, including a hiatal hernia and sigmoid colon diverticulum. Contrast-enhanced CT imaging revealed a retrosternal goitre, while FDG-PET scanning identified an FDG-avid lesion in the left thyroid lobe with ipsilateral cervical lymphadenopathy. Thyroid ultrasound showed a TIRADS 4 nodule, and subsequent core needle biopsy confirmed MTC. She underwent total thyroidectomy and modified neck dissection without complications. At one-month postoperative follow-up, her proteinuria had slightly improved.

CONCLUSION

This case underscores the importance of a thorough malignancy workup in atypical presentations of nephrotic syndrome and highlights a rare paraneoplastic link between MTC and glomerular disease. In the context of raised CEA with negative findings despite extensive investigations for gastrointestinal tract causes, one might need to consider other non-gastrointestinal related causes for raised CEA such as medullary thyroid carcinoma.

EP_A137

NOT JUST TYPE 2 DIABETES: SEVERE INSULIN RESISTANCE WITH ATYPICAL FAT DISTRIBUTION SUGGESTS LIPODYSTROPHY SYNDROME

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INTRODUCTION/BACKGROUND

Lipodystrophy syndromes are rare disorders of adipose tissue distribution, often leading to severe insulin resistance and metabolic complications. We present a case of a young woman initially diagnosed with type 2 diabetes, unresponsive to standard insulin therapy, who was ultimately diagnosed with familial partial lipodystrophy (FPLD).

CASE

A 26-year-old female, with diabetes diagnosed 4 years ago, was referred for uncontrolled capillary blood glucose levels persistently ranging from 20–25 mmol/L despite high-dose basal-bolus insulin and oral hypoglycemic agents. Her body mass index (BMI) was 22 kg/m^2 with an HbA1c of 12.2%. Autoantibody screening (GAD, ICA, IA2 antibodies) was negative, and C-peptide was markedly elevated (2193 pmol/L). Her metabolic profile showed hypertriglyceridemia, raised liver enzymes suggestive

of metabolic-dysfunction associated steatotic liver disease, proteinuria due to diabetic kidney disease, and oligomenorrhea.

She had a well-defined muscular appearance in her limbs with prominent veins, raising suspicion of partial lipodystrophy. Fat loss was noted in the trunk, hips, and gluteal regions, contrasting with fat accumulation in the face, neck, and viscera. Mild acanthosis nigricans were present, but there was no significant hirsutism.

She denied antiretroviral therapy use and autoimmune features were absent. While her family history was unremarkable for diabetes or consanguinity, her mother had died from renal failure at the age of 40. She acknowledged a distinct body habitus compared to her siblings.

Whole-exome sequencing confirmed the presence of a heterozygous pathogenic p.Arg482Trp variant in the LMNA gene, diagnostic of autosomal dominant FPLD type 2. Her management included increased insulin doses and the addition of pioglitazone to enhance adiponectin levels and insulin sensitivity.

CONCLUSION

This case highlights the need to consider lipodystrophy syndromes in young patients with severe insulin resistance and atypical fat distribution. Early diagnosis enables targeted therapy and better metabolic control.

EP_A138

DORSAL PANCREATIC AGENESIS PRESENTING AS NEW-ONSET TYPE 3C DIABETES IN A YOUNG MALAYSIAN ADULT: A CASE REPORT

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INTRODUCTION/BACKGROUND

Type 3C diabetes mellitus (DM), secondary to exocrine pancreatic disease, is uncommon. Dorsal pancreatic agenesis (DPA), a rare congenital absence of part of the pancreas, can lead to both exocrine insufficiency and DM. We present a unique case of new-onset Type 3C DM due to DPA in a young Malaysian adult.

CASE

A 26-year-old Malaysian male with no known medical illness presented with a 6-month history of worsening loose stools, significant 15 kg weight loss, increased hunger, foot numbness, and blurred vision. His initial blood glucose was very high (58.7 mmol/L), leading to a diagnosis of new-onset DM. However, his weight loss and diarrhea were atypical. Tests for viral hepatitis, HIV, and diabetes autoantibodies were negative. Colonoscopy was normal. A CT scan of the abdomen revealed findings suggestive of DPA. Consequently, a diagnosis of Type 3C DM secondary to DPA and likely exocrine pancreatic insufficiency-related diarrhea was made. He was started on insulin, and his gastrointestinal symptoms improved moderately with diet and lifestyle changes.

DPA is a rare cause of DM, especially in young adults. The absence of typical autoimmune markers and the presence of significant exocrine symptoms were key in identifying this unusual etiology. The development of diabetes in DPA is thought to be due to reduced pancreatic beta-cell mass. This case highlights the importance of considering rare causes like DPA in atypical diabetes presentations. Thorough evaluation, including imaging, is crucial for accurate diagnosis and management. While insulin therapy was initiated, dietary modifications provided some relief for his gastrointestinal issues.

CONCLUSION

This case demonstrates a rare instance of Type 3C DM secondary to DPA in a young Malaysian adult. It emphasizes the need for awareness of such unusual associations in young patients with new-onset diabetes and unexplained gastrointestinal symptoms. Further research on DPA-related diabetes in Malaysia is warranted.

EP_A139

CASE REPORT: BEYOND THE TOXICOLOGY SCREEN: RECOGNIZING THYROID STORM IN A PATIENT INITIALLY SUSPECTED OF SUBSTANCE-INDUCED CARDIOMYOPATHY

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INTRODUCTION/BACKGROUND

Thyroid storm is a life-threatening endocrine emergency characterized by exaggerated hyperthyroidism. Its diverse clinical manifestations can sometimes mimic other acute conditions, leading to diagnostic challenges. We present a unique case of a young adult with thyroid storm whose initial presentation strongly suggested substance-induced cardiomyopathy.