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

hypothyroidism post-RAI therapy (TSH >49.9 mIU/L, free T4 3.9 pmol/L) and levothyroxine 50 mcg daily was started. He was also started on risperidone by the psychiatric team for acute delirium secondary to hypothyroidism. Following treatment, he became calmer and more manageable.

CONCLUSION

Myxoedema madness has been reported in patients with untreated or inadequately treated hypothyroidism, particularly post-thyroidectomy or RAI therapy, and in patients with psychiatric comorbidities. Symptoms such as hallucinations, delusions, and disorganized behavior are typically reversible with appropriate treatment, including thyroid hormone replacement. Clinicians should maintain vigilance for myxoedema madness in hypothyroid patients presenting with acute behavioral changes.

EP_A143

A CASE OF PANHYPOPHYSITIS THAT MYSTERIOUSLY DISAPPEARED

https://doi.org/10.15605/jafes.040.S1.151

Fathiyah Ramli, Siti Sanaa Wan Azman, Masliza Hanuni Mohd Ali, Wan Mohd Hafez Wan Hamzah
Endocrinology Unit, Department of Internal Medicine, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Terengganu, Malaysia

INTRODUCTION/BACKGROUND

Panhypophysitis is a rare inflammatory condition that affects the entire pituitary gland, predominantly affecting women of reproductive age. Presentation is often vague, complicating diagnosis and management. We report a possible lymphocytic panhypophysitis that resolved with corticosteroids given for another indication.

CASE

A 31-year-old Indonesian female with an underlying diabetes mellitus presented with lethargy, polyuria, and polydipsia for four months. Previously, she had 3 uneventful deliveries. She was admitted for hyperosmolar hyperglycaemic state and noted to have persistent hypernatraemia with urine output of 3-4 litres daily. Further investigations were consistent with central diabetes insipidus (urine osmolality: 74 mOsm/kg, serum osmolality: 337 mOsm/kg, serum sodium: 152mmol/), and responded to desmopressin. Anterior pituitary hormones showed central hypothyroidism (TSH 0.14 mIU/L, T4: 7.8 pmol/L), hypogonadothrophic hypogonadism (LH 0.9 IU/L, FSH 3.4 IU/L, estradiol 108 pmol/L) and secondary hypocortisolism (18 nmol/L). She received hormonal replacement. MRI pituitary reported a homogeneously-enhancing pituitary lesion extending into the suprasellar region, which abuts the chiasm, with loss of the posterior pituitary bright spot, concerning for panhypophysitis. Further investigations for secondary hypophysitis were negative. Later, she was admitted for bilateral lower limb weakness and sensory deficit, with initial concern of transverse myelitis, and she was started on IV methylprednisolone for 3 days. Subsequent MRI spine revealed no spinal cord pathology, and the diagnosis was revised to diabetic neuropathy. Follow-up MRI pituitary after 9 months showed complete resolution of the pituitary lesion and normalization of the infundibulum. Her clinical condition improved, and the desmopressin dosage was reduced.

CONCLUSION

The resolution of the pituitary lesion after high-dose corticosteroids in our case supports a diagnosis of lymphocytic hypophysitis, the most common form of hypophysitis. High-dose steroids likely halted the inflammatory process, resulting in structural and functional recovery. A trial of medical therapy may be considered in similar cases before opting for surgical intervention.

EP_A144

DIFFERENT CLINICAL PRESENTATIONS OF PARAGANGLIOMA FROM TWO DIFFERENT ORIGINS: A CASE SERIES

https://doi.org/10.15605/jafes.040.S1.152

Fathiyah Ramli,[1] Masliza Hanuni Mohd Ali,[1] Siti Sanaa Wan Azman,[1] Syed Omar[2]
[1]Endocrinology Unit, Department of Internal Medicine, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Terengganu, Malaysia
[2]Urology Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Terengganu, Malaysia

INTRODUCTION/BACKGROUND

Paragangliomas are rare neuroendocrine tumours that arise from extra-adrenal paraganglia. Presentation can vary based on the anatomic origin. Sympathetic paragangliomas typically manifest with classic adrenergic symptoms. Here we present two cases of functional paraganglioma from two different origins.

CASE

A 25-year-old Malay female was diagnosed with pregnancy-induced hypertension during her last pregnancy 3 years ago, necessitating admission for impending eclampsia at 37 weeks. She complained of palpitations and chest pain. Post-partum, she remained hypertensive. A workup for secondary hypertension revealed marked elevation of 24-hour urine normetanephrines, 36 times the upper limit of normal (95.42 umol/day) and 2.5 times the elevation of