**CONCLUSION**

This case illustrates the profound difficulty in diagnosing dopaminoma when exogenous L-DOPA therapy creates a near-identical biochemical profile. The diagnostic dilemma is further amplified by vague symptomatology, multiple comorbidities, and non-suggestive imaging. However, the finding of isolated dopamine hypersecretion with suppressed metanephrines serves as a critical clinical clue. This pattern points toward an intratumoral biosynthetic defect rather than drug interference. Clinicians must maintain a high index of suspicion and perform meticulous biochemical fractionation to identify these rare, dopamine-isolated secreting tumors.

## EP_A009

### THE HEMODYNAMIC PARADOX: SYNCHRONOUS ROBOTIC SURGERY FOR NORMOTENSIVE PHEOCHROMOCYTOMA IN VHL

**Thiru Murugaan Balakrishnan[1], Nurbadriah Jasmiad[1], Ng Wei Wei[1], Anilah Abdul Rahim[1], Ijaz Hallaj Rahmatullah[1], Subashini Rajoo[2]**
[1]*Hospital Raja Permaisuri Bainun*
[2]*Hospital Kuala Lumpur*

**INTRODUCTION**

Normotensive pheochromocytomas in Von Hippel-Lindau (VHL) syndrome present unique perioperative challenges. Standard alpha-blockade may induce intolerable orthostatic hypotension, making calcium channel blockers (CCB) a practical alternative. Furthermore, the primary intraoperative danger in these specific phenotypes may not be a hypertensive crisis, but profound vasoplegia. We report a VHL patient undergoing synchronous robotic surgery exhibiting this paradoxical hemodynamic response.

**CASE**

A 37-year-old female with VHL syndrome presented with an incidental 3.5-cm left adrenal mass and bilateral renal masses. Biochemistry confirmed a normotensive, noradrenergic pheochromocytoma (24-hour urine normetanephrines 4.2x upper limit of normal). Renal biopsy revealed a clear cell papillary renal cell tumor. Due to prior severe intolerance to Prazosin (hypotension/dizziness with low-dose Prazosin 0.5 mg ON), we utilized amlodipine for preoperative optimization. She was only able to tolerate low-dose 2.5 mg OD alongside oral sodium chloride and ample oral fluid loading. She underwent a synchronous robotic-assisted left adrenalectomy and left midpole renal tumor excision. Strikingly, tumor manipulation did not precipitate a hypertensive crisis. Instead, she developed hypotension requiring an intravenous noradrenaline infusion prior to adrenal vein ligation and tumor removal. Vasopressor support was successfully weaned 12 hours postoperatively, and she was discharged well.

**CONCLUSION**

Normotensive, noradrenergic pheochromocytomas in VHL are hemodynamically fragile. Chronic catecholamine excess induces homologous desensitization and downregulation of alpha-1 adrenergic receptors. This physiological adaptation explains the normotensive presentation and highlights the intraoperative vasoplegia experienced once sympathetic tone is altered by anesthesia. While CCB monotherapy with volume expansion safely facilitates prolonged, synchronous robotic surgeries, clinicians must anticipate and combat refractory hypotension rather than classical hypertensive spikes.

## EP_A010

### DISSEMINATED HISTOPLASMOSIS PRESENTING AS ADDISONIAN CRISIS: A DIAGNOSTIC MIMIC OF TUBERCULOSIS WITH BILATERAL ADRENAL MASSES

**Aminuddin Baki Amran[1], Nur Aini Eddy Warman[1], Aimi Fadilah Mohamad[1], Nur Haziqah Baharum[1], Mohd Hazriq Awang[1], Fatimah Zaherah Mohamed Shah[1], Rohana Abdul Ghani[1]**
[1]*Department of Internal Medicine, Faculty of Medicine, Universiti Teknologi MARA*

**INTRODUCTION**

Disseminated histoplasmosis is a rare but important cause of adrenal insufficiency (AI), particularly in tuberculosis (TB)-endemic regions, where it may mimic granulomatous diseases. Adrenal involvement occurs in up to 80% of disseminated cases, although overt AI is less common. Reported cases described bilateral adrenal masses mimicking malignancy or TB, even in immunocompetent individuals. Addisonian crisis may be the initial manifestation, especially when the diagnosis is delayed. In TB-endemic settings, fungal infections are often overlooked, leading to delayed diagnosis and inappropriate therapy.

**CASE**

We reported a case of a 68-year-old male with underlying diabetes mellitus who presented with fever, cough, dysphagia, and weight loss for 1 month. He was empirically treated as smear-negative disseminated TB. On day 2 of therapy, he developed hypotension (80/50 mmHg), hypoglycemia (3.9 mmol/L), hyponatremia (Na 129 mmol/L), and hyperkalemia (K 5.1 mmol/L), suggestive of adrenal crisis, and was started on intravenous hydrocortisone. Serum cortisol prior to treatment was 61