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.

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

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Yip Xiong Woon, Yi Jiang Chua, Syahrizan Samsuddin
Endocrine Unit, Department of Internal Medicine, Hospital Sultan Idris Shah, Serdang, Malaysia

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.

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A CURIOUS CASE OF RECURRENT HYPOGLYCAEMIA IN NEUROFIBROMATOSIS

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Liew Min, Aina Mardiah Zulkifle, Noor Lita Adam, Yong Lit Sin, Nor Afidah Karim
Endocrine Unit, Internal Medicine Department, Hospital Tuanku Ja'afar Seremban, Malaysia

INTRODUCTION/BACKGROUND

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