and each was associated with a gonadal vein, suggestive of bilateral ectopic gonadal structures on imaging. These findings were consistent with atypical MRKH syndrome type II in the context of underlying renal anomalies.

CONCLUSION

This case highlights the importance of evaluating primary amenorrhea even in patients with significant chronic illness. In phenotypic females with CAKUT, associated Müllerian anomalies should be actively considered. Atypical MRKH syndrome type II should be recognized early to enable accurate diagnosis, multidisciplinary follow-up, and appropriate reproductive and psychosocial counseling.

EP_A148

ACTIVE MODERATE-TO-SEVERE THYROID EYE DISEASE: A CASE SERIES

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INTRODUCTION

Thyroid eye disease (TED) is a heterogeneous condition and the most common extrathyroidal manifestation of Graves' disease. Although most cases are mild, disease progression may threaten vision and significantly impact quality of life.

METHODOLOGY

We described four patients with active moderate-to-severe TED, highlighting their clinical characteristics, therapeutic approaches, and clinical outcomes.

RESULTS

Three males and one female patient were included in this descriptive study. Most were identified by the endocrine team. Their median age was 52.5 years (range 47–56 years). All patients had long-standing Graves' disease (range 6–10 years). Two of them were active smokers. Their clinical activity score ranged from 3 to 5. Common presenting features included diplopia (60%), proptosis (60%), and ocular redness (60%).

At the onset of active TED, all patients were euthyroid while receiving either antithyroid therapy or were maintained on stable levothyroxine following radioactive iodine treatment and thyroidectomy. Thyroid receptor autoantibodies were assessed in only two patients, with one elevated result. Orbital computed tomography, performed in 3 patients, demonstrated extraocular muscle enlargement consistent with TED, particularly involving the inferior and medial recti.

All patients received standard-dose intravenous methylprednisolone (cumulative 3.5–4.5 g). They showed improvement in visual acuity following treatment, with partial improvement in ophthalmoplegia.

CONCLUSION

Clinical risk factors observed in this series were consistent with the literature. TED diagnosis relies heavily on recognition by the endocrine team, underscoring the importance of holistic Graves' disease management. High-dose corticosteroids remain the mainstay of treatment in our setting, with generally favorable outcomes when timely multidisciplinary care is provided.

EP_A149

BEYOND THE PITUITARY STALK: PRIMARY HYPOTHYROIDISM AS A RARE PRESENTATION OF MULTISYSTEM LANGERHANS CELL HISTIOCYTOSIS

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INTRODUCTION

Langerhans cell histiocytosis (LCH) is a clonal proliferative disorder of langerin-positive histiocytes. Endocrine involvement most frequently manifests as central diabetes insipidus or secondary hypothyroidism, caused by infiltration of the hypothalamic-pituitary axis. Conversely, direct infiltration of the thyroid gland leading to primary hypothyroidism is an exceptionally rare clinical entity, particularly when presenting concurrently with central disease.

CASE

A 21-year-old female with known right otic and multisystem LCH presented with septic shock secondary to a right ear abscess accompanied by polyuria and polydipsia. Physical examination revealed a palpable goiter. Clinical and biochemical evaluation confirmed central diabetes insipidus with associated anterior hypopituitarism (low adrenocorticotropic hormone, follicle-stimulating hormone, and luteinizing hormone). However, concurrent thyroid function tests demonstrated overt primary hypothyroidism, evidenced by an appropriately elevated thyroid-stimulating hormone (26.19 mIU/L) and low free T4 (5.47 pmol/L), rather than the anticipated secondary hypothyroidism. Neck ultrasound showed diffuse thyroid enlargement with heterogeneous echotexture. Crucially, anti-thyroid peroxidase and anti-thyroglobulin antibodies were both negative, rendering Hashimoto's thyroiditis highly unlikely. Although the patient declined confirmatory

fine-needle aspiration, the constellation of a palpable goiter, characteristic ultrasonographic findings, negative autoimmunity, and active multisystem disease strongly supported a diagnosis of direct histiocytic infiltration of the thyroid gland. She was initiated on appropriate glucocorticoid coverage and subsequent levothyroxine replacement, alongside systemic intravenous cytarabine.

CONCLUSION

This case highlights a rare, mixed endocrine profile in multisystem LCH, demonstrating that pituitary and direct end-organ infiltration can coexist. Hypothyroidism in LCH patients with established central diabetes insipidus should not be reflexively assumed to be central in origin. A comprehensive diagnostic workup, including autoantibody screening, ultrasound, and ideally histopathological confirmation, is essential to accurately identify primary endocrine failure and guide appropriate clinical management in these complex cases.

EP_A150

IMMUNE-MEDIATED PANCYTOPENIA ASSOCIATED WITH GRAVES' DISEASE MIMICKING EVANS SYNDROME AND CARBIMAZOLE-INDUCED AGRANULOCYTOSIS

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INTRODUCTION

Autoimmune thyroid disease is frequently associated with other immune-mediated disorders; however, clinically significant pancytopenia is rare. In patients with Graves' disease receiving antithyroid therapy, leukopenia raises concern for drug-induced agranulocytosis, a rare but potentially life-threatening complication characterized by severe neutropenia requiring immediate drug withdrawal. The coexistence of hemolytic anemia and thrombocytopenia may instead suggest Evans syndrome, defined by autoimmune hemolytic anemia with immune thrombocytopenia, with or without neutropenia. Importantly, uncontrolled thyrotoxicosis itself may cause immune-mediated cytopenias, creating a diagnostic challenge.

CASE

We report a 55-year-old female with thyroid receptor antibody-positive Graves' disease who presented with jaundice and pancytopenia while receiving carbimazole therapy. Laboratory evaluation demonstrated anemia with reticulocytosis and a positive direct antiglobulin test, thrombocytopenia and leukopenia. Complement testing revealed reduced C3 with normal C4, consistent with immune-mediated hemolysis. Peripheral blood film showed no blast cells or marrow infiltration, and autoimmune screening, including antinuclear antibodies and anti–double stranded DNA, was negative.

The coexistence of Coombs-positive hemolysis and thrombocytopenia initially raised suspicion for Evans syndrome, while leukopenia during carbimazole therapy prompted concern for drug-induced agranulocytosis. However, neutropenia was not severe, and the absence of marrow infiltration or systemic autoimmune disease made alternative causes of pancytopenia less likely. Importantly, blood counts progressively improved following the optimization of thyroid control despite continuation of carbimazole at a reduced dose, without the use of immunosuppressive therapy. This clinical course supported the interpretation of thyrotoxicosis-associated immune cytopenia rather than primary Evans syndrome or carbimazole-induced agranulocytosis.

CONCLUSION

This case highlights thyrotoxicosis-associated immune cytopenia as an important mimic of Evans syndrome and carbimazole-related hematological toxicity. Recognizing this entity is essential to avoid unnecessary discontinuation of antithyroid therapy or inappropriate immunosuppressive treatment.

EP_A151

COLD SPOT WITHIN A HOT NODULE: THYROID STORM FROM TOXIC ADENOMA REVEALING RARE HURTHLE CELL ADENOMA

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INTRODUCTION

Hurthle cell adenoma is a rare benign thyroid neoplasm that can only be diagnosed through histopathological examination. Hurthle cell neoplasm typically presents as nonfunctioning cold nodule on thyroid scintigraphy. We report a rare case of Hurthle cell adenoma presenting with thyroid storm, with unusual findings of "cold" within "hot" thyroid nodule on scintigraphy.