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

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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

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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