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.