carbimazole dose. TSH-receptor Antibodies (TRAb) taken was negative and we referred this patient for an outpatient Thyroid Ultrasonography to rule out toxic adenoma.

CONCLUSION

TpNOCA may be induced by hyperthyroidism due to heightened oxygen demand and coronary vasospasm leading to Type-2 Myocardial Infarction in the presence of unobstructed coronary arteries. Prompt identification and management of hyperthyroidism is crucial to avert severe complications and ensuring a favourable outcome.

EP_A167

A CASE OF HEART FAILURE UNVEILING HIDDEN ACROMEGALY

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Wan Awatif Wan Mohd Zohdi, D N Ezrinah D N Esham, Ku Noor Aimi Ku Azizi
Medical Department, Hospital Pendang, Kedah, Malaysia

INTRODUCTION/BACKGROUND

Acromegaly is a rare disease caused by hypersecretion of growth hormone. Cardiovascular disease is the most common comorbidity in acromegaly and constitutes a leading cause of mortality. However, there is currently limited direct literature addressing heart failure with preserved ejection fraction (HFpEF) in acromegaly. We present a case of acromegaly presenting with heart failure.

CASE

At a district hospital in Kedah, a 46-year-old female with a known case of hypertension since the age of 23 years old presented with dyspnoea on exertion, orthopnoea, and bilateral leg swelling. She had significant weight gain following her hypertension diagnosis. Her physical examination showed a weight of 121 kg, height of 1.75 m, and body mass index of 46.7 kg/m2. Her blood pressure was 141/89 mm Hg with a heart rate of 90 beats/min. Lung examinations revealed coarse crepitations with bilateral pitting oedema. A comprehensive physical examination revealed spade-like hands and feet, prominent supraorbital ridges, widening of teeth spaces with thick lips, and an enlarged nose. Given the characteristic clinical findings, we suspected the provisional diagnosis of acromegaly. Chest radiography showed cardiomegaly with congestive features. Echocardiogram revealed an ejection fraction of 57%, mildly dilated left atrium with grade 1 diastolic dysfunction which is consistent with HFpEF. Laboratory workup showed elevated insulin-like growth factor 1 level of 278.4ng/ml (normal 56.8-194.5 ng/ml). Subsequently, she was referred to an endocrinologist in a tertiary centre for further investigation and treatment.

CONCLUSION

This case highlights the critical importance in recognizing acromegaly as a rare underlying cause of cardiac manifestations. The clinical suspicion based on physical examination can facilitate prompt diagnosis to prevent early cardiovascular death in acromegaly patients. Clinicians should maintain a high index of suspicion for endocrine disorders that may present with cardiovascular manifestations.

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A RARE PRESENTATION OF MEDULLARY THYROID CARCINOMA: A CASE REPORT

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Amie-Anne Augustine, Jin Hui Ho, Hwee Ching Tee
Department of Endocrinology, Queen Elizabeth Hospital II, Kota Kinabalu, Sabah, Malaysia

INTRODUCTION/BACKGROUND

Medullary thyroid carcinoma (MTC) is a rare neuroendocrine tumour arising from the parafollicular C cells of the thyroid gland, accounting for approximately 4% of all thyroid malignancies. We present a case of MTC with an unusual and life-threatening initial manifestation — cardiac tamponade — which led to the diagnosis.

CASE

A 63-year-old Kadazan male with a medical history of myocardial infarction with non-obstructive coronary arteries (MINOCA) in 2017, intracranial haemorrhage in 2018, polycythaemia rubra vera, dyslipidaemia, hypertension, and type 2 diabetes mellitus, presented with a three-day history of exertional dyspnoea and chest tightness. He also reported a gradual neck swelling and unintentional weight loss over the past year.

Initial chest radiography revealed a right lower zone lung opacity, and he was empirically treated for pneumonia. However, a neck ultrasound demonstrated a right thyroid nodule categorized as TIRADS 4, raising suspicion for malignancy. A contrast-enhanced CT (CECT) of the thorax revealed a suspicious right thyroid nodule with bilateral cervical, supraclavicular, and mediastinal lymphadenopathy, multiple pulmonary nodules, a segment VIII liver lesion, and a significant global pericardial effusion measuring 2.8 cm. Fine needle aspiration cytology (FNAC) of the right thyroid nodule and left cervical lymph node confirmed medullary thyroid carcinoma, with positive staining for calcitonin and amyloid deposits identified