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Editorial

Editorial for July/August Issue of AACE Clinical Case Reports

Dear Colleagues,

Welcome to another issue of *AACE Clinical Case Reports* (ACCR). ACCR continues to grow in both manuscript submissions and readership; this growth would not have been possible without the dedication of our associate editors, editorial board members, and editorial/publication staff. Special thank you to our excellent reviewers that provided meaningful and constructive reviews to help the educational value of the published cases.

The current issue includes interesting and educational cases to share. We will provide a summary of some of those cases below. For more details, please access ACCR online journal available at https://www.aaceclinicalcasereports.com/

Under the pituitary-gonadal-adrenal access in this issue, a case highlight the diagnostic difficulties in identifying secondary hypertension due to pheochromocytoma/paraganglioma (PPGL) in patients with end-stage renal disease.[1]

Another case reviewed collision tumors with craniopharyngioma and growth hormone-secreting pituitary adenoma which are associated with more aggressive clinical course and worse prognosis.[2]

A very interesting case (visual vignette) reviewed the steps in diagnosing adrenal artery aneurysm mistaken for adrenal mass.[3]

On Diabetes, Lipids, and Metabolism, authors shared 3 cases for patients with heterozygous familial hypobetalipoproteinemia (h-FHBL) due to loss-of-function mutation in the apolipoprotein B gene. Two with confirmed h-FHBL, and one with suspected h-FHBL, and reviewed their associated risks of developing metabolic dysfunction associated with liver steatosis.[4] Another case described potential benefit of using rituximab to treat severe allergy to insulin, which is rare, in patient with type one diabetes.[5]

A case described patient presentation with hypoglycemia mistakenly thought to be due to illicit drug use, work-up revealed sulfonylurea exposure. Sulfonylurea substitution or drug contamination should be suspected when severe hypoglycemia is diagnosed in unresponsive patients suspected of taking illicit drugs.[6]

In the field of thyroid disease, a case reviewed the diagnosis and management of follicular thyroid cancer presented with lung metastasis with no evidence of primary thyroid tumor.[7]

Another case described multiple endocrine tumors with papillary thyroid cancer, ACTH producing pituitary tumor in addition to adrenal cancer in patients with Li-Fraumeni syndrome (LFS), an inherited sequence variant in TP53, characterized by the early onset of various malignancies including adrenocortical carcinoma, sarcomas, breast cancer, leukemia, and central nervous system tumors.[8]

In the area of bone and calcium disorders , a case attributed the rapid progression of aortic valve stenosis in older adult after teriparatide initiation. Whether this reflects causation or merely an association is further reviewed in the case discussion as chronic exposure of human valvular endothelial cells to parathyroid hormone can trigger endothelial dysfunction and valvular calcification.[9]

Another case describe the presentation of hypoparathyroidism and subsequent hypocalcemia in a critically ill patient with aplastic anemia and review potential proposed mechanisms.[10]

A case highlighted the rare but potentially fatal association of pancreatic neuroendocrine tumor (pNET) with hypercalcemia due to parathyroid hormone related peptide secretion.[11]

Finally, this issue of ACCR includes an interesting video to show neurological manifestation associated with hyperglycemia.[12]

As always, we truly appreciate all contributing authors, reviewers, editors, and staff that help improve our journal and create an educational platform to our readers to help best manage our patients.

Thank you again for your interest in ACCR. We welcome all feedback, questions, and comments from our readers. Please feel free to reach us at publications@aace.com.

Warmest regards,

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Sina Jasim, MD, MPH
Editor in Chief

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