Adult E-Poster

CONCLUSION
This case serves as a reminder of the diverse clinical mani-festations of lymphocytic hypophysitis and the importance of considering pituitary pathology in patients with chronic headaches. Early radiological investigation in cases of persistent or worsening headaches, coupled with hormonal evaluation, is crucial for timely diagnosis and management. Furthermore, addressing factors influencing treatment adherence, including patient beliefs and prefe-rences, is essential for optimal outcomes in chronic endocrine disorders.

EP_A141

CUTANEOUS TUMOUR IN MULTIPLE ENDOCRINE NEOPLASIA TYPE 1

https://doi.org/10.15605/jafes.040.S1.149

Afifah Kamarudin, Jiun Yan Tan, Wee Mee Cheng, Lit Sin Yong, Nor Afidah binti Karim, Noor Lita Adam
Endocrinology Unit, Department of Internal Medicine, Hospital Tuanku Ja'afar Seremban, Malaysia

INTRODUCTION/BACKGROUND
Multiple Endocrine Neoplasia (MEN) 1 syndrome is a genetic disease characterized by pituitary adenoma, parathyroid hyperplasia, and pancreatic tumors. Cutaneous manifestations of the syndrome are rare. We report a case of MEN 1 syndrome with collagenoma, initially misdiagnosed as neurofibromatosis.

CASE
A 48-year-old male with hypertension and gouty arthritis was diagnosed with Neurofibromatosis type 1 10 years ago based on neurofibromas on his neck and abdomen. He defaulted follow-up until admission in June 2024 for hypertensive emergency. During admission, incidental findings of asymptomatic moderate PTH-dependent hypercalcemia (corrected calcium: 3.02 mmol/L, phosphate: 0.37 mmol/L, iPTH: 31.9 pmol/L [Normal range 1.58 - 6.03]) and a suspicious right hilar mass on chest X-ray, prompting further workup. Calcium-creatinine clearance ratio was 0.046. His tumor marker levels, including B-HCG, were normal. CT of the thorax, abdomen, and pelvis showed a solid anterior mediastinal mass with a superior mediastinal lesion and an enhancing pancreatic mass. A DOTATATE scan confirmed somatostatin receptor avid disease in the pancreas and anterior mediastinal mass with nodal, liver, and bone metastases. CT-guided biopsy of anterior mediastinal mass followed by anterior mediastinal mass resection and endoscopic guided biopsy of pancreatic mass confirmed neuroendocrine tumor. His clinical condition was suggestive of MEN 1. It is exceptionally rare for two autosomal dominant syndromes to coexist. There was no other diagnostic manifestation for neurofibromatosis type 1 except for skin lesions. Skin biopsy was done and reported as collagenoma, supporting MEN 1. Genetic study is ideal but limited by financial constraints.

CONCLUSION
Without the luxury of genetic testing, tactful correlations of clinical manifestations are essential to diagnose rare inheritable syndromes. Relevant investigations may help identify clinical signs and their association with the syndrome. In our patient, the initial diagnosis of neurofibromatosis was later revised to collagenoma with MEN 1 after HPE result from skin biopsy.

EP_A142

MYXOEDEMA MADNESS: WHEN HYPOTHYROIDISM TURNS PSYCHOTIC

https://doi.org/10.15605/jafes.040.S1.150

Nurul Syamimi Yahaya and Marisa Khatijah Borhan
Department of Medicine, Hospital Raja Perempuan Zainab II, Kelantan, Malaysia

INTRODUCTION/BACKGROUND
Myxoedema madness is a rare but serious neuropsychiatric manifestation of severe hypothyroidism. We report a case of overt hypothyroidism following radioactive iodine (RAI) therapy, presenting with paradoxical psychotic symptoms.

CASE
A 43-year-old Malay male with underlying ischemic heart disease, severe mitral regurgitation, and toxic multinodular goiter (MNG) was admitted for acute behavioral changes. Diagnosed with toxic MNG in 2019, he was initially treated with carbimazole before undergoing his first RAI therapy in January 2024. He reported mood swings that improved after starting carbimazole, not needing psychiatric evaluation. A second RAI therapy was administered in January 2025 after failed first therapy. Two months post-RAI therapy, his thyroid function test (TFT) showed a TSH of 7.6 mIU/L and a free T4 of 7.8 pmol/L; hence, carbimazole 2.5 mg daily was withheld, and he was scheduled for follow-up. One month after stopping carbimazole, he presented to the Emergency Department with a five-day history of disorganized behavior, irrelevant speech, and bizarre ideations. Clinically, he was restless, requiring physical restraint. There were no signs of meningism or hypothyroidism. His inflammatory markers and brain CT were normal, and both urine drug toxicology and infective screening were negative. A repeat TFT confirmed overt