Surgery and diagnosis or onset of hypoparathyroidism was in our Austrian retrospective cohort the time lag between
.xticks

Conclusion: The presence of a heterozygous
variants
shorter 17.5 kD isoform of GH protein and
in these patients. 

Methods In this retrospective Austrian single-center co-
Patients with a HgbA1c testing frequency of >6 months have poorer glycemic control. The American Diabetes


clinical manifestations including heart failure and seizures

Results We identified a total of 119 patients treated be-

Conclusion Our data suggest that diagnosis of perma-

occurrence of the disease or a delayed diagnosis of a condi-

Healthcare Delivery and Education

Is Late Diagnosis of Postsurgical

Background The most prevalent etiology for hypopara-

Application of Lean Six-Sigma DMAIC tool for

Bone and Mineral Metabolism

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The use of Lean Six-Sigma DMAIC quality improvement tools are an effective method to improve quality of care in the outpatient setting. These strategies can be replicated for other clinical quality outcomes.

Neuroendocrinology and Pituitary CASE REPORTS IN SECRETORY PITUITARY PATHOLOGIES, THEIR TREATMENTS AND OUTCOMES

The Unique Etiology and Management of a Third Cranial Nerve Palsy

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SAT-LB51

The Unique Etiology and Management of a Cranial Nerve III Palsy

Background: Cranial nerve palsies (CNP) in association with a hypophyseal process can be uni/bilateral, single, multiple, with or without visual deficits and pain. It is reported 14-30% of pituitary tumors lead to a palsy. Often the acute cause of palsy is apoplexy (1) but other rare etiologies exist such as abscess or prolactinoma (2, 3).

Clinical Case: A 40-year-old woman with no PMH presented to the ED for acute on chronic headaches. Two days prior she started having blurry vision in her R eye. The headache improved with medications and she was sent home. Two days later she returned with new symptoms of the R eye deviating laterally and down, associated ptosis and a 6 mm nonreactive pupil. A stat MRI was obtained for her new CN III palsy, showing a 1.4 cm sellar mass with suprasellar extension. Further history revealed that two months prior her regular menses had stopped. Labs were obtained that included a prolactin 127 (nl 4.8-23.3); fT4 1.2 (nl .93-1.7); IGF1 129 (nl 52-328); 9 am cortisol 2.2 mg/dL, and HbA1c 6.6%. Abdominal computed tomography revealed a type B aortic dissection with both right (6.1 x 3.1 cm) and 3.6 x 2.4 cm, and left (largest 1.7 cm) sided adrenal masses. Plasma and 24 hour-urine metanephrine, normetanephrine and catecholamines, as well as plasma renin and aldosterone levels, were normal. AM cortisol on three different occasions was 21.30, 20.70, and 21.30 mcg/dL. Midnight cortisol was 17.8 mcg/dL, and 24 hour urine free cortisol on two occasions was 163 mcg (urine volume 3.4L with creatinine 1.14) and 99.2 mcg (urine volume 1.15L). After 1mg dexmethasone her AM ACTH and cortisol were <5 and 18.70 mcg/dL, respectively. Preoperative AVS was performed and 8mg of dexamethasone was administered the night prior to ensure ACTH suppression during the procedure, and epinephrine was measured to ascertain adequate adrenal vein cannulation. Cortisol levels (in mcg/dL) from the common iliac, right and left adrenal veins were 14.7, 61.5, and 23.5 at 0 minute and 15.2, 61.0, and 22.7 at 2 minutes, respectively. Epinephrine levels (in pg/dL) from the common iliac, right and left adrenal veins were 42, 577, and 3225 at 0 minutes, and 46, 718, and 2989 at 2 minutes. Despite higher epinephrine levels from the left adrenal, the cortisol ratio of the right adrenal vein to peripheral vein was 4.18 with the right-to-left ratio of 2.59 and 2.68 at 0 and 2 minutes, suggesting hypersecretion of cortisol from the right adrenal gland. Unilateral right adenalecetomy revealed a 5.6 cm adrenal adenoma arising in a background of adrenal cortical hyperplasia. Morning postoperative cortisol was 2.2 mcg/dL. She was placed on hydrocortisone and tapered over a 10-month period with remission maintained for more than 3.5 years post-operatively. Conclusion This case demonstrates the safety, usefulness, and necessity, of AVS in localizing cortisol production when bilateral adrenal masses are present. In addition, this case suggests that the use of high dose dexamethasone and measurement of catecholamines may be helpful for more accurate interpretation. More data on AVS in CS patients with bilateral adrenal masses is needed so a well validated and standardized CS-specific ACS protocol can be developed.

Adrenal

ADRENAL CASE REPORTS III

Adrenal Venous Sampling in the Lateralization of AACTH-Independent Cushing Syndrome With Bilateral Adrenal Masses: A Case With a 5-Year Follow-Up

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Yale New Haven Health; Bridgeport Hospital, Bridgeport, CT, USA.

MON-LB035

Background Nearly 25% of adrenal Cushing syndrome (CS) patients with bilateral adrenal masses have unilateral hypercortisolism, making localization crucial for surgical planning. Since there is no standardized protocol for adrenal venous sampling (AVS) in lateralizing adrenal hypercortisolism, we share our experience with a case of CS with bilateral adrenal masses in which lateralization via AVS permitted unilateral adrenalectomy. Clinical Case A 59-year-old woman with hypertension, hyperlipidemia, and prediabetes was hospitalized for worsening back pain and hypertension. Her BMI was 26.5 kg/m², BP 173/93 mmHg, HR 73/min, she was anxious, diaphoretic, and hirsute. Glucose was 118 mg/dL, and HbA1c 6.6%. Abdominal computed tomography revealed a type B aortic dissection with both right (6.1 x 3.1 cm and 3.6 x 2.4 cm), and left (largest 1.7 cm) sided adrenal masses. Plasma and 24 hour-urine metanephrine, normetanephrine and catecholamines, as well as plasma renin and aldosterone levels, were normal. AM cortisol on three different occasions was 21.30, 20.70, and 21.30 mcg/dL. Midnight cortisol was 17.8 mcg/dL, and 24 hour urine free cortisol on two occasions was 163 mcg (urine volume 3.4L with creatinine 1.14) and 99.2 mcg (urine volume 1.15L). After 1mg dexmethasone her AM ACTH and cortisol were <5 and 18.70 mcg/dL, respectively. Preoperative AVS was performed and 8mg of dexamethasone was administered the night prior to ensure ACTH suppression during the procedure, and epinephrine was measured to ascertain adequate adrenal vein cannulation. Cortisol levels (in mcg/dL) from the common iliac, right and left adrenal veins were 14.7, 61.5, and 23.5 at 0 minute and 15.2, 61.0, and 22.7 at 2 minutes, respectively. Epinephrine levels (in pg/dL) from the common iliac, right and left adrenal veins were 42, 577, and 3225 at 0 minutes, and 46, 718, and 2989 at 2 minutes. Despite higher epinephrine levels from the left adrenal, the cortisol ratio of the right adrenal vein to peripheral vein was 4.18 with the right-to-left ratio of 2.59 and 2.68 at 0 and 2 minutes, suggesting hypersecretion of cortisol from the right adrenal gland. Unilateral right adrenalectomy revealed a 5.6 cm adrenal adenoma arising in a background of adrenal cortical hyperplasia. Morning postoperative cortisol was 2.2 mcg/dL. She was placed on hydrocortisone and tapered over a 10-month period with remission maintained for more than 3.5 years post-operatively. Conclusion This case demonstrates the safety, usefulness, and necessity, of AVS in localizing cortisol production when bilateral adrenal masses are present. In addition, this case suggests that the use of high dose dexamethasone and measurement of catecholamines may be helpful for more accurate interpretation. More data on AVS in CS patients with bilateral adrenal masses is needed so a well validated and standardized CS-specific ACS protocol can be developed.