panic attacks. Family history was positive for Hashimoto's thyroiditis. Initial lab evaluation was significant for elevated erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), mildly elevated free T4 (FT4) with suppressed thyroid stimulating hormone (TSH). She was found to have a nearly 6 cm left-sided thyroid abscess, which was eventually drained. Contrasted CT imaging showed multiple left laryngeal space abscesses with extension to the left thyroid gland. TSH gradually increased over two months to nearly 4 times upper limit of normal accompanied by low normal FT4. TSI and TPO antibodies were negative. Clinical course was complicated by recurrent abscesses which required percutaneous drainage and intravenous antibiotics. **Discussion:** Acute infectious thyroiditis is extremely rare disorder of the thyroid gland in adults. Most patients present with recurrent abscesses early during childhood. Imaging studies such as CT scan, preferred over MRI, and barium swallow can show a fistula connecting the piriform sinus and left lobe of the thyroid gland. Treatment includes needle aspiration, followed by drainage and IV antibiotic therapy. Surgical excision of the entire sinus tract and the involved area of the thyroid gland is the best method to achieve definitive cure.
Conclusion: Lower left-sided thyroid abscess extending from the pyriform fossa to the thyroid bed should raise the suspicion for underlying third or fourth branchial fistula. Most cases present during childhood, but one third of cases occur in adults. Surgical excision after confirming the presence of a fistulous tract with imaging is the treatment of choice.

Thyroid
THYROID DISORDERS CASE REPORT

Non-MAS Non-APS Rare* Case: *Co-Occurrence of Graves' Disease (GD), Latent Autoimmune Diabetes in Adult (LADA), Systemic Lupus Erythematosus (SLE), and Ulcerative Colitis (UC)

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Background: Advancement in medical technology has allowed us to diagnose complicated autoimmune diseases. There is a growing report of multiple autoimmunity co-occurence. Multiple Autoimmune Syndrome (MAS) is a combination of at least three autoimmune diseases, whereas Autoimmune Polyendocrine Syndromes (APS) comprise autoimmunity that involves multiple endocrine gland. **Case Illustration:** A 47-year old female came with chief complaint of palpitation. She had a history of systemic lupus erythematosus in the last three years, after suffering from malar rash, alopecia, and polyarthritis. Her 24-hour urine protein was 1575 mg. She routinely consumes methylprednisolone, hydroxychloroquine, and mycophenolic acid. She also experienced hematochezia and the biopsy from colonoscopy revealed chronic colitis with crypt destruction. She was diagnosed with ulcerative colitis and was treated with mesalazine. Since last year, her blood glucose was consistently high, accompanied with polydipsia and polyuria. She was treated with metformin, despite persistent increase in her A1C, as well as fasting and random blood glucose. We performed GAD65 test which came back positive, hence we diagnosed her with latent autoimmune diabetes in adult. In the past three months, she experienced palpitations, tremor, diarrhea, diaphoresis, and unexplainable weight loss. No exophthalmos was found, but she complained of an enlargement around her neck. We run thyroid hormone test, her TSHs was <0.003 (0.35-4.94 μIU/mL) and FT4 was 4.17 (0.70-1.48 ng/mL). Her ultrasound revealed diffuse enlargement of both thyroid with increased vascularization. We diagnosed her with Graves' disease and treated her with methimazole and propranolol. **Discussion:** This case highlighted the rare co-occurrence of four autoimmune diseases. The underlying genetic predisposition of individual with autoimmune disease, will make them prone to develop multiple defect in their self-tolerance mechanism. However, the strict criteria of APS or MAS constrained us from putting all her autoimmunities into one big umbrella. Based on epidemiological data, hyperthyroidism in female productive age, with diffuse thyroid enlargement, is commonly due to Graves' disease. However, this diagnosis needs to be further evaluated with thyroid scintigraphy and confirmed with TSH-receptor antibody test. **Conclusion:** Improvement in medical diagnostic tools as well as better understanding of the underlying pathophysiology will make it inevitable to find more autoimmunity co-occurrence in the future. In order to keep up with this progress, the traditional classification of APS or MAS should be reviewed to allow clinician to see the case in one big entity. **Keywords:** GD, LADA, SLE, UC

Thyroid
THYROID DISORDERS CASE REPORT

Oscillating Hypo-Hyperthyroidism; a Rare Type of Autoimmune Thyroiditis in Adolescence

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Background: Spontaneous conversion of hypothyroidism to hyperthyroidism and vice versa is a unique autoimmune entity characterized by the oscillating activity of thyrotropin blocking inhibiting immunoglobulin (TBII) and thyroid-stimulating immunoglobulin (TSI). The simultaneous presence of both antibodies is a rare phenomenon in children. **Clinical Case:** At 11 years of age a female with Trisomy 21 and mild developmental delay had elevated TSH 5.4uIU/mL (0.4-4.5), normal thyroxine (T4), negative thyroglobulin peroxide antibody (anti-TPO), and thyroglobulin antibody (Anti-Tg). Levothyroxine (LT4) 1.2mcg/kg/day was started. At 12 years of age, she relocated, and the same treatment was continued. About 7 months later, she was referred for weight loss of 8lbs, tachycardia, high BP, suppressed TSH <0.015uIU/mL, high total T4 15.9ng/dL (4.5-12.0), and anti-TPO 38 IU/mL (<9). She was diagnosed with hyperthyroidism and LT4 was discontinued. Repeat lab showed persistently undetectable TSH, high T4, TBII 70 (normal <16%), and TSI 698 (<140 %). Methimazole (MMI) 0.38mg/kg/day and Atenolol 25mg daily was started for Grave's disease.
At 15 years of age, she presented with symptoms of hypothyroidism; 10lb weight gain in 2months, high TSH