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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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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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

Adult E-Poster

via Congo red staining. Transthoracic echocardiography showed right atrial and right ventricular collapse, consistent with cardiac tamponade. Emergency pericardiocentesis was performed, and cytology of the pericardial fluid confirmed metastatic MTC.

Further laboratory evaluation revealed markedly elevated serum calcitonin and carcinoembryonic antigen (CEA), along with raised urinary levels of normetanephrine, metanephrine, and 3-methoxytyramine, suggesting a paraneoplastic neuroendocrine profile. Germline RET mutation analysis could not be performed due to resource limitations.

Given the presence of distant metastases and extensive locoregional disease, the patient was scheduled for systemic therapy with Cabozantinib with plans for total thyroidectomy following tumour debulking.

CONCLUSION

This case highlights a rare and aggressive presentation of medullary thyroid carcinoma (MTC), manifesting as cardiac tamponade — a life-threatening complication seldom associated with thyroid malignancies. The diagnosis was confirmed through cytological evaluation and supported by elevated tumour markers and imaging. This case underscores the importance of considering metastatic MTC in patients with unexplained pericardial effusion and systemic symptoms, especially in the presence of a suspicious thyroid lesion. Prompt recognition and multidisciplinary management are crucial in optimizing outcomes in such advanced and atypical presentations.

EP_A169

ECTOPIC ACTH SYNDROME SECONDARY TO METASTATIC NEUROENDOCRINE CARCINOMA FROM A PRIMARY MEDIASTINAL TUMOUR

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INTRODUCTION/BACKGROUND

We report a case of ectopic ACTH syndrome secondary to metastatic neuroendocrine neoplasm of the anterior mediastinum.

CASE

A 26-year-old male was diagnosed at age 23 to have ectopic ACTH syndrome secondary to neuroendocrine tumour of mediastinum, size 7 x 6 cm. Gallium-68 DOTATATE PET-CT revealed somatostatin receptor (SSTR) avid disease in mediastinum only, Krenning 3. He underwent surgical excision and achieved remission postoperatively. HPE reported ACTH-producing typical mediastinal carcinoid with nodal involvement, Ki67 ~ 10%, mitosis count 1 per 10 high power field, and metastatic typical carcinoid of the excised para-aortic lymph node. 6 months later, ACTH was noted to be increasing in trend although he was not Cushingoid clinically. FDG and Dotatate PET-CT scan revealed metastatic lymphadenopathy to the left supraclavicular fossa and mediastinum with low SSTR affinity (Krenning score 1 and 2). He was referred to the surgical and oncology team for further treatment. However, he opted for a second opinion in an overseas institution and started proton therapy and everolimus there, which was discontinued within weeks due to side effects.

He presented again a year later, not overtly Cushingoid, but he then developed more prominent Cushingoid signs and hypokalaemia within months. Biochemical investigation showed persistent disease with increasing ACTH. Ketoconazole was initiated. Dotatate and FDG PET-CT imaging revealed progressive metastatic lymphadenopathy involving cervical, supraclavicular, mediastinal and coeliac regions. The lesions had concordant FDG and Dotatate avidity but were more FDG-avid (Dotatate avidity Krenning 2). Multidisciplinary team discussion concluded a diagnosis of neuroendocrine carcinoma with progressive disease, thus requiring chemotherapy. He was referred to oncology team but remained undecided about proceeding further.

CONCLUSION

Neuroendocrine tumours can have heterogeneity in grade within a given lesion, in different sites, and over time. SSTR PET imaging aids in stratifying tumour differentiation thus guiding diagnostic and therapeutic decisions, as illustrated in this case.

EP_A170

THE MAN WITH MALIGNANT INSULINOMA: CHALLENGE IN MANAGEMENT

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INTRODUCTION/BACKGROUND

Insulinoma is an uncommon pancreatic neoplasm that results in excessive insulin production. Excessive insulin