of severe headache, nausea, vomiting, altered level of consciousness, visual impairment and endocrine deficiency. Sheehan took credit for obstetric associated pituitary necrosis however, apoplexy can also be life threatening outside of pregnancy.

***Case Presentation***: This case features 68-year-old females w history of migraines, bradycardia requiring a pace maker, CAD s/p stents, Rheumatoid Arthritis, and urothelial carcinoma of the left kidney which resulted in unilateral nephrectomy. Following surgery: Patient developed generalized weakness, weight loss, Headache. Presented later to ED with severe headache, photophobia, and hypotension. CT Head showed growth of suprasellar mass, edema of hypothalamus and thalamus. Laboratory tests showed Free T4 0.39 (08-1.7), LH < 0.3, FSH 3.7, Ptolactin diluted 85.7, Low Utine Osm 105, cortisol baseline 6.9, cortisol 60 min value post high dose Cosytropin stimulation was 15.5.Spinal fluid analysis was suggestive of aseptic meningitis. Our patient was treated for 10 days in ICU for Sepsis syndrome and viral meningitis before Endocrine consult was obtained, then he got started on hormonal treatment and referred to pituitary Neurosurgeon. Patient underwent Transphenoidal surgery. Pathology revealed Metastasis of Urothelial cancer to pituitary.

***DISCUSSION & CONCLUSION:*** Apoplexy causing an atypical meningitis is a rare presentation. We theorize apoplexy can lead to aseptic meningitis by leakage of blood or necrotic tissue into the subarachnoid space. Either agent can induce a cytokine mediated response and the presentation of meningitis. Based on CTs, our patient's pituitary tumor grew significantly in 30 days. Medical management of pituitary apoplexy includes fluid electrolyte balance, glucocorticoids, hemodynamic monitoring, replacement of missing hormones, and the use of Decadron to decreases cerebral edema. Diabetes insipidus was an alarming symptom for possible metastatic cancer to pitutary

CONCLUSION

This case highlights the difficulty in diagnosing pituitary pathologies and the rare presentation of apoplexy. Aseptic meningitis and a decrease in centrally controlled hormones should alert Physicians to include pituitary apoplexy in the differential diagnosis. Metastatic urothelial cancer to pituitary is extraordinarily uncommon.

# Thyroid

## THYROID CANCER CASE REPORTS II

### *A Rare and Unusual Presentation of Adenoid Cystic Carcinoma as Thyroid Mass with Metastasis to the Lung*

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**MON-445**

**Introduction:** Adenoid cystic carcinoma is a rare form of cancer that most commonly originates within the secretory cells of the major and minor salivary glands. In rare and unusual cases, adenoid cystic carcinoma can present as Thyroid mass. Adenoid cystic carcinoma is described presenting in papillary carcinoma of thyroid and as poorly differentiated thyroid carcinoma with mixed or unclear histology. We describe the case of a patient diagnosed with poorly differentiated thyroid carcinoma with complete thyroidectomy later presenting with metastatic lung disease diagnosed as adenoid cystic carcinoma.

**Case Presentation:** A 53-year-old male with history of palpable neck mass, lymphadenopathy, and hoarseness with a diagnosis of poorly differentiated thyroid carcinoma with unclear histology. He underwent total thyroidectomy with level 6 compartment neck dissection, laryngeal nerve sparing with tracheostomy tube. Patient presented 2 months' post thyroidectomy with right facial swelling. Labs were significant for microcytic anemia with Hgb 10, MCV 71, TSH and metabolic panel within normal limits. Radiographic imaging demonstrated residual-recurrent malignancy in the thyroid bed, lymphatic disease, and compression of surrounding structures including trachea, distal right internal jugular, and right subclavian vein. Follow up radiographic studies showed a 1.7 x 4.6 x 5.5cm soft tissue mass behind the trachea at the level of previously resected mass. Multiple pulmonary nodules were noted. Image guided needle biopsy of largest left lung nodules carcinoma with adenoid cystic pattern. Final path report was metastatic adenoid cystic carcinoma.

**Conclusion:** This case is unique in that it describes a rare and uncommon presentation of adenoid cystic carcinoma as metastatic thyroid carcinoma in a patient with prior history of thyroidectomy. Adenoid cystic carcinoma is a rare glandular malignancy that commonly presents as the second most common histologic subtype of salivary cancer. Adenoid cystic carcinoma as a histologic subtype has a high morbidity and mortality, if not identified and managed promptly. Prognosis and survival outcomes are poor with some studies comparing its prognosis to that of anaplastic carcinoma. This case also illustrates the complexity and diverse presentation of adenoid cystic carcinoma. The initial diagnosis in this patient was nonspecific with biopsy revealing poorly differentiated carcinoma. Adenoid cystic carcinoma was diagnosed later at time of disease progression to the lung. This case reviews the diagnostic workup, evaluation, and appropriate management of adenoid cystic primary thyroid carcinoma. In addition, it evaluates the appropriate differential diagnosis in patients enlarging neck mass and progressive thyroid cancer.

# Thyroid

## THYROID DISORDERS CASE REPORTS I

### *Extragonadal Germ Cell Tumor Induced Thyrotoxicosis*

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**SUN-499**

**Background:** Extragonadal Germ Cell Tumors (EGCTs) are extremely rare, with an incidence of around

1/1,000,000 and highly variable prognosis dependent on subclassification as seminomatous or non-seminomatous. Non-seminomatous germ cell tumors can cause significant enough elevations in hCG to induce thyrotoxicosis via structural homology allowing for cross-reactivity with the TSH-receptor. Limited cases involving EGCTs inducing thyrotoxicosis have been studied.

**Case:** A 27-year-old male presented to the emergency department with intractable abdominal and back pain. He reported night sweats, nausea, dizziness, and a 10 lb weight loss in 1 week. He was resting comfortably and only complaining of pain. He was moderately tachycardic, tachypneic and hypertensive, with a physical exam only remarkable for tenderness to palpation of the abdomen. Abdominal CT revealed mesenteric and retroperitoneal lymphadenopathy, bilateral adrenal enlargement, a mass in the head of the pancreas, as well as gallbladder and common bile duct distention. Lymph node biopsy was conducted for a suspected lymphoma; however, pathology found a poorly differentiated carcinoma. A diagnosis of a non-seminomatous EGCT was made when ultrasound of the testes was negative for masses and labs revealed elevations in hCG (74842 mIU/ml), and LDH (1421 U/L) with normal AFP (6.98 ng/mL). Further workup showed a slightly elevated T4 Free Thyroxine (1.55 ng/dl) with normal TSH (0.555 mIU/L); thus his thyrotoxicosis was secondary to the high HCG. Treatment for thyrotoxicosis was deferred with the expectation that symptoms would resolve when the tumor burden was decreased. Our patient had numerous other complications requiring management from nephrology, GI and urology teams in addition to endocrinology and hematology-oncology. Bleomycin, Etoposide and Cisplatin (BEP) combination chemotherapy was initiated after recovery from acute complications. Further pathology evaluation suggested tumor susceptibility to the biologics nivolumab and pembrolizumab.

**Conclusion**: Patients with thyrotoxicosis secondary to metastatic non-seminomatous germ cell tumors often present with widespread metastasis and relatively few symptoms of thyrotoxicosis that resolve as the hCG levels decrease with chemotherapy without specific antithyroid medication. This case highlights the importance of considering clinically occult thyrotoxicosis in patients who have elevated hCG secondary to germ cell tumors. Early detection of germ cell tumor and recurrence is crucial for chemotherapeutic success. Thus, patients should be closely followed for thyrotoxicosis relapse which could potentially herald a carcinoma relapse and aid in early diagnosis.

# Thyroid

## THYROID CANCER CASE REPORTS II

### *The Case of a Rare Anaplastic Thyroid Cancer Variant with Rhabdoid Features*

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**MON-444**

**Introduction:** We present a very rare case of a variant of anaplastic carcinoma, a high-grade thyroid carcinoma with rhabdoid features. Less than 15 cases have been reported in English literature over the last 20 years. The prognosis of thyroid cancer with this variant phenotype is unfortunately very poor with a mean survival time of only 6 months after diagnosis. Treatment includes surgery, often a total thyroidectomy due to the rapid rate of growth of this tumor type. The benefits of chemotherapy and radiation are not yet apparent.

**Case presentation:** A 49 year old female with history of breast cancer status-post recent chemoradiation therapy presented to the emergency department for a rapidly enlarging, right-sided neck mass. The mass had been present for approximately one month, but it was estimated to have grown from 3cm to 5cm within the two weeks prior. The patient was being followed by her ENT specialist and had a recent outpatient CT scan done. The results of the CT revealed a large thyroid tumor partially obstructing the esophagus and given the rapid progression of symptoms, she was instructed to go straight to the ED for emergent admission. Upon arrival, the patient reported not having consumed any solids or liquids for the past day due to concerns of aspiration and increasing neck pain. She had complaints of worsening dysphagia. Initial lab work revealed low thyroglobulin (1.4 ng/mL), elevated T4 (15.42 nmol/L) presumably due to Tamoxifen exposure, and elevated PTH (96.9 pg/mL), likely primary hyperparathyroidism. She was admitted and endocrine was consulted for further evaluation. The patient underwent a fine-needle aspiration biopsy showing high-grade anaplastic carcinoma with extensive necrosis and rhabdoid features. The tumor was eventually classified as stage 4B with gross extra thyroidal extension to the adventitial layers of the esophagus, thus it was determined to be unresectable. It was recommended at that time she have a percutaneous tracheostomy and feeding tube to protect her airway. However, the patient requested to be discharged so that she could obtain a second opinion regarding treatment options and prognosis. She subsequently underwent a total thyroidectomy at another hospital.

**Conclusion:** It remains unclear whether this patient's history of breast cancer treated with chemoradiation therapy played a role in the development of this rare thyroid carcinoma. Some cases of the rhabdoid phenotype are documented to have transformed from papillary thyroid carcinoma, for which radiation therapy is a well-known risk factor. Future studies should use molecular markers, such as BRAF V600E mutations common to papillary and anaplastic thyroid carcinomas, to help differentiate between types of thyroid cancers and avoid delayed treatment options for rapidly metastasizing thyroid tumors.

# Diabetes Mellitus and Glucose Metabolism

## PREGNANCY, LIPIDS, AND CV RISK — IMPACT OF DIABETES ACROSS THE SPECTRUM

### *Differences in Advanced Lipoprotein Profile Between Rabson-Mendenhall Syndrome and Lipodystrophy*