nmol/L. Computed tomography (CT) imaging revealed bilateral lipid-poor adrenal lesions (right: 3.6 × 2.2 × 4.9 cm, Hounsfield Unit (HU) 36 and absolute washout 33%; left: 3.5 × 2.4 × 5.4 cm; HU 35 and absolute washout 17%), raising suspicion of infectious or malignant etiologies. Endoscopic ultrasound-guided biopsy demonstrated necrotizing granulomatous inflammation with budding fungal yeasts on Pituitary Apoplexy Score and GMS staining, consistent with *Histoplasma capsulatum*. TB and malignancy were excluded. He received amphotericin B for 14 days, followed by oral itraconazole for 1 year, and oral hydrocortisone replacement. At 1-year follow-up, adrenal lesions remained stable on CT images, and he continued to require hydrocortisone replacement.

### CONCLUSION

This case highlights the importance of considering disseminated histoplasmosis as a differential diagnosis of bilateral adrenal masses with AI, especially with poor response to anti-TB therapy. Early tissue diagnosis is essential, as imaging findings are non-specific. Prompt recognition is critical to prevent life-threatening adrenal crisis and improve clinical outcomes.

## EP_A011

## LARGE "GROWING" ADRENAL MASS WITH AN UNEXPECTED HISTOLOGY

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### INTRODUCTION

Large, rapidly enlarging adrenal masses typically mandate surgical intervention given the high probability of adrenocortical carcinoma (ACC). However, benign processes can mimic these aggressive growth kinetics, creating a diagnostic challenge for clinicians.

### CASE

A 74-year-old male with hypertension, atrial fibrillation on rivaroxaban, and prostate cancer was referred for evaluation of a right adrenal incidentaloma detected on computed tomography imaging performed for prostate cancer staging. The well-defined mass measured 8.9 × 7.8 × 7.5 cm (AP × W × CC) with areas of calcification. Mean attenuation was +40 Hounsfield Unit, with no significant washout. Biochemical evaluation confirmed a non-functioning lesion (24-hour urine metanephrines 756 mcg/24 hours [N 246–753 mcg/24 hours]; serum cortisol 62 nmol/L post overnight dexamethasone suppression test). The patient was otherwise asymptomatic and declined surgical intervention. Repeat imaging 4 months later demonstrated interval enlargement of the mass to 9.8 × 8.8 × 10.7 cm. Due to this rapid growth, which was highly concerning for ACC, the patient underwent laparoscopic right adrenalectomy. Histopathological examination unexpectedly revealed an adrenal hematoma without evidence of an underlying tumor or malignancy.

This case illustrates the difficulty in differentiating aggressive cortical tumors from atypical hemorrhagic events. Larger series on adrenal hemorrhage reported trauma and procedural complications as the leading causes, with a median size of 3–4 cm. Idiopathic large adrenal hematomas presenting as rapidly expanding "pseudotumors" are exceptionally rare, with fewer than 20 cases reported in which surgical resection was performed due to high preoperative suspicion of malignancy. Additionally, adrenal hemorrhage attributed to anticoagulant therapy often occurs bilaterally. Unilateral lesion, especially when large, can pose a diagnostic challenge as highlighted in this case.

### CONCLUSION

In patients on anticoagulation, rapid interval growth of an adrenal mass does not always equate to malignancy. Recognizing this mimicry in the era of widespread Direct Oral Anticoagulant use is essential for refining treatment decision regarding surgical intervention, as most cases exhibited a self-limiting process with spontaneous resolution.

## EP_A012

## SILENT ADRENAL MASS WITH DIAGNOSTIC CHALLENGE: A CASE OF HUGE NON-FUNCTIONING ADRENAL LESION MIMICKING MALIGNANCY

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### INTRODUCTION

Adrenal incidentalomas are increasingly detected with the widespread use of imaging, whereby the large or heterogeneous lesions often raise concern for adrenocortical carcinoma (ACC). However, certain rare benign