



## RESULTS

Twenty eight percent of patients were Asian (39/137) and enrolled in Korea (n = 14), Japan (n = 9), India (n = 7), Thailand (n = 5) and China (n = 4). Most non-Asian patients were Caucasian (n = 89/98;91%). Median (range) osilodrostat exposure from baseline to study end was 115 (1–194) weeks in Asian patients and 141 (4–245) weeks in non-Asian patients, median (range) osilodrostat dose was 3.7 (1–18) and 10.1 (1–47) mg/day, respectively. The mUFC was  $\leq$ ULN in 62% (24/39) of Asian and 68% (67/98) of non-Asian patients at W48, increasing to 68% (21/31) and 87% (65/75), respectively, at W72. Improvements in cardiovascular parameters were observed in both groups during osilodrostat treatment. Hypocortisolism-related adverse events, mostly of mild or moderate severity, occurred in 64% (25/39; n = 2 discontinued) of Asian and 50% (49/98; n = 3 discontinued) of non-Asian patients.

## CONCLUSION

Beneficial effects of osilodrostat were similar in Asian and non-Asian patients in terms of biochemical control and clinical improvement, although Asian patients generally received lower doses. Osilodrostat was well tolerated in both groups.

## PP-PN-06

### SUCCESSFUL USE OF RITUXIMAB TO TREAT GLUCOCORTICOID RESISTANT LYMPHOPLASMACYTIC HYPOPHYSITIS: A CASE REPORT

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#### BACKGROUND

Lymphoplasmacytic hypophysitis is very rare and due to that its treatment is unclear. We present a case of glucocorticoid resistant lymphoplasmacytic hypophysitis successfully treated with rituximab.

#### CASE

A 34-year-old Sri Lankan male, presented with subacute onset severe headache and right sided visual impairment over 2 weeks without fever. He experienced nocturia with polydipsia since late adolescence which worsened with the onset of current symptoms. Later, he developed right sided parotitis. His height was 153 cm, BMI was 22.4 kg/m<sup>2</sup>. There was complete vision loss in right visual field and bilateral optic nerve atrophy with more severe involvement on the right. He lacked secondary sexual characteristics. Hormonal evaluation demonstrated secondary hypothyroidism, hypoadrenalism, hypogonadism, low

IGF-1, and normal prolactin levels. Osmolality studies confirmed the presence of diabetes insipidus. Brain MRI showed hypoplastic pituitary with contrast enhancing stalk, infiltration in the sellar, suprasellar and parasellar regions with optic nerve and cavernous sinus invasion. Parotid biopsy was normal. Inflammatory markers were elevated. Complete blood count was normal except for mild anemia. Tuberculosis, HIV, Aspergillosis, vasculitis, sarcoidosis and Langerhans Cell Histiocytosis were excluded.

Lymphocytic hypophysitis was presumed and was started on methyl prednisolone pulses with pituitary hormone replacement. Due to poor response and progression of disease, he underwent transsphenoidal biopsy which showed lymphoplasmacytic infiltration with sclerosis suggesting possible IgG4 disease. IgG4 staining was not available. Serum IgG4 levels were normal. Intravenous rituximab pulses (1 g) were given 2 weeks apart

There was marked response to rituximab. His headache settled, nasal desmopressin was tailed off and resulted in slight improvement of the vision of blind eye. Follow-up MRI scans after 5 months revealed no progression from baseline.

## CONCLUSION

Rituximab may give promising results in the presence of glucocorticoid resistant lymphoplasmacytic hypophysitis.

## PP-PN-07

### DIAXOZIDE INDUCED THROMBOCYTOPENIA IN TREATMENT OF INSULINOMA

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#### BACKGROUND

Insulinoma is a rare neuroendocrine tumor. Hypoglycaemia due to insulinoma is managed by diazoxide, a benzothiadiazine derivative with antihypertensive and hyperglycemic activities prior to definitive surgery.

#### CASE

A 65-year-old female was admitted with hunger pangs, sweating and giddiness after a large carbohydrate meal and weight gain of 14 kg in 2 years. On fasting, she developed symptomatic hypoglycaemia within 2 hours with random blood glucose 2.1 mmol/L, serum insulin 1213 pmol/L (N 17.8–173), C-peptide 7784 pmol/L (N 367–1469) and cortisol 598.5 nmol/L. CT pancreas showed a 5 x 5.1 x 5.3 cm irregular walled lesion with coarse calcifications at the tail of pancreas (HU 13–15) with no septation- likely insulinoma.