

## Adult E-Poster

### EP\_A165

#### THE VOICE WITHIN: ADULT LARYNGOMALACIA AS A RARE COMPLICATION OF ACROMEGALY

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#### INTRODUCTION/BACKGROUND

Acromegaly is a chronic disorder caused by excess growth hormone (GH) and insulin-like growth factor 1 (IGF-1), most often due to a GH-secreting pituitary adenoma. Adult-onset laryngomalacia is rarely reported.

#### CASE

A 69-year-old male with a history of hyperthyroidism and colon cancer presented with progressive left eye blurring. He was initially treated for herpetic keratouveitis. During follow-up, coarse facial features suggestive of acromegaly—thickened skin, enlarged jaw, tongue, hands, and feet—were noted. He had noisy breathing, prompting ENT referral. Flexible laryngoscopy revealed redundant mucosa over the arytenoids prolapsing into the laryngeal inlet during inspiration, consistent with adult-onset laryngomalacia. Biochemical evaluation confirmed acromegaly (GH >50 ng/mL; IGF-1: 973.5 ng/mL) with secondary hypogonadism. MRI showed a 1.6 × 2.2 × 1.6 cm pituitary macroadenoma compressing the left optic nerve. He was started on intramuscular Octreotide LAR and underwent supraglottoplasty.

Laryngomalacia is typically a pediatric condition caused by dynamic supraglottic collapse during inspiration. In adults, it is uncommon and may result from structural abnormalities or acquired soft tissue redundancy, as seen in acromegaly. Chronic GH and IGF-1 excess leads to hypertrophy of soft tissues, including the larynx, epiglottis, aryepiglottic folds, and arytenoids, contributing to narrowing of the upper airway. Awake fiberoptic laryngoscopy is the diagnostic gold standard. Findings include inspiratory collapse of supraglottic structures, which may cause stridor, dysphonia, or sleep-disordered breathing. In acromegaly, cartilage overgrowth and mucosal thickening reduce airway diameter and alter tissue compliance. The hyoepiglottic ligament may also lose tensile strength, further predisposing to dynamic airway obstruction. Laryngomalacia may be misdiagnosed or attributed to obstructive sleep apnea, a

common comorbidity in acromegaly and distinct anatomical distortion should prompt ENT evaluation.

#### CONCLUSION

Laryngomalacia should be considered in acromegalic patients presenting with stridor or noisy breathing. Early recognition and surgical management can prevent airway complications and improve patient outcomes.

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#### HYPERTHYROIDISM MASQUERADING AS ACUTE MYOCARDIAL INFARCTION

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#### INTRODUCTION/BACKGROUND

Troponin-Positive Non-Obstructive Coronary Arteries (TpNOCA) are conditions characterized by elevated troponin levels accompanied by absent obstructive coronary artery disease (CAD) as observed on coronary angiography. It encompasses both coronary and noncoronary causes of myocardial injury.

#### CASE

A 31-year-old female with no known medical illness presented with fever, vomiting and diarrhea for 4 days. She did not have any features or family history of Graves' Disease. She had no goiter and denied any biotin supplements or illicit drugs. On arrival she had a fever of 38.5°C, palpitations with a pulse ranging between 110-130 beats/min, and a Blood Pressure of 89/47. She was intubated due to impending respiratory distress. Initial Electrocardiogram (ECG) done showed Atrial Fibrillation (AF). Repeated ECG showed ST-segment Elevation over the Lateral leads with reciprocal ST depression. High-Sensitivity Troponin-T taken on arrival was markedly raised at 957 ng/L, and repeated 2 hours later was 3089 ng/L. Patient was rushed for an emergency angiogram by the cardiology team which revealed unobstructed coronaries. Echocardiography performed was normal.

A thyroid function test (TFT) taken due to AF revealed Free T4 of 33 pmol/L with a suppressed TSH of 0.02 mIU/L. Alanine Aminotransferase (ALT) taken was 383 U/L attributable to ischemic hepatitis. Patient was commenced on carbimazole 10 mg daily with careful daily ALT monitoring. Lugol's Iodine 10 drops TDS and IV hydrocortisone 100 mg TDS were given for 5 days. Patient eventually improved with normalization of TFT and liver profile with tapering