Her clinical course was complicated by severe hospital-acquired infection leading to septic shock, requiring intensive care support, mechanical ventilation, and renal replacement therapy. She was commenced on desmopressin, with subsequent clinical and biochemical improvement, alongside multidisciplinary management.

CONCLUSION

In patients with type 2 diabetes mellitus, persistent polyuria may obscure an underlying water balance disorder. This case highlights the importance of considering alternative causes of polyuria and a systematic endocrine approach to ensure accurate diagnosis and appropriate management.

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RARE CASE: EMPTY SELLA SYNDROME, GROWTH HORMONE DEFICIENCY, AND HASHIMOTO'S THYROIDITIS IN THALASSEMIA SPECTRUM

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INTRODUCTION

Thalassemia is a hemoglobin synthesis disorder associated with chronic anemia and transfusion-related iron overload, which predisposes patients to multiple endocrine complications. Iron deposition in the pituitary and gonads may result in growth hormone deficiency (GHD) and hypogonadism. Empty sella syndrome (ESS), characterized by herniation of the subarachnoid space into the sella turcica, may also contribute to hypopituitarism. The coexistence of thalassemia-related endocrinopathies, ESS, and autoimmune thyroid disease is rare and presents significant diagnostic complexity.

CASE

A 27-year-old female with transfusion-dependent thalassemia on deferiprone presented with secondary amenorrhea and short stature. Her height was 145 cm (below the target range of 140.5–157.5 cm), body mass index 17.3 kg/m^2, and Tanner stage M3P1.

Laboratory evaluation revealed elevated thyroid-stimulating hormone (10.92 mIU/L) with low-normal free thyroxine 4 (11.4 pmol/L), consistent with primary hypothyroidism. Thyroid ultrasound demonstrated features of chronic thyroiditis, and anti-thyroid peroxidase antibodies (8.18 IU/mL) supported a diagnosis of Hashimoto's thyroiditis. Insulin-like growth factor-1 was markedly reduced (68 ng/mL), indicating GHD. Morning cortisol was within normal range (14.5 µg/dL). Gonadotropins were inappropriately low-normal (follicle-stimulating hormone 7.42 mIU/mL, luteinizing hormone 11.41 mIU/mL) with low estradiol (26.49 pg/mL), suggesting hypogonadotropic hypogonadism.

Skeletal survey showed thalassemia-related bone changes, including trabecular coarsening and metaphyseal widening, with a predicted adult height of 142.7 cm. Pituitary magnetic resonance imaging revealed an empty sella.

CONCLUSION

Thalassemia must be recognized not only as a primary hematologic condition but also as a complex multisystem disorder with profound endocrine implications. Furthermore, the co-occurrence of these conditions with rare manifestations such as ESS and Hashimoto's thyroiditis underscores the diagnostic complexity faced by clinicians. Therefore, early detection and rigorous, regular endocrine screening are essential to optimize management strategies and improve the long-term quality of life for patients with thalassemia.

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THYROID-STIMULATING HORMONE (TSH)-SECRETING MACROADENOMA PRESENTING WITH RECURRENT ATRIAL FIBRILLATION IN FAILURE

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INTRODUCTION

Accounting for less than 2% of all pituitary adenomas, TSH-secreting pituitary adenomas (TSHoma) are an uncommon cause of hyperthyroidism. Majority are macroadenomas with delayed diagnosis as most patients are unwittingly treated for primary hyperthyroidism. Recurring discordant thyroid function test (TFT) with elevated thyroid-stimulating hormone (TSH) and Free T4 is a hint and warrants additional investigation to facilitate diagnosis.

CASE

We report a case of a 48-year-old female who was treated for primary hyperthyroidism since her late 20s with multiple admissions for recurrent congestive heart failure