

MON-354

Transfusion-associated hemochromatosis (TAH) can result in multiple endocrinopathies. Timely diagnosis and treatment can prevent life-threatening consequences. Here we report a misdiagnosed case of a transfusion-dependent 32 yo female with severe hypocalcemia.

CASE DESCRIPTION

Patient is a 32 yo female with Diamond-Blackfan anemia requiring chronic blood transfusions every 2-3 weeks. She has a history of non-compliance with iron chelation therapy, and as a child was diagnosed with TAH complicated by pancreatic diabetes, GH deficiency, hypogonadotropic hypogonadism, and primary hypothyroidism. In 2014, patient was evaluated for bilateral calf pain and found to have low calcium (6.9mg/dL) and elevated phosphorus (6.4mg/dL). She was started on calcium carbonate and calcitriol, but subsequently lost to endocrine follow up. During that time, calcitriol was discontinued, and she was treated with calcium alone for presumed hypocalcemia due to transfusion-related calcium chelation.

In 8/2019, patient was seen in the ED for symptomatic hypocalcemia (Ca 6.2mg/dL, PTH 3pg/mL, vitamin D 25-OH 43.5ng/mL and ferritin 1147ng/mL). She was not taking medications for her other endocrinopathies at that time, with TSH 104, estradiol <30, FSH <1, IGF-1 11. MRI confirmed no pituitary abnormality. She was evaluated by Endocrinology and diagnosed with hypoparathyroidism. She was started on calcium carbonate and calcitriol with stabilization of calcium levels, restarted on levothyroxine and discussion of estrogen replacement was started. She is not currently requiring insulin for treatment of her diabetes.

DISCUSSION

Patients with TAH develop organ damage from iron deposition in a pattern similar to hereditary hemochromatosis, with preferential deposition in the gonadotrophs and lactotrophs leading to hypogonadism and hypoprolactinemia. Primary hypothyroidism, GH deficiency and primary hypoparathyroidism are rare by comparison. Our patient is unique in her wide range of endocrinopathies.

More importantly, this case highlights that failure to recognize these endocrinopathies can lead to inappropriate management and increased morbidity to patients. Despite frequent contact with the health care system for management of her anemia, her endocrine labs were not consistently monitored, leading to the false diagnosis of calcium chelation for her hypocalcemia and treatment with calcium replacement alone. A correct diagnosis of primary hypoparathyroidism due to iron deposition ensured proper treatment with both calcium and calcitriol in this patient's case.

CONCLUSION

Hypocalcemia associated with transfusion may be due to TAH or calcium chelation. It is important to recognize the rare case of primary hypoparathyroidism when present, in addition to other endocrinopathies, to ensure patients receive appropriate treatment.

Adipose Tissue, Appetite, and Obesity**OBESITY TREATMENT: GUT HORMONES, DRUG THERAPY, BARIATRIC SURGERY AND DIET*****Obesity Pharmacotherapy Is Effective in the United States Veterans Affairs Patient Population: A Local and Virtual Cohort Study.***

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MON-601

Background: Overweight and obesity are major health burdens, and the military veteran population may be disproportionately affected. Multiple new pharmacologic agents and combinations have been approved by the FDA for use in medical weight management. Using deidentified records from our local interdisciplinary weight management clinic and a national clinical data repository, we assessed obesity pharmacotherapy use and its real-world effectiveness for weight loss and improvement of comorbid metabolic parameters in this vulnerable population.

Methods: During the initial year of the local weight management clinic, we found over 50 records with monthly followup of lifestyle intervention augmented by obesity pharmacotherapy. In the national clinical data repository, we identified over 2 million records for unique individuals prescribed bupropion-naltrexone, liraglutide, lorcaserin, orlistat, or phentermine-topiramate, and metformin considered as a control prescription. We selected records with detailed documentation of weight trends from 1 year before to 1 year after first prescription date for further analysis.

Results: The most commonly prescribed medications in our local weight management clinic were metformin, liraglutide, orlistat, and combination phentermine/topiramate. On average, we observed -4.0 ± 2.1 kg weight loss over the initial 6-month intervention in records that completed at least 3 visits within this period. In the national database, over 800,000 records for an obesity or control metformin prescription provided adequate weight documentation to compare weight slopes during the year before and after the prescription start date. Records for metformin prescriptions showed -0.04 ± 0.008 kg/week difference in weight slope over one year before versus after the prescription start date. The greatest difference in weight slope was seen with phentermine-topiramate (-0.13 ± 0.03 kg/week), followed by lorcaserin, liraglutide, bupropion-naltrexone, and orlistat.

Conclusions: Our data suggests that veterans with obesity experience weight loss at 1 year follow-up when engaged with our interdisciplinary weight management clinic. Nationally, veterans with obesity experience modest weight loss when prescribed pharmacotherapy. Taken together, our two data sources provide complementary perspectives to help guide obesity pharmacotherapy in veterans with obesity.

Neuroendocrinology and Pituitary**CASE REPORTS IN UNUSUAL PATHOLOGIES IN THE PITUITARY II*****A Late-Onset Case of Sheehan's Syndrome Presenting as Life Threatening Adrenal Insufficiency***

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