She was started on diaxozide for endogenous hyperinsulinemic hypoglycaemia with dose titrated up to 400 mg/day. One week after diaxozide initiation, she developed symptoms of diazoxide overdose, fever and thrombocytopenia (nadir level 10 x 10^9/L) with no source of infection. Diaxozide was stopped and she was switched to subcutaneous octreotide 100 mg TDS. Symptoms of overdosage, fever, and thrombocytopenia resolved after 4 days of stopping diaxozide. She then underwent distal pancreatectomy which was curative.

Thrombocytopenia is a rare complication of diaxozide and occurs due to platelet destruction from antibody formation. It is dose dependent and occurs 13-23 days after initiation of diaxozide and resolution will occur after discontinuing diaxozide.

CONCLUSIONS

Although thrombocytopenia is a rare complication of diaxozide, close monitoring of platelet count is needed to prevent complications.

PP-PN-08

DELAY IN GROWTH HORMONE THERAPY IS NOT DETRIMENTAL

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BACKGROUND

Pituitary hypothyroidism with growth hormone deficiency is often missed in primary care due to scarce health resources in developing countries. Well-meaning primary care with thyroxine for misdiagnosed primary hypothyroidism may be detrimental. However, the initial use of thyroxine in neonatal central hypothyroidism and growth hormone deficiency prevented long term intellectual decline even when it was inappropriately diagnosed as primary hypothyroidism.

CASE

Twin male siblings born to second degree consanguineous parents were managed by a pediatric specialist as primary hypothyroidism, requiring unusually high thyroxine doses. T4 was used to guide therapy. After consultation with an endocrinologist, the associated growth hormone deficiency was diagnosed. Pituitary structures on magnetic resonance imaging were normal.

The dose of thyroxine was beyond age-matched norms, with free T4 and free T3 values significantly high at 4 years of age. Confirmation of growth hormone deficiency was guided by hormone assay and auxology. Assistance from a growth hormone manufacturing company and government support helped manage both siblings from age 4 up to 18 years, notwithstanding limitations in periodic monitoring. The siblings are now in graduate technical college with respectable height gain.

CONCLUSION

Appropriate and timely diagnosis of pituitary hypothyroidism and associated growth hormone replacement, even in poor socioeconomic situations, can help nurture productive citizens.

PP-PN-09

AUTOIMMUNE POLYGLANDULAR SYNDROME (APS) TYPE 2 WITH CENTRAL DIABETES INSIPIDUS

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BACKGROUND

APS involves functional abnormalities in several endocrine and non-endocrine glands. Deficits may manifest over time. Screening for other manifestations is important. The major components of the syndrome are adrenal insufficiency, thyroid autoimmunity and type 1 diabetes. It is very rarely described with central diabetes insipidus (DI).

We present a very uncommon presentation of APS-2 with the onset of Addison's at age 7, developing other polyglandular associations over time and central DI in adulthood.

CASE

A 31-year-old woman with a history of Addison's disease diagnosed and treated with dexamethasone at age 7 presented with acute polyuria and polydipsia. She had negative water deprivation test according to the North Bristol protocol. Due to persistent symptoms, she was empirically commenced on desmopressin (Minirin) with good response. Testing finally diagnosed central DI: magnetic resonance imaging (MRI) demonstrated absence of the posterior pituitary bright spot and a 3 mm stalk thickening thought to be pathognomonic and possibly related to arginine vasopressin antibody status. Antibodies to thyroglobulin, thyroid receptor, ZnT8, GAD and IA2 were negative. TSH and HbA1c were normal.