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

https://doi.org/10.15605/jafes.040.S1.146

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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

https://doi.org/10.15605/jafes.040.S1.147

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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.

Adult E-Poster

CASE

A 29-year-old Malay male with a history of active smoking and drug abuse presented with a one-week history of non-productive cough and sudden onset of shortness of breath after physical exertion. On initial assessment, he exhibited marked restlessness, diaphoresis, and irregular narrow complex tachycardia on electrocardiogram (ECG). Urine toxicology was positive for amphetamine and methamphetamine, leading to an initial suspicion of substance-induced cardiomyopathy complicated by rapid atrial fibrillation. He was managed with anti-arrhythmics and non-invasive ventilation. However, persistent tachycardia and clinical deterioration necessitated intubation. A chest X-ray revealed cardiomegaly.

Interestingly, routine thyroid function tests, which were ordered due to the patient's unexplained tachycardia, returned with a significantly suppressed thyroid-stimulating hormone (TSH) of <0.008 mIU/L and an elevated free thyroxine (FT4) of 64 pmol/L. This, coupled with a Burch-Wartofsky score of 65, strongly indicated thyroid storm. The initial diagnosis was revised accordingly. Despite aggressive management for thyroid storm, including anti-thyroid medications, beta-blockers, and supportive care, the patient developed acute infarcts in the right middle cerebral artery territory with subsequent hemorrhagic transformation and significant cerebral edema on serial computed tomography (CT) scans of the brain. Neurosurgical intervention was considered but declined by the family due to the guarded prognosis. The patient eventually succumbed to death due to massive cerebral infarct.

This case highlights the importance of considering thyroid storm in the differential diagnosis of young adults presenting with acute cardiac symptoms and agitation, even in the presence of positive toxicology screens. The initial clinical picture and positive drug screen misleadingly pointed towards a primary cardiac etiology. The significantly abnormal thyroid function tests were crucial in establishing the correct diagnosis. While the exact mechanism of the cerebral infarction in this context remains unclear, it could be a rare complication of severe thyroid storm, potentially exacerbated by underlying substance abuse or other unidentified factors. This case underscores the need for a broad differential diagnosis and timely thyroid function testing in patients with unexplained acute cardiovascular symptoms, particularly when atypical features are present.

CONCLUSION

This case serves as a reminder of the protean manifestations of thyroid storm and the potential for diagnostic confusion with other acute conditions. A high index of suspicion and prompt laboratory investigations are essential for timely and accurate diagnosis, which is critical for improving patient outcomes in this life-threatening endocrine emergency.

EP_A140

DELAYED DIAGNOSIS OF LYMPHOCYTIC HYPOPHYSITIS PRESENTING AS CHRONIC HEADACHES: A CASE REPORT

https://doi.org/10.15605/jafes.040.S1.148

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INTRODUCTION/BACKGROUND

Lymphocytic hypophysitis (LH) is a rare autoimmune inflammatory disorder of the pituitary gland, often presenting with non-specific symptoms leading to diagnostic delays. This case highlights the challenges in the timely diagnosis of LH and the consequences of treatment default in a young male.

CASE

A 37-year-old male with a three-year history of chronic headaches, initially managed symptomatically, presented with recurrent episodes of worsening headaches, vomiting, and chest pain requiring multiple emergency department visits over two years. After 2 years of intermittent visits, a non-contrast computed tomography (CT) brain, performed due to persistent and escalating headaches, revealed a possible pituitary fossa mass. Subsequent urgent magnetic resonance imaging (MRI) confirmed a bulky pituitary gland with minimal suprasellar extension. Hormonal evaluation revealed panhypopituitarism. Based on clinical and radiological findings, a diagnosis of lymphocytic hypophysitis was suspected. The patient was commenced on hydrocortisone and thyroid hormone replacement. Regrettably, the patient defaulted on follow-up and discontinued his prescribed medications in favour of traditional treatment.

This case underscores the insidious presentation of LH, where chronic headaches can be the predominant initial symptom, leading to significant delays in diagnosis. The patient's repeated emergency department visits for non-specific symptoms highlight the need for a high index of suspicion for underlying endocrine disorders in patients with persistent and evolving complaints. The eventual radiological findings of a pituitary mass and subsequent confirmation of panhypopituitarism were crucial for suspecting LH. The patient's decision to discontinue conventional treatment and opt for traditional remedies emphasizes the importance of patient education, adherence strategies, and culturally sensitive approaches in managing chronic endocrine conditions. The potential long-term sequelae of untreated panhypopituitarism warrants concern.