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

3-Methoxytyramine (4.46 umol/day). Adrenal CT showed a well-defined, enhancing lesion at the aortocaval region, measuring 5.1×5.8×7.0 cm. CT scans of the neck and thorax were unremarkable. A Gallium-68 PET scan demonstrated SSTR-avid uptake in the aortocaval mass, with no evidence of SSTR-avid disease elsewhere. Currently, she requires three antihypertensive agents to control her blood pressure while awaiting surgical intervention.

A 67-year-old Malay female with underlying hypertension, diabetes, and ischaemic stroke had multiple admissions for urosepsis. Ultrasound revealed a bladder mass suspicious for malignancy, a left ureteric stone, and hydronephrosis. CT and MRI showed a 4.0×3.6×3.7 cm heterogeneously enhancing mass arising from the right lateral bladder wall. She underwent transurethral resection of bladder tumour (TURBT); intraoperatively, her blood pressure was labile with systolic BP of 65-320 mm Hg. Histopathology confirmed paraganglioma. Post-operative 24-hour urine normetanephrines were four times the upper limit of normal. Due to her poor performance status, she was managed conservatively. Her blood pressure is currently controlled on double antihypertensives.

CONCLUSION

Paragangliomas can present variably depending on their anatomical origin and catecholamine-secreting status. A high index of suspicion, appropriate biochemical testing, and functional imaging are key to diagnosis. Individualized management is essential, especially in patients with comorbidities or poor performance status.

EP_A145

STEROID-UNMASKED CENTRAL DIABETES INSIPIDUS IN A PATIENT WITH PITUITARY METASTASIS FROM BREAST CARCINOMA: A CASE REPORT

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INTRODUCTION/BACKGROUND

Pituitary metastases are rare but clinically significant, most commonly originating from breast or lung cancers. Diabetes insipidus (DI) is the most frequent manifestation of posterior pituitary involvement. We describe a case of pituitary metastasis presenting with panhypopituitarism and central diabetes insipidus (CDI), initially unmasked by adrenal insufficiency.

CASE

A 68-year-old female with metastatic left breast carcinoma, post-mastectomy and on hormonal therapy, presented with a generalized tonic-clonic seizure and a Glasgow Coma Scale (GCS) score of 4. She exhibited persistent hypoglycemia requiring repeated dextrose corrections, along with hypotensive episodes.

Brain CT revealed a well-defined iso-to-hyperdense lesion in the sellar and suprasellar regions (2.0 × 2.5 × 3.0 cm). Subsequent pituitary MRI showed a heterogeneously enhancing lobulated mass (2.2 × 2.5 × 3.0 cm) with loss of normal anterior pituitary architecture.

Laboratory tests confirmed adrenal and thyroid insufficiency, with a random cortisol level of 284 nmol/L, TSH at 0.072 μIU/mL, and free T4 below 3.20 mmol/L. Hydrocortisone therapy was initiated, leading to a significant increase in serum sodium from 132 to 160 mmol/L. Serum and urine osmolality measured 318 and 183 mOsm/kg, respectively, with urine sodium under 10 mmol/L, raising suspicion for CDI. Desmopressin was commenced, resulting in improved sodium (145 mmol/L) and osmolality levels (serum 335 mOsm/kg, urine 646 mOsm/kg). Gonadotropin levels (FSH, LH) and estradiol were also low, indicating panhypopituitarism.

A multidisciplinary team confirmed pituitary metastasis secondary to breast carcinoma. The patient was transitioned to palliative care with hormone replacement: hydrocortisone, desmopressin, and levothyroxine.

CONCLUSION

Hypocortisolism in breast cancer patients should raise suspicion for pituitary metastasis. Polyuria after steroid therapy may indicate underlying central diabetes insipidus. Prompt diagnosis and hormone replacement can significantly enhance symptom management and patient well-being.

EP_A146

A CURIOUS CASE OF RECURRENT HYPOGLYCAEMIA IN NEUROFIBROMATOSIS

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INTRODUCTION/BACKGROUND

Neurofibromatosis type 1 (NF-1) is commonly associated with neural tumors such as pheochromocytomas, para-