discordance between androgen excess and normal adrenal imaging, despite absent ovarian tissue, suggested an extra-adrenal androgen-secreting steroid cell tumor. A second histopathology review and multidisciplinary discussion with radiology, gynecologic oncology, and pathology teams were undertaken. As the disease was deemed inoperable, repeat retroperitoneal lesion biopsy confirmed metastatic steroid cell tumor and guided palliative chemotherapy. She was subsequently referred to gynecologic oncology for systemic chemotherapy.

CONCLUSION

Extra-adrenal steroid cell tumors, though rare, should be considered in patients with hyperandrogenism long after bilateral oophorectomy, especially when adrenal imaging is normal. Multidisciplinary evaluation and repeat biopsy are often crucial for establishing the diagnosis and guiding treatment.

EP_A083

SEVERE HYPERTRIGLYCERIDEMIA-INDUCED ACUTE PANCREATITIS IN PREGNANCY: A CASE REPORT AND REVIEW OF MANAGEMENT

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INTRODUCTION

Severe hypertriglyceridemia during pregnancy is a rare yet potentially life-threatening disorder. It is frequently linked to acute pancreatitis and poses considerable risks for both maternal and fetal morbidity.

CASE

We report a 35-year-old G4P3 female at 33 + 6 weeks gestation with underlying type 2 diabetes mellitus who presented with acute abdominal pain, nausea, vomiting, and poor oral intake, initially mistaken for preterm labor and sepsis. Further evaluation revealed profound hypertriglyceridemia (triglycerides 79.1 mmol/L) with markedly elevated total cholesterol (>32 mmol/L) and raised serum amylase, consistent with hypertriglyceridemia-induced acute pancreatitis. She was managed in a multidisciplinary setting with intravenous insulin infusion, dextrose supplementation, aggressive fluid resuscitation, and empiric antibiotics. Due to clinical deterioration and ongoing risk of maternal complications, she underwent emergency lower segment caesarean section and exploratory laparotomy at 34 weeks of gestation. Intraoperative findings included inflammatory intra-abdominal fluid and a bulky pancreas, supporting the diagnosis. Rapid biochemical improvement was observed following treatment, with triglyceride levels decreasing by approximately 70% within 24 hours (79.1–24.0 mmol/L) and achieving >90% reduction over 10 days. Postpartum management included initiation of omega-3 fatty acids, fibrate, and statin therapy, resulting in sustained lipid control. Ophthalmologic examination demonstrated lipemia retinalis, further confirming severe dyslipidemia.

CONCLUSION

This case highlights the importance of early recognition of severe hypertriglyceridemia in pregnancy, particularly in patients with metabolic risk factors such as diabetes. Prompt initiation of insulin therapy can achieve rapid triglyceride reduction and may obviate the need for plasmapheresis in selected cases. Delivery should be considered in the setting of maternal instability. Long-term lipid management postpartum is essential for preventing recurrence and reducing future metabolic risk. A multidisciplinary approach remains critical in optimizing both maternal and fetal outcomes in this rare but serious condition.

EP_A084

SEVERE PREMATURE CORONARY ARTERY DISEASE IN HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA WITH MARKED LIPID REDUCTION AFTER INCLISIRAN THERAPY

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INTRODUCTION

Homozygous familial hypercholesterolemia (HoFH) is a rare inherited disorder characterized by markedly elevated low-density lipoprotein cholesterol (LDL-C) from birth, childhood xanthomas, and accelerated atherosclerotic cardiovascular disease. Achieving LDL-C targets remains difficult despite statins, ezetimibe, and lipoprotein apheresis, especially in patients with treatment interruption, poor adherence, or limited access to specialized lipid services. We report a female with genetically confirmed HoFH who developed severe premature coronary artery disease and showed marked lipid reduction after inclisiran therapy.

CASE

A 28-year-old Malay female with LDL receptor mutation-confirmed HoFH, diagnosed at age 7, had a strong family history of premature cardiovascular death. She underwent biweekly lipoprotein apheresis from ages 8 to 15 years, but later defaulted on follow-up. During pregnancy in 2021, weekly then biweekly apheresis was reintroduced for severe hypercholesterolemia, but she disengaged postpartum. In 2025, she re-presented with exertional

chest pain, orthopnea, and palpitations. Examination showed widespread xanthomas. Electrocardiography demonstrated sinus tachycardia with inferolateral ST depression. Echocardiography revealed a left ventricular ejection fraction of 40%, anterior and septal akinesia, severe mitral regurgitation, moderate tricuspid regurgitation, and pulmonary hypertension. Her lipid profile showed total cholesterol 18.1 mmol/L and LDL-C 14.9 mmol/L. Coronary angiography demonstrated triple-vessel disease with left main stem involvement and critical right coronary ostial stenosis. Coronary artery bypass grafting was advised but declined. She was treated with high-dose rosuvastatin, ezetimibe, dual antiplatelet therapy, and inclisiran 284 mg. After one dose of inclisiran, total cholesterol fell to 6.78 mmol/L and LDL-C to 4.71 mmol/L, a reduction of more than 60%.

CONCLUSION

This case highlights the aggressive natural history of inadequately controlled HoFH and the importance of sustained lifelong therapy. Inclisiran may provide additional LDL-C reduction in selected HoFH patients, although long-term cardiovascular outcome data remain limited.

EP_A085

CONCURRENT DIABETIC KETOACIDOSIS AND THYROID STORM IN LATE PREGNANCY: A RARE DUAL ENDOCRINE EMERGENCY

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INTRODUCTION

Diabetic ketoacidosis (DKA) and thyroid storm are individually rare but potentially fatal endocrine crises in pregnancy. Each carries significant maternal and fetal morbidity, with mortality risk compounded when they occur concomitantly. Physiological and pharmacokinetic changes of pregnancy, combined with overlapping symptoms, necessitate urgent treatment strategies.

CASE

A 29-year-old G2P2 female at 29 weeks' gestation, with poorly controlled type 2 diabetes mellitus (hemoglobin A1c 8.1%) on a basal–bolus insulin regimen and Graves' disease managed with carbimazole, non-adherent to medications, presented with fever, vomiting, and dyspnea. On examination, she was tachycardic (HR 138 bpm), hypotensive (BP 94/60 mmHg), and hypoxic. Laboratory investigations revealed hyperglycemia (glucose 27.1 mmol/L), severe metabolic acidosis (pH 7.02, bicarbonate 4.9 mmol/L), and elevated serum ketones (4.6 mmol/L), consistent with DKA. Thyroid function tests showed suppressed thyroid-stimulating hormone (<0.005 mIU/L) and elevated free T4 (28.2 pmol/L), with a Burch–Wartofsky score of 70. Unfortunately, intrauterine fetal demise was confirmed upon the patient's presentation to the emergency department. She was intubated and admitted to the intensive care unit, receiving fluid resuscitation judiciously according to the DKA regimen, with frequent assessment of volume status. Intravenous insulin and potassium supplements were commenced concurrently. Metabolic stabilization was achieved within 24 hours. Carbimazole, propranolol, Lugol's iodine, and intravenous hydrocortisone were started for treatment of thyroid storm. A breech-assisted vaginal delivery was performed, and her postpartum course was uneventful.

CONCLUSION

The case reveals the catastrophic potential of concurrent DKA and thyroid storm in pregnancy, where rapid maternal deterioration and poor fetal outcomes can occur despite timely intervention. High clinical suspicion, early biochemical confirmation, and coordinated multidisciplinary management are vital. Precipitating factors, particularly medication non-adherence, must be addressed through intensive patient education and structured follow-up to prevent recurrence.

EP_A086

EXTRA-ADRENAL AND UNEXPECTED: A RARE CASE OF PRIMARY RETROPERITONEAL PARAGANGLIOMA

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INTRODUCTION

Paragangliomas are rare neuroendocrine tumors arising from extra-adrenal chromaffin cells, with an estimated incidence of 2–8 cases per million per year. These tumors originate from neural crest–derived cells of the sympathetic and parasympathetic paraganglia and may secrete catecholamines, resulting in malignant hypertension or symptoms such as headache, palpitations, and diaphoresis. They can occur anywhere along the paravertebral and para-aortic regions from the skull base to the pelvic floor.