

## Poster Presentations

PP001

### A Rare Case of Secondary Hypertension Accompanied by Low Renin and Low Aldosterone Level: Chronic Consumption of Supplement Consisting Licorice Root

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**Background** We have talked about a rare case of secondary hypertension caused by intake of licorice in an unusual way.

**Case Report** An 83-year-old female patient was consulted to our department for hypokalemia and resistant hypertension. In the initial evaluation, there was no history of drug use to explain the current picture. A detailed anamnesis was taken, and all medications used by the patient were questioned again and it was learned that the patient had been taking high amounts of supplements for a long time. Some of these supplements were contained licorice extract. Using of supplements which containing licorice were stopped. The supportive treatment relieved the patient's symptoms. Deadly complications were prevented thanks to early diagnosis.

**Conclusions** Our aim in sharing our case is to remind the importance of asking questions about herbal medicines and getting detailed medical history in all patients.

calcium level of 14.6-15.9 mg/dL. We aimed to present you with a normocalcemic and asymptomatic case.

**Case Report** A 22-year-old patient without any known comorbidity applied to the emergency service after falling. Magnetic resonance imaging was performed on the left knee due to lytic lesions in the radiograph of the left knee. Lesions with dimensions of approximately 30x10 mm in the anterior part of the proximal tibia and approximately 11x5 mm in the posterior part of the distal metaphysis of the femur, causing thinning of the cortex and protrusion from the contour, were detected. In the foreground, pathologies such as Langerhans cell histiocytosis, metastasis, or multiple myeloma were considered. Thereupon, the patient who had lytic lesions in many bones in PET-CT was referred to us. The patient who has no active complaints has calcium 10 mg/dL, phosphorus 2.1 mg/dL, parathormone 2,172 ng/L, 25-OH vitamin D level <3 ng/mL, ALP bone isoenzyme 636 (3-14) ng/mL, urea and creatinine were normal. In the neck ultrasound of the patient who was suspected of having parathyroid pathology, a 10x15 mm mass lesion was observed behind the lower pole of the left thyroid lobe and adjacent to the esophagus. Protein electrophoresis was normal. The 24-hour urine calcium level was 526 mg. Bone densitometry was performed, and the patient had lower bone mineral density than expected for her age. No nephrolithiasis was detected in the urinary ultrasonography. The patient underwent left hemithyroidectomy and left lower upper parathyroidectomy. Its pathology was reported as parathyroid carcinoma (KI67 25% GATA3+). The starving bone syndrome was considered in the patient with postoperative parathormone level of 43.8 ng/L, calcium 7.2 mg/dL, and phosphorus 1.4 mg/dL. Calcium was given, and vitamin D replacement was continued. Tests for MEN were sent. The cd73 (HRPT-2) mutation was submitted for genetic analysis. The patient was currently being followed up with parathormone and calcium levels.

**Conclusions** Parathyroid carcinoma can lead to many symptoms by causing hypercalcemia in more than 90% of patients. In our case, there was a concomitant low vitamin D. The patient was normocalcemic and asymptomatic. It should be kept in mind that calcium levels to screen for hyperparathyroidism may be normal due to concomitant vitamin D deficiency, and parathormone levels should be checked in patients with lytic lesions in the second bone osteoporosis, nephrolithiasis, and renal failure.

PP002

### Parathyroid Carcinoma with Atypical Presentation

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**Background** Parathyroid carcinoma is a rare cause of primary hyperparathyroidism, usually caused by parathyroid adenoma and rarely by primary parathyroid hyperplasia. Its frequency varies between 0.3% and 2.1%. Patients are often (90%) symptomatic and have significant hypercalcemia, bone and kidney disease, neck mass, and significant parathyroid hormone levels. Studies have shown that patients have an average

PP003

### Sheehan Syndrome and Central Hypothyroidism: A Case Report

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**Background** Sheehan's syndrome occurs as a result of ischemic pituitary necrosis due to severe postpartum hemorrhage. The syndrome is characterized by varying degrees of anterior pituitary dysfunction resulting from the deficiency of multiple pituitary hormones. The order of frequency of hormone loss has generally been found to be growth hormone and prolactin, gonadotropins, ACTH and thyrotropin. Women with Sheehan's syndrome exhibit a variety of signs and symptoms including failure to lactate or resume menses, loss of genital and axillary hair, and often occurring long after delivery clinical manifestations of central hypothyroidism and secondary adrenal insufficiency. Sheehan syndrome is one of the causes of secondary empty sella syndrome. Treatment of Sheehan's syndrome involves hormone replacement therapy. In our case, we evaluated a patient who had a history of severe vaginal bleeding at her third birth, followed by amenorrhea, developed slowly and was diagnosed years later, and was diagnosed with chronic sheehan syndrome, which primarily developed central hypothyroidism.

**Case Report** A 32-year-old patient who had a normal vaginal delivery, had a history of excessive bleeding at her third birth, was followed up with amenorrhea, and received intermittent oral contraceptive treatment. She was evaluated with complaints of type 2 diabetes mellitus and fatigue at the age of 46. There was no feature in her family history. In the physical examination, the patient was conscious, full of orientation and cooperation. Blood pressure was 125/80 mmHg, pulse 70/min, and temperature 36.6 °C. Other system findings were within normal limits. Hemogram and biochemistry are normal in the examinations, TSH: 0.6 mIU/L (0.27-4.20), free T4: 0.49 ng/L (0.93-1.71), and free T3: 1.75 ng/L (2.04-4.44) detected. File review revealed that free T3, free T4 levels were not measured for 2 years in previous examinations, and the TSH level measured was close to the lower limit. Evaluating the anterior pituitary hormone panel, cortisol 11.8 µg/dL (6.7-22.6), ACTH 28 ng/L (7.2-63.3), prolactin 7.74 ng/mL (5.18-26.53), LH 1.5 mIU/mL, FSH 2 mIU/mL, estradiol (E2) <5 µg/mL, growth hormone <0.05

µg/L (0.06- 5), IGF-1 54 µg/L (74-196), and thyroid function tests were found to be compatible with central hypothyroidism. No abnormal finding was detected in the thyroid ultrasonography of the patient. There was no sign of empty sella in the MRI of the sella. The pituitary parenchyma was minimally heterogeneous. In the images taken in the late phase, an unenhanced area of 2 mm in diameter was detected in the middle part of the pituitary gland. No pathology was detected in the hypothalamic, suprasellar or parasellar regions.

**Conclusions** Although rare, Sheehan's syndrome can occur months or even years after postpartum hemorrhage. Diagnosis may be missed due to slow development. Diagnosis of central hypothyroidism may be delayed by only looking at TSH level in patients. In our case, it was observed that Sheehan syndrome had a slow development, unusually presenting primarily with central hypothyroidism, the diagnosis was delayed because only TSH level was checked, and patients with central hypothyroidism and Sheehan syndrome should be followed up as pituitary hormone deficit may develop in the long term.

PP004

### Diabetic Ketoacidosis Patient with A Painful Leg: Consider Pyomyositis!

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**Background** The risk of infection significantly increases in diabetes, especially among patients with uncontrolled disease. A rare but extremely serious type of infection called "pyomyositis" needs the close attention of physicians to recognize the case immediately as any delay in diagnosis might lead to severe complications, including septic shock, endocarditis, brain abscess, or even death. Pyomyositis is an uncommon purulent infection of skeletal muscle that usually presents with abscess formation. The main predisposing factors are immunodeficiency, temperate climates, trauma, drug injection, and malnutrition. Furthermore, patients mainly refer to a doctor with entirely obscure signs and symptoms which imitate other musculoskeletal issues, including osteomyelitis, septic arthritis, muscle

rupture, or deep venous thrombosis. Herein, we report a patient with diabetic ketoacidosis who presented with a painful leg and was diagnosed with pyomyositis.

**Case Report** A 45 years-old female patient presented to the emergency room with meaningless speech. She was dehydrated, and her right thigh was warm and mildly erythematous. She had a diabetes mellitus diagnosis three years ago in past medical history. Her medical compliance to prescribed oral antidiabetics was minimal, though. She had no trauma or injection history. Her blood glucose level was 523 mg/dL with urine ketone positivity in the first workup. Blood gas analysis confirmed metabolic acidosis. Although the patient was afebrile, C-reactive protein was 344 mg/L, and white cell count was 24.55 K/ $\mu$ L. COVID-19 PCR test was negative, and other blood tests were normal. Cranial computed tomography ruled out acute infarction or hemorrhage in case of blurred consciousness. Following the monitorization, insulin infusion, potassium replacement, hydration, and ampicillin-sulbactam antibiotics therapy were immediately initiated, the patient was admitted to Endocrinology and Metabolism Clinic with diabetic ketoacidosis and cellulitis early diagnosis. Her HbA1c level was 117.5 mmol/mol Hb (12.9%). Doppler ultrasonography of the lower extremity did not infer any abnormal blood flow. Lumbosacral magnetic resonance imaging (MRI) showed a 30x5 cm sized abscess in vastus lateralis and quadratus femoris muscles. Additionally, right elbow ultrasonography demonstrated 1cm anechoic fluid as well. Drainage of abscess in the right thigh was urgently planned. In her blood culture tests, *Staphylococcus aureus* was isolated, and teicoplanin therapy was started as *Staphylococcus aureus* was ampicillin-resistant and teicoplanin susceptible in her abscess drainage culture. She was HIV-negative, and her immunoglobulin levels were normal. Her echocardiography did not show infective endocarditis findings. Her cranial MRI showed nasopharyngeal mass corresponding with cystic findings in the biopsy. After successfully treating pyomyositis with drainage and teicoplanin, the abscess completely disappeared in the right elbow and thigh without any sequelae. Her procalcitonin was negative, and C-reactive protein was below 10 mg/L at the time of discharge. Her stay at our clinic was 35 days.

**Conclusions** An uncommon complication of poorly controlled diabetes is pyomyositis with possible serious morbidity and mortality risk. Abscess drainage and appropriate antibiotic therapy are essential for managing diabetic pyomyositis following the confirmation of diagnosis with MRI. In the long term, control of diabetes is a must to minimize the infective and other systemic complications in these patients.

### Nursing Management in a Patient Developing Pancytopenia After Chemotherapy: A

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**Background** Pancytopenia is a sudden decrease in the three main series of formed elements of the blood (erythrocyte, platelet and leukocytes). Pancytopenia can occur by various mechanisms. Combined chemotherapy used in cancer treatments can cause pancytopenia by affecting the bone marrow while affecting the cancer cell. As a result of pancytopenia, the patient may develop anemia, bleeding, and infection, and if not managed well, life-threatening conditions may occur. Here, an exemplary nursing management of a patient who developed pancytopenia after folfirinnox chemotherapy is presented.

**Case Report** A 61-year-old female patient was diagnosed with hypertension and depression. She uses Fludex SR, esplus and redepra. He was examined for 6 months due to complaints of weight loss, abdominal and back pain. After the biopsy, he was diagnosed with metastatic pancreatic adeno cancer. The patient with liver, peritoneum and small intestine metastases was considered unresectable, and a port catheter was inserted, and the first course of folfirinnox (irinotecan, oxaliplatin, calcium leucovorin and 5-fluorouracil) was given. Durajesic 25 TTS was started for his pain. The patient went to the emergency room 10 days after chemotherapy treatment, body temperature 38.3 °C, blood pressure 120/70 mmHg, pulse 98/min, SpO<sub>2</sub> 97% (without O<sub>2</sub>), diarrhea 5 times a day and Grade 3 mucositis applied with. The ECG was unremarkable in the patient who had negative PCR test, cough, sputum and no symptoms. Laboratory tests (blood, urine, stool fresh) were checked and he was admitted to the oncology clinic. The patient's blood (peripheral and catheter), urine and sputum cultures were taken and treatment was started. Laboratory results in emergency: leukocyte 0.42 K/ $\mu$ L (4.5-11), neutrophil 0.010 K/ $\mu$ L (2-6.9), hemoglobin 7.8 g/dL (11.5-15), hematocrite 25.2% (33-44), platelet 6.5 K/ $\mu$ L (145-400), CRP 252.9 mg/L (<5), procalcitonin 1.64  $\mu$ g/L (<0.05), potassium 3 mmol/L (3.5-5.1), sodium 132 mmol/L (136-145),

creatinine 2.52 mg/dL (0.56-0.85), BUN 42.1 mg/dL (9.8-20.1), urea 90 mg/dL (20.9-43). Urine sediment leukocyte 3, bacteria less, stool fresh no feature. The patient was promptly started on G-CSF, antibiotics and antifungal therapy. Necessary fluid, electrolyte and blood products were replaced. Tatum, mycostatin, gaviscon/lidocaine mouthwash, intravenous TPN were started. Duragesic dose was increased for his pain and interrupted with parol infusion. Vital signs, pain and fluid intake and output, daily laboratory follow-up were performed. Risk of falling, nutritional imbalance (less than requirement), electrolyte imbalance, risk of infection, deterioration of oral mucous membrane, lack of fluid volume, hyperthermia, change in bowel excretion habits (diarrhea), bleeding risk, self-care syndrome, discomfort in sleep pattern, information deficiency, acute pain, anxiety and fatigue” nursing care diagnoses were made and the process was successfully managed by applying care for them.

**Conclusions** In the direct microscopic examination of only the sputum culture of the patient, gram (+) cocci, gram (+) bacilli were observed, there was no growth in other cultures. On the 6th day of treatment, her neutropenia resolved. Mucositis continues to decrease (Grade 2). The patient continues to be followed in the clinic. When his general condition improved, it was planned to change the chemotherapy regimen. Pancytopenia that develops after chemotherapy can be prevented, especially in patients receiving high-risk chemotherapy regimens, with close monitoring, and education of the patient and their relatives on chemotherapy and symptom control, or it can be detected in the early period and prevented from serious conditions. In such cases, oncology nurses play a key role.

PP006

### Nursing Management in a Patient Developing Grade 4 Infusion Reaction Due to Chemotherapy: A Case Report

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**Background** Infusion reactions (IR) may develop frequently in systemic chemotherapy applications. The incidence of IR may increase when chemotherapeutics and different agents are used together. IR appears as an allergic reaction (usually IgE-mediated response) or non-immune-mediated reactions to foreign proteins. IR can be seen especially due to taxanes, platinum derivatives, pegylated liposomal doxorubicin, monoclonal antibodies and immunotherapy. Although IR usually occurs during drug infusion or within a few hours, it can also be seen in the late period. The severity of IRs is often mild and is accompanied by symptoms such as chills, fever, nausea, skin rash, itching. But some can also be severe and deadly. Here, as an example, a case of nursing management in a patient who developed a Grade 4 infusion reaction due to carboplatin is presented.

**Case Report** A 65-year-old male patient has diagnoses of diabetes, hypertension, heart disease (stent) and chronic obstructive pulmonary disease (COPD). Beloc uses diaformin, karrum, monolong. He has no known history of allergies. He is constantly using nasal oxygen. He was examined for 6 months due to cough complaints. In December 2018, he was diagnosed with lung squamous cell carcinoma (AC SCC) as a result of biopsy from the left lower lobe of the lung. The patient presented to the council received 6 courses of neoadjuvant paclitaxel + carboplatin. After the operation, she received radiotherapy to the mediastinum for 18 days and weekly paclitaxel + carboplatin simultaneously. 1,8,15 paclitaxel+carboplatin was continued after radiotherapy. The patient came to the unit on 24 November 2021, on the 15th day of the 4th cycle, in a wheelchair with O2 accompaniment, conscious and cooperative. Initial vital signs were normal (Blood pressure 130/80 mmHg, pulse 88/min, temperature 36.5 °C, SpO<sub>2</sub> 97% [with O<sub>2</sub> 3 L/min]). Paclitaxel infusion was administered in 1 hour after premedication (pheniramine in 100 cc isotonic + 16 mg dexamethasone + granisetron) was administered

according to the physician's request. Intermediate washing was done with isotonic and carboplatin was started. At the 15th minute of the carboplatin infusion, due to the development of redness on the face and hands and respiratory distress, chemotherapy treatment was stopped and vascular access was established with isotonic and intravenous 80 mg methylprednisolone and pheniramine were administered. He was brought to the recovery position, monitored, and the physician was informed. Blood pressure 100/60 mmHg, pulse 134/min, temperature 36.4 °C, SpO<sub>2</sub> 75% (with O<sub>2</sub>). Oxygen was switched to the mask and increased to 10 L/min. The patient relaxed a little, but after his resaturation decreased, SpO<sub>2</sub> 60% (with O<sub>2</sub>), and he became unconscious. Epinephrine 0.5 mg was administered intramuscularly to the right thigh lateral and the ambu mask was switched. The patient who developed cardiac arrest at 11.05 was given a blue code. With CPR, the apex beat was taken at the 2nd minute. His dentures were removed and he was intubated with sedation upon resistance. Aspiration was provided, blood gas was sent and a second vascular access was established. He was delivered to the emergency room intubated in the presence of a physician, with blood pressure 110/70 mmHg, pulse 108/min, temperature 36.4 °C, SpO<sub>2</sub> 98%. The patient was taken to the intensive care unit from the emergency room and was extubated 24 hours later and taken to the oncology service. He was discharged home two days later.

**Conclusions** of platinum derivatives and concomitant drug use are factors that increase the risk of IR. The patient's co-morbidities such as COPD and heart disease caused more severe hypoxia and cardiac arrest when IR developed. Necessary equipment and the management of these reactions should always be kept ready and easily accessible. Life-threatening infusion reactions that develop within seconds can be effectively managed as a team with timely and correct intervention. The knowledge and experience of nurses on the subject is important in positively influencing patient outcomes.

### Thyrotoxic Hypokalemic Periodic Paralysis: A Case Report

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**Background** Thyrotoxic hypokalemic periodic paralysis (THPP) is a rare complication of hyperthyroidism, characterized by low serum potassium levels and acute muscle weakness, without any sensory deficit or confusion. Increased beta-adrenergic stimulation and overactive Na-K-ATPase channels cause potassium leak into muscle cells, and muscle cells can not be stimulated due to hyperpolarization.

**Case Report** A 22-year-old male patient who was diagnosed with Graves' disease three years ago admitted to the emergency department with the complaints of weakness in his upper and lower limbs. He did not use his antithyroid medication for eight months. Physical examination revealed his upper and lower limb power as grade 1/5 with intact sensation. Electrocardiogram showed sinus tachycardia. Serum biochemical parameters were potassium 2.2 mmol/L (3.5–5.5), thyroid-stimulating hormone <0.01 mU/L (0.35–4.94), thyroxine 2.92 ng/dL (0.7–1.47), free triiodothyronine 14.31 ng/L (1.71–3.71). All the other parameters were within normal limits including venous blood gas analysis. Based on the neurological examinations and the biochemical results, THPP was diagnosed. 30 mEq intravenous potassium chloride in 0.9 sodium chloride solution was started immediately and the patient was treated with 40 mg oral propranolol every six hours and 30 mg methimazole daily. After intravenous potassium replacement, complete clinical recovery and normalization of potassium levels were seen.

**Conclusions** Thyrotoxicosis is the most common cause of acquired periodic paralysis. In the absence of a family history of paralysis, renal tubular acidosis should also be kept in mind. Symptoms of hyperthyroidism may not always be evident in patients, or muscle paralysis could be the first manifestation of thyrotoxicosis. In summary, THPP is an infrequent complication of hyperthyroidism that can be fatal. The most important step in preventing THPP is to achieve euthyroidism.

### Acute Lymphoblastic Leukemia Presenting with Loss of Bilateral Visual Acute: A Case Report

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**Background** Acute lymphoblastic leukemia (ALL) is an aggressive disease caused by the expansion of lymphoid blasts in the blood, bone marrow and other organs. It makes its first peak at the age of 4-5 and the second at the age of 50. In less than 5% of cases, genetic syndromes play a role in the etiology. Other risk factors include advanced age (>70 years) and radiation exposure. Patients may present with non-specific symptoms and signs (fever, night sweats, weight loss). Other symptoms such as infection, easy bruising/bleeding, dyspnea and fatigue are among the applications. On physical examination, pallor, petechiae, purpura, ecchymoses and hepatosplenomegaly (20%) may be present. Other extramedullary involvement areas can be testis, skin or mediastinum (especially in T-cell ALL). CNS involvement (cranial neuropathies and meningeal infiltration) at the time of diagnosis is found in 8% of cases. More than 30% of patients have ocular complaints. However, significant eye involvement is rare. Orbital involvement is specific to children. It is generally found unilaterally, under 10 years of age, and is very rare in adult patients. Presentation with bilateral loss of visual acuity is extremely rare. Herein, we presented a case who had bilateral visual acuity loss and was diagnosed as common B ALL with exudative serous retinal detachment.

**Case Report** A 49-year-old female patient with a history of chemotherapy and radiotherapy with a diagnosis of breast cancer and in remission for 5 years applied to the ophthalmology outpatient clinic with blurred vision in both eyes for the last two days. Fundus fluorescein angiography performed in the ophthalmology outpatient clinic revealed diffuse fluorescein leaks (pinpoint leaks) and exudative serous retinal detachment (SRD) due to choriocapillaris involvement.

Thereupon, he was referred to the hematology outpatient clinic with the preliminary diagnosis of ALL and Vogt Kayanagi Harada disease. On physical examination, blood pressure, pulse and temperature were within the normal range. The patient had weakness, loss of appetite, night sweats and involuntary weight loss (5

kg) for the last 15 days. There was a decrease in visual acuity in both eyes. Peripheral lymphadenopathy and hepatosplenomegaly were not detected. Other system examinations were normal. There was no finding in favor of ALL in the complete blood count examination, which was requested for a different reason 10 days before the admission. In the examinations performed at the time of application: leukocyte 58,200/mm<sup>3</sup>, neutrophil 36,400/mm<sup>3</sup>, lymphocyte 14,000/mm<sup>3</sup>, monocyte 2,830/mm<sup>3</sup>, eosinophil 20/mm<sup>3</sup>, hemoglobin 12.9 g/dL, platelet 198,000/mm<sup>3</sup>, D-dimer 3.61 mg/dL, fibrinogen 342 mg/dL, sedimentation rate 21 mm/h, urea 19 mg/dL, creatinine 0.7 mg/dL, uric acid 7.4 mg/dL, AST 48 U/L, ALT 41 U/L, ferritin 1,070 µg/L. Granulocytic precursor cells and blastic cells were seen in the peripheral blood smear. The patient was diagnosed with common B ALL by evaluating the bone marrow with aspirate, imprint and flow cytometry. In the cerebrospinal fluid flow cytometry examination, 10.7% blastic cells were seen. CD10, CD19, CD22, CD33 and HLA-DR were positive. He was admitted to the hematology clinic to evaluate the extent of the disease and to plan chemotherapy. In the follow-up of the patient who started HyperCVAD chemotherapy protocol, Philadelphia chromosome was found to be t(9;22) positive. Due to cytopenia, dose modification was made and tyrosine kinase inhibitor imatinib (400 mg) was added to his treatment.

**Conclusions** As in our case, ALL may present with rare clinical findings. The patient presenting with bilateral visual acuity loss should also be examined with the preliminary diagnosis of ALL. SRD is a rare manifestation of ALL. A comprehensive literature review was conducted in a case report published in the American Society of Ophthalmology in September 2021, and presenting ALL with 11 other SRDs reported worldwide was shown. Early recognition of this hematological malignancy is crucial for prompt initiation of life-saving therapy.



Picture 1.

PP009

### Bilateral Gout Arthritis Developing After Covid-19 Infection: A Case Report

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**Background** SARS-CoV-2 virus started in Wuhan, China in 2019 and caused the COVID-19 pandemic by affecting the whole world in a short time. Arthralgia is one of the symptoms that can be seen after COVID-19 infection and can be seen in 14.9% of the cases. However, data on rheumatic and inflammatory symptoms such as arthritis are scarce. Viral infections are known causes of acute arthralgia and arthritis. In the literature, there are many examples of reactive arthritis cases developing after COVID-19 infection. Gouty arthritis is the most common form of inflammatory arthritis. Acute gouty arthritis most often affects the first metatarsophalangeal joint in the foot.

**Case Report** A 76-year-old male patient with chronic kidney disease, hypertension, and a history of coronary artery bypass using both leg saphenous 12 years ago was admitted to the emergency service with chest pain and increasing fatigue. Since the COVID-19 PCR result was positive, he was hospitalized for further examination and treatment. On the 14th day of hospitalization, the patient complained about pain around both big toes that started suddenly at night and worsened in the morning. In the patient's history, he stated that he had completely similar complaints several times with an interval of one year in the last 3 years and he recovered spontaneously in 10-15 days. There was limited redness, swelling, and tenderness in the bilateral foot metatarsophalangeal joints on physical examination. It was evaluated as bilateral gouty arthritis according to the 2015 gout classification criteria, and the patient was treated with colchicine 3x0.5 mg and methylprednisolone 8 mg/day. His complaints regressed after treatment. At the end of 6 days, the physical examination findings improved, and the complaint decreased. It was completely healed after 14 days.

**Conclusions** Although developing gouty arthritis etiology is not clear for our patient in this case, it is thought to be a secondary condition due to the development of the disease after COVID-19 infection. It was considered that our patient has bilateral gouty arthritis triggered primarily by COVID-19. Due to the limited number of studies, more case reports should be added to the literature on this subject.

PP010

### Cetuximab-Induced Acneiform Eruption: A Case Report

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**Background** Colorectal cancer is the third most common cancer globally. About a quarter of them are metastatic at diagnosis, and metastasis develops in 40-50% of early-stage cancers. Cetuximab is an epidermal growth factor receptor (EGFR) inhibitor drug used to treat metastatic colorectal cancer and head and neck cancer. Since EGFR inhibitors target specific molecular pathways, systemic severe side effects seen in cytotoxic chemotherapy are not observed. Cutaneous side effects have been reported frequently during cetuximab treatment. Acneiform eruptions, one of the severe side effects of cetuximab treatment, are usually reversible but rarely lead to dose reduction or discontinuation. We presented a case with cetuximab-induced acneiform eruption.

**Case Report** A 54-year-old male patient with no known comorbid disease was taken to emergency operation due to colonic obstruction in March 2020 and was diagnosed with colon adenocarcinoma due to a left hemicolectomy operation. As a result of the systemic evaluation at the diagnosis, multiple liver metastases were seen. Since K-ras/nras/braf mutations were not detected, the patient was started on mFOLFOX (folinic acid + fluorouracil + oxaliplatin) + cetuximab in April 2020. The patient, who had no history of rash (acneiform) and had not used systemic steroids recently, developed pruritic papules and pustular lesions on the nose and sides of the nose and in the nasolabial grooves after the ninth cycle of chemotherapy. No pathology was detected in the evaluation of the skin and mucosa of the whole body, except for the lesions. Comedones did not accompany the lesions. Laboratory examinations were unremarkable. Based on the current clinical findings, the patient was diagnosed with cetuximab-induced acneiform eruption, and clindamycin + 10% sodium sulfacetamide cream treatment was started once a day, and protection from sunlight was recommended. In control on the seventh day of the treatment, it was observed that the skin lesions regressed almost wholly. The patient's treatment was continued at the current dose. In outpatient follow-ups, no recurrence was

observed.

**Conclusions** Cetuximab inhibits the EGFR pathway in the skin, causing various dermatological side effects by impairing keratinocyte proliferation, differentiation, and hair follicle development. Among these dermatological side effects associated with EGFR inhibitors, the acneiform eruption is the most common and the earliest. Papulopustular rash, nail and hair disorder, xerosis, telangiectasia, hyperpigmentation, seborrheic dermatitis are other cutaneous side effects. Acneiform lesions are usually seen on the face, scalp, trunk, and upper back. Topical metronidazole, clindamycin, and salicylic acid can be used in mild cases and systemic tetracyclines in moderate and severe cases. It is recommended that patients be protected from sunlight during and up to 2 months after cetuximab treatment, and sunscreen creams are recommended. As a result, cetuximab-related skin rashes may develop in patients, and the lesions must be recognized and treated to continue their treatment.

PP011

### A Rare Cause of Anemia Etiology: Gastrointestinal Stromal Tumours

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**Background** Gastrointestinal Stromal Tumours (GIST) are rare neoplasms originating from the interstitial cajal cell in the gastrointestinal tract. They constitute 1-2% of gastrointestinal system tumours. The predominant localization of GISTs seems to be the stomach and small intestine, but GISTs may develop any level of the gastrointestinal tract and sometimes in the omentum, mesentery, and peritoneum. 18% of cases are asymptomatic and diagnosed during CT scans, endoscopic procedures or surgical procedures. GISTs can be identified on ultrasound examination of the abdomen, computerized tomography (CT) scanning, magnetic resonance imaging (MRI), and positron emission tomography. The definitive diagnosis of GIST is made by histopathological examination and immunochemistry. We presented the case of GIST

which we investigated the etiology of iron deficiency anemia and found the tumour.

**Case Report** A 51-year-old male patient was evaluated by abdominal ultrasonography at an external center 8 months ago with the complaint of pain in the right upper abdomen. The patient with cholelithiasis had a laparoscopic cholecystectomy operation. The patient re-evaluated in an external center with complaints of weakness, fatigue, continued swelling in the right upper abdomen and weight loss 12 kg in the last 6 months. Iron deficiency anemia was observed in the examinations. Upper gastrointestinal system endoscopy and colonoscopy were performed. No abnormal observed in endoscopic procedures. Duodenal wall thickening was detected in non-contrast abdominal CT. After transfusion of 2 units erythrocyte suspension, iron treatment was given. In the physical examination of the patient whose complaints continued to increase, his vital signs were normal, his conjunctiva was pale and there was fullness in the epigastric region. The hemoglobin value; 7.5 mg/dL, which was consistent with iron deficiency anemia. MR enterography was planned to investigate small bowel diseases because the patient's endoscopic evaluations were normal. A mass lesion of approximately 13.5x15.5x16 cm in size at the level of the 3-4 th part of the duodenum was detected. The mass had a connection with the intestinal lumen and air and fluid levels were monitored in its central unit. Contrast-enhanced abdominal CT was performed. Diffuse wall thickening was observed in a 14 cm segment in the distal part of the duodenum. An exophytic mass, approximately 14x8 cm in size, with cavitation in the center was observed. Combined MRI and CT evaluations reported that the mass lesion describe was consistent with GIST a malignant mass. The patient was referred to the general surgery department. The patient was operated and biopsy was performed from the mass. Pathology examination results; high grade malignant mesenchymal tumour, morphological and immunohistochemical findings were interpreted as compatible with GIST. The patient was referred to oncology and imatinib was started as preoperative chemotherapy.

**Conclusions** The etiology of iron deficiency anemia is a finding must be found. Underlying gastrointestinal system losses should be investigated. Normal endoscopic procedures do not mean that there is no gastrointestinal disease. Other small bowel diseases such as GIST, which are rare, should also be investigated.



### Preventable, Mitigable, and Treatable: Oral Mucositis

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**Background** Mucositis is a common complication of radiotherapy (RT), chemotherapy (CT), combination of RT and CT, and hematopoietic stem cell transplantation (HSCT). It is characterized by erythema and ulceration. Oral mucositis (OM) may result in pain, dysphagia, need for enteral or parenteral nutrition, increased consumption of opioid drugs, and interruption of cancer treatment. In immunocompromised patients, OM may increase the cost of treatment by prolonging the length of hospital stay and increasing mortality in relation to bacteremia.

**Material and Methods** Evidence-based practice guidelines have been created by conducting many studies to prevent, alleviate and treat the symptoms of cancer-related mucositis. The Multinational Society for Supportive Care in Cancer and the International Society of Oral Oncology (MASSC/ISOO) published its first guideline in 2004, then updated it in 2009 and 2013. Finally, it collected and updated the collected evidence in one article, 1,197 published in 2020.

**Results** According to this;

- Basic oral care; It is recommended in all cancer treatment Material and Methods. Basic oral care includes teeth cleaning, mouthwash, rinsing and moisturizing. Dental evaluation and treatment is recommended before cancer treatment to reduce the risk of local and systemic infections. It is recommended to give basic oral hygiene education to ensure oral hygiene. Expert opinion assumes that there are gentle rinses for both saline and sodium bicarbonate that increase oral hygiene and can help to maintain oral hygiene and improve patient comfort. Data on this subject are limited and there is insufficient evidence (level of evidence 3).
- Cryotherapy; Oral ice use for 30 minutes is recommended for patients taking 5-FU and high-dose melphelan (level of evidence 2).
- Chlorhexidine; It is recommended not to use chlorhexidine for the prevention of OM in patients undergoing RT in head and neck cancers (level of evidence 3).
- Benzydamine hydrochloride; Use of benzydamine hydrochloride is recommended for the prevention of OM in patients with moderate RT (<50 GA) in

head and neck cancer (level of evidence 1). The use of benzydamine hydrochloride is recommended in combinations of RT and CT in head and neck cancer (level of evidence 2).

- Low level laser therapy; Low-level laser therapy is recommended for the prevention of OM in adult patients undergoing HSCT. Low-level laser therapy is recommended in patients with head and neck cancer who receive RT and CT together (level of evidence 1). Low-level laser therapy is recommended for patients with head and neck cancer who only receive RT (level of evidence 2).

- Recombinant human keratinocyte growth factor-1 (KGF-1); Intravenous use of KGF-1 is recommended for the prevention of OM in hematological cancers undergoing autologous HSCT (level of evidence 1).

- Granulocyte-macrophage colony stimulating factor (GM-CSF); It is recommended not to use topical GM-CSF for the prevention of OM in patients undergoing HSCT (level of evidence 2).

- Analgesic drugs; Topical morphine 0.2% mouthwash is recommended for the treatment of OM-related pain in patients with head and neck cancer receiving RT-CT (level of evidence 3). Sucralfate (combined topical and systemic) is not recommended for the prevention and treatment of OM-related pain in solid cancer patients receiving CT and head and neck cancer patients receiving RT (level of evidence 2).

- Natural products; Parenteral glutamine: Careful use is recommended because parenteral glutamine administration for OM in patients undergoing HSCT shows higher mortality (level of evidence 1). Oral glutamine: Oral glutamine is recommended for the prevention of OM in patients with head and neck cancer receiving RT-CT (level of evidence 2). Honey: Honey is recommended for the prevention of OM in patients with head and neck cancer treated with RT or RT-CT (level of evidence 2).

Oncology nurses should evaluate their patients in terms of mucositis using the Oral Evaluation Guide and determine the frequency of oral care and the oral care protocol to be used in accordance with the clinical evidence according to the score they get.

**Conclusions** The main purpose in the fight against mucositis; identifying risk factors, taking protective measures and preventing disruptions that may occur in the treatment process. For this purpose, oral mucositis will become a preventable, mitigable and treatable problem with the use of evidence-based practices and guidelines by oncology nurses, who are responsible for oral care and education of patients.

## PP013

**A Finding That Is Not Clear What Will Emerge When You See It: Hypoalbuminemia**

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**Background** Hypoalbuminemia can occur for many different reasons such as chronic kidney damage, nephrotic syndrome, chronic liver diseases, malnutrition. We presented a case of protein-losing enteropathy due to gastrointestinal malignancy presenting with symptoms such as hypoalbuminemia and edema in the hands and legs.

**Case Report** A 67-year-old male patient with no known history of chronic disease had come to the emergency department with an increase in swelling in both legs that had increased, soft, pitting edema for the last week. His albumin level is 19.7 g/L, total protein value was 4.25 g/L. The patient was admitted to our internal medicine clinic for hypoalbuminemia examination. The patient's echocardiography was normal. When the causes of hypoalbuminemia were examined, abdominal ultrasound and abdominal tomography and liver function tests requested for a possible liver disease were normal. Albumin loss was thought to be due to renal causes, but urea and creatinine levels and 24 hour urine protein level were normal. In our research on malnutrition, which may be the cause of hypoalbuminemia, there were no malnutrition findings. In the gastrointestinal system screening, the patient underwent colonoscopy. Colonoscopy revealed an ulcerovegetant mass in the transverse colon that almost completely occluded the lumen.

**Conclusions** In this case, who underwent colonoscopy two months ago, systematically examining the causes of hypoalbuminemia and excluding other causes, and advocating the idea that the case was of gastrointestinal origin, led to the renewal of the colon screening of the patient and the early detection of malignancy and seconder protein losing enteropathy.

## PP014

**Combination with Azathioprine and Allopurinol Causes of Anemia in Kidney Transplant Patients**

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**Background** Patients with solid organ transplantation have an increased risk of developing hyperuricemia. When hyperuricemia develops after kidney transplantation, the combined use of these two drugs should be avoided because azathioprine and allopurinol interact and cause cytopenia. Here, we presented a case of cytopenia developing after starting allopurinol due to hyperuricemia in a kidney transplant patient using azathioprine.

**Case Report** A 57-year-old male patient underwent living donor kidney transplantation in 1997 due to the development of chronic renal failure secondary to Alport syndrome. While he was using cyclosporine 125 mg and azathioprine 100 mg, he applied to the rheumatology department due to the development of gout. When he applied to the hospital with the complaint of weakness 1 month after starting the use of allopurinol for gout prophylaxis, low hemoglobin was detected in the examinations. He was admitted to the nephrology-tx clinic for the etiology of anemia. Iron was 263 mcg/dL, iron binding capacity 285 mcg/dL, ferritin 519 mcg/L, vitamin B12 281 ng/L. Peripheral smear was evaluated; 50 cells were counted: 20 segments, 5 rods, 15 lymphocytes, 5 atypical lymphocytes, 3 monocytes, 2 eosinophils were seen. No blast was seen. The platelet count was consistent with the complete blood count. The erythroid series was normochromic normocytic. No schistocyte or fragmented erythrocytes were observed. B symptoms were not detected in the examination for the exclusion of malignancy. Neck and abdomen ultrasonography were taken and there was no malignancy findings. Anemia was thought to have developed primarily due to the combination of azathioprine and allopurinol. Azathioprine was discontinued and followed up. Hemogram was followed at one-week intervals. It was observed that the hemoglobin value increased to 13.3 g/dL.

**Conclusions** Gout has been reported in 28% of solid organ transplant recipients. Gout can become a challenging clinical problem in solid organ recipients due to

potential drug interactions. Nausea, vomiting, and reversible bone marrow suppression leading to anemia, leukopenia, and thrombocytopenia are the hallmarks of azathioprine toxicity. Concomitant use of the two drugs is not actually possible due to drug interactions, but it is recommended to reduce azathioprine doses by 66-75% when co-administered with allopurinol. Although reducing the dose of azathioprine when administered together with allopurinol leads to a relative decrease in the risk of myelosuppression, it does not completely eliminate the risk. After stopping azathioprine, his anemia improved. Therefore, these two drugs should preferably not be used together. However, if necessary, it should be followed up with frequent complete blood count.

PP015

### Proteinuria Secondary to Renal Vein Thrombosis associated with Oral Contraception

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**Background** The common symptoms of renal vein thrombosis are flank pain, hematuria, and acute kidney injury. Nephrotic syndrome, renal cell carcinoma, trauma, renal transplantation, hypovolemia, and hereditary procoagulant defects are reasons for RVT in the foreground, and it is a complication observed in the course of COVID-19 in recent times. Oral contraceptives can be accounted for rare causes. Commonly, RVT can occur due to hyper coagulants formed during nephrotic syndrome. It is mainly seen as bilateral RVT. In our case, we wanted to show that renal vein thrombosis secondary to oral contraceptives may cause subnephrotic proteinuria.

**Case Report** A 29-year-old female patient, who has followed up with trigeminal neuralgia, applied with complaints of left flank pain and nausea-vomiting for two days. The left costovertebral angle tenderness revealed positive, and pretibial edema revealed +/- during physical examination. It was learned that she used non-steroidal anti-inflammatory and oral contraceptives during the drug inquiry. In complete

urine analysis, protein 2+, erythrocyte 38/HPF, and leucocyte 15/HPF. In the results of biochemistry, creatinine was 0.92 mg/dL, urea 10 mg/dL, albumin 31 g/L, D-dimer 13 mg/L, LDH 351 U/L, triglyceride 334 mg/dL. A thrombus that induces total occlusion inside the left renal vein extends from the left renal vein to the inferior vena cava observed from the contrast-enhanced computerized tomography taken from the acute abdomen. The thrombolytic treatment, thrombectomy, and balloon angioplasty procedures were applied by interventional radiology by considering acute renal vein thrombosis. The flow was coded in both renal veins in control doppler ultrasonography. The ANA, ANA profile, anticardiolipin IgM, IgG, beta-2 glycoprotein IgM, IgG of the thrombosis were reported as negative. The Thrombophilia Panel results in PAI as 4g/5g, MTHFR as heterozygote, f13 as normal, prothrombin gene mutation as negative, factor V Leiden mutation as negative, and it was thought that thrombosis developed secondary to the oral contraceptive used in the foreground from these results. The patient whose proteinuria was 2,562 mg/day in urine before the procedure followed up with anticoagulant therapy after the procedure. The patient was not receiving any other treatment for nephrotic syndrome. Her albuminuria had decreased to 150 mg/day in urine. In her control 5 months after the discharge, her kidney functions were normal ranges.

**Conclusions** When patients using oral contraceptives apply with flank pain and hematuria, acute renal vein thrombosis should be considered among differential diagnoses. The treatment can change depending on the patient's prognosis and clinic. Patients who do not develop acute kidney injury should generally be followed up with anticoagulant therapy. Thrombolytic treatment and thrombectomy should be considered primarily in patients that are in acute kidney injury table, have transplanted kidneys, and with bilateral RVT or unilateral patients with a high thrombus load.

## PP016

**Thrombocytopenic Thrombotic Purpura Presenting with Neurological Symptoms: A Case Report**<sup>1</sup>Yagmur Çakır, <sup>2</sup>Bedrettin Orhan, <sup>2</sup>VildanÖzkocaman, <sup>2</sup>Fahir Özkalemkas<sup>1</sup>Bursa Uludag University Faculty of Medicine, Department of Internal Medicine Bursa, Turkey<sup>2</sup>Bursa Uludag University Faculty of Medicine, Department of Internal Medicine, Division of Hematology, Bursa, Turkey

**Background** Thrombotic thrombocytopenic purpura (TTP) is a thrombotic microangiopathy (TMA) caused by severely reduced activity of the von Willebrand factor-cleaving protease ADAMTS13. Complete pentad includes thrombocytopenia, microangiopathic hemolytic anemia (MAHA), fever, neurological findings and renal failure. However, the complete pentad may not be detected in most patients. In this article, we aimed to present a case of TTP presenting with neurological symptoms.

**Case Report** A 53-year-old male patient was admitted to the emergency service with the complaints of slurring of the tongue, headache and weakness. The patient's temperature was 36.2 °C at the time of admission. Cranial computed tomography (CT) or magnetic resonance imaging (MRI) was found to be normal in the patient whose neurological and systemic examination did not reveal any obvious pathology. Complete blood count (CBC) revealed anemia and thrombocytopenia (leukocyte 6,070/mm<sup>3</sup>, neutrophil 4,220/mm<sup>3</sup>, hemoglobin 8.9 mg/dL, platelet 20,300/mm<sup>3</sup>) and features of hemolysis (lactate dehydrogenase [LDH] 821U/1, total bilirubin 2.9 mg/dL) was detected. In biochemical parameters, creatinine 1.17 mg/dL, urea 35 mg/dL were found to be normal. In the peripheral blood smear; schistocytes were seen in 3-4 high power field and 1 orthochromatophilic cell was seen also. The platelet count and frequency were consistent with the hemogram. Evaluated with these findings, the patient was admitted to the hematology clinic with a preliminary diagnosis of TTP. The blood sample was stored at -80 °C for the ADAMTS13 test at the patient's admission. Therapeutic plasma exchange (TPE) and 1mg/kg methylprednisolone were initiated. With 15 sessions of TPE, the platelet count increased to 154,400/mm<sup>3</sup>, and LDH levels decreased to 207 U/L. The complaints of slurring of the tongue and headache disappeared. After the patient received 19 sessions of TPE, the platelet count were 183,500/mm<sup>3</sup>

and the LDH levels were within the normal range, so it was decided to open the intervals between the TPE sessions. The diagnosis of TTP was confirmed after ADAMTS13 activity was reported as 6.84% (low), ADAMTS13 antigen 0.096 (low), and ADAMTS13 inhibitor 16.07 (high). TPE was performed two days a week for three weeks. Afterwards, he was discharged with stable vitals and hemodynamics. After discharge, TPE was performed once a week for a total of five weeks. Methylprednisolone treatment was tapered and discontinued. The patient is being followed up.

**Conclusions** Deficiency of the ADAMTS13 is seen in 90-95% of TTP cases. Microangiopathic hemolytic anemia (MAHA) and thrombocytopenia are hallmarks of TTP. Neurological symptoms are seen in 39-80% of cases, fever in 27-42%, renal failure in 10-75% of cases, while the complete pentad is seen in only 7%. According to A review of 78 patients with acquired TTP from the Oklahoma, published by Evaren E. Page et al. in 2017, 41 (53%) had neurological symptoms, 8 (10%) had fever, 11 (14%) creatinine level  $\geq$ 2.5 mg. /dL, 4 (5%) had acute kidney injury. In the first presentation of our patient, neurological findings, microangiopathy and thrombocytopenia were present, but there was no fever and elevated creatinine. In conclusion considering that complete pentad is seen in only 7% of patients, possibility of TTP should be suspected in any patient presenting with MAHA findings and thrombocytopenia with or without symptoms of organ involvement and without an alternative explanation.

## PP017

**Juvenile Idiopathic Arthritis Complicated with Atlantoaxial Subluxation: A Case Report**<sup>1</sup>Yagmur Çakır, <sup>2</sup>Belkıs Nihan Coskun, <sup>2</sup>Nihal Lermi, <sup>2</sup>Zeynep Yılmaz Bozkurt, <sup>2</sup>Ali Ekin, <sup>2</sup>Ediz Dalkılıç, <sup>2</sup>Yavuz Pehlivan<sup>1</sup>Bursa Uludag University Faculty of Medicine, Department of Internal Medicine, Bursa, Turkey<sup>2</sup>Bursa Bursa Uludag University Faculty of Medicine, Department of Internal Medicine, Division of Rheumatology, Bursa, Turkey

**Background** Juvenile idiopathic arthritis (JIA) is a disease that onsets before the age of 16, manifestations persist for at least six weeks, cannot be explained by any other reason, and can progress with uveitis as well as arthritis involving one or more joints. Bone erosions and joint destruction, osteopenia and osteoporosis, temporomandibular joint anomalies, mobility problems

due to contractures, and ocular complications such as anterior uveitis can be seen in the course of JIA. We aimed to present our case who was diagnosed in pediatric rheumatology and followed up in adult rheumatology, which was complicated by atlantoaxial subluxation.

**Case Report** A 25-year-old male patient, who had been followed up with the diagnosis of JIA for 14 years, described a complaint of dizziness during the control of the adult rheumatology outpatient clinic. The foreign national patient, who was diagnosed with JIA and given steroid, methotrexate and nonsteroidal anti-inflammatory drug treatment after being examined in his home country with a complaint of swelling in the knee and foot joints when he was 11 years old, was transferred to us by pediatric rheumatology at the age of 19. In the examinations performed in pediatric rheumatology, HLA B27 (+) and FMF gene test M694V and E148Q were found as (+). The patient, whose treatment was planned as an anti-TNF agent, had a history of irregular drug use due to social reasons. The patient had significant mobility restriction. Findings of arthrosis were observed in both knees and hip joints. The patient, who was evaluated in the rheumatology council after the transfer to us, was referred to orthopedics because of arthrosis in both hip joints. Anti-TNF was planned to be started and he was followed up. In the systemic and neurological examination of the patient who had been using etanercept for 5 years, no features were found except that he had 2/5 paraparesis (joint movements were completely limited due to bilateral frozen hip). Cranial MRI was performed on the patient and the MRI shows a "4.9 mm displacement of C2 vertebra odontoid process towards the cranial, in sections passing through the level of the skull base (basilar invagination). Both cavernous segments are mildly dolichoectatic." The patient was consulted to the neurosurgery department with the preliminary diagnosis of atlantoaxial subluxation. Surgical intervention was not considered for the patient who had no neurological symptoms, and control was recommended 6 months later. The patient is being followed up in our outpatient clinic with anti-TNF therapy, and periodic neurosurgery control was recommended for atlantoaxial subluxation.

**Conclusions** Cervical joint destruction in patients with rheumatoid arthritis and JIA may lead to vertebral malalignment (e.g., subluxation), causing pain, neurologic deficit, and deformity. It should not be forgotten that atlantoaxial subluxation findings can be detected by imaging patients without symptoms. The young age of the patients is essential in terms of being careful before the surgical procedures that may take place. Although routine imaging is not required in asymptomatic patients, cervical spine imaging is recommended before elective surgery that will require neck manipulation.

## A Case Report of Subacute Thyroiditis After mRNA COVID-19 Vaccine

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**Background** COVID-19 causes a variety of clinical scenarios, from a flu-like syndrome to more serious conditions such as acute respiratory distress syndrome and death. As a result of recent research, it is known that many complications related to the endocrine system develop in patients with COVID-19. COVID-19 infection causes thyroid dysfunction through destruction of the thyroid gland and immune-mediated mechanisms. Discovery of an effective vaccine against COVID-19 is an important step in the fight against the epidemic. Although the relationship between upper respiratory tract viruses and subacute thyroiditis is well known, rare cases have been reported with inactivated vaccines or live attenuated vaccines such as influenza. There are very limited data on subacute thyroiditis following COVID-19 vaccine. To date, only a few cases of subacute thyroiditis have been reported in the literature after mRNA COVID-19 vaccination. Here, we present a case diagnosed with subacute thyroiditis following COVID-19 mRNA vaccine (Pfizer/BioNTech®) administration.

**Case Report** A 44-year-old Caucasian female patient was admitted to our Endocrinology Clinic with complaints of anterior neck pain, headache, palpitation, sweating and tremor for about 2 months. She did not use any medication regularly, but her pain was relieved when she used non-steroidal anti-inflammatory drugs during periods of increased pain. She had received two doses of COVID-19 mRNA vaccine (Pfizer/BioNTech®) on July 22, 2021 and August 20, 2021. She stated that her symptoms started after the first dose of vaccine and gradually increased after the second dose of vaccine. She did not have a recent upper respiratory infection or COVID-19 infection. On her physical examination, her heart rate was 88/min; body temperature was 38.5°C; blood pressure was 110/70 mmHg; respiratory rate was 14/min. Thyroid gland was sensitive, painful, and enlarged. Laboratory examination revealed elevated fT4 and fT3 levels, as well as suppressed TSH. Anti-TPO: 362 IU/mL (Reference range: 0-75 IU/mL) was detected. Erythrocyte sedimentation rate (ESR), elevated C-reactive protein (CRP) levels were high. Diffuse heterogeneity and hypoechoic

areas were observed in thyroid USG. Thyroid blood flow was decreased in doppler ultrasonography. The Tc99 pertechnetate radionuclide thyroid scan showed poor thyroid uptake. The patient was considered for subacute thyroiditis associated with the COVID-19 mRNA vaccine (Pfizer/BioNTech®). Ibuprofen 600 mg/8 h treatment was started. Within the next weeks, the symptoms resolved completely. At the first month control, TSH, fT3 and fT4 were in the normal range and acute-phase reactants were normal. Thus, ibuprofen treatment was terminated. The patient was called for outpatient follow-up 1 month later in terms of the risk of developing hypothyroidism after subacute thyroiditis.

**Conclusions** Vaccination rates against COVID-19 infection are increasing rapidly all over the world. Considering the vaccine recommendations against COVID-19 infection, we think that we will see more cases as a result of increased immunological reactions. Therefore, clinicians should be aware of the possible side effects of the vaccine.

PP019

### Development of AA Amyloidosis in a Patient with Psoriasis: A Case Report

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**Background** Psoriasis is a chronic, recurrent, inflammatory and common skin disease of unknown etiology. Amyloidosis is defined as a heterogeneous group of diseases in which normally soluble plasma proteins accumulate in the extracellular space in an insoluble abnormal fibrillar form. Diagnosis is made by demonstrating the accumulation of these proteins in the tissue sample. AA type amyloidosis is a late and serious complication of chronic inflammatory diseases and some chronic infections. Although psoriasis is a common inflammatory skin disease, the development of amyloidosis is rare. Here, we presented a case of AA type amyloidosis accompanying the diagnosis of psoriasis.

**Case Report** A 64-year-old female patient has been

diagnosed with plaque psoriasis on the scalp and joint extensor surfaces for two years. She applied to an external center with complaints of weakness and dry mouth. She was referred to our emergency service because of high creatinine in laboratory tests. In the laboratory tests of the patient evaluated in the emergency department hemoglobin 8.9 g/dL, creatinine 6.4 mg/dL, urea 195 mg/dL, potassium 7.2 mmol/L and metabolic acidosis was detected, the patient was taken to hemodialysis (HD) for 2 hours. Afterwards, she was admitted to the nephrology clinic for further examination and research with the diagnosis of acute renal failure. Complete urinalysis revealed protein (+) and hematuria. When serum albumin was 2.6 g/L and proteinuria was found 3,300 mg in 24-hour urine analysis, renal biopsy was performed for etiology: the pathology result was compatible with AA type amyloidosis. Our patient was born in Azerbaijan and it was learned from her history that she did not have abdominal pain and fever attacks in her childhood, and there was no family history of FMF. Therefore, FMF was not considered. Antinuclear antibody (ANA), anti-dsDNA, anti-Sm, anti-Ro, anti-La, rheumatoid factor (RF), anti-CCP, and HLA B27 were requested for the aetiology of AA amyloidosis and the results were negative and serum immunoglobulin levels, serum complement levels were within the normal range. Both sacroiliac joints were found to be of normal width in the sacroiliac joint radiography. Eye examination was performed and uveitis was not detected. The patient received 4 sessions of HD in total, and then she did not need HD anymore. Colchicine 0.5 mg 2x1 was started and she was discharged.

**Conclusions** A case of psoriasis-associated amyloidosis was first reported in 1965. Few cases with coexistence of psoriasis and amyloidosis have been reported to date. Therefore, we tried to exclude other diagnoses accompanying amyloidosis in our patient, who did not have any other known comorbidities apart from the diagnosis of psoriasis. Amyloid deposition accompanying psoriasis is a rare complication and is detected later than other diseases accompanied by amyloidosis. However, in our case, it was observed that this situation was not always late, and amyloid deposition could be observed earlier.

## PP020

**Post-COVID ANCA-Associated Vasculitis: A Case Report**

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**Background** COVID-19 is an infectious disease caused by severe acute respiratory syndrome coronavirus-2 (SARS-coV-2). Anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis (AAV) are life-threatening autoimmune diseases frequently accompanied by necrotizing rapidly progressive crescentic glomerulonephritis, which include findings of glomerulonephritis in mononuclear cell infiltration of small and medium-sized vessels and kidney biopsy. In cases with a history of COVID-19 disease, various complications and symptoms spread over a long period have been identified. We presented a case of ANCA-associated vasculitis after COVID-19.

**Case Report** A 51-year-old male patient has a diagnosis of chronic obstructive pulmonary disease and diabetes mellitus, and is being followed up in the chest diseases clinic with the diagnosis of post-COVID-19 pneumonia with the complaint of shortness of breath about one month after the COVID-19 treatment is completed. In the physical examination of the patient, there was rale in the bilateral bases upon listening to the lung, there was no feature in the cardiovascular system and abdominal examination, pretibial edema was negative. When he was consulted to the nephrology department due to high creatinine and urea levels during his hospitalization, he was taken to hemodialysis (HD) intermittently, considering acute kidney injury (AKI). In the follow-ups, hematuria was observed in the complete urinalysis and 2 g proteinuria was accompanied in the 24-hour urine analysis. PR3, ANA, ANA profile and anti-GBM were negative. C-ANCA, P-ANCA and MPO were positive at 1/10 E.P. C3 and C4 complements were normal, immunoglobulin G, A, and M were within normal ranges. The hepatitis markers were negative. Thoracic computed tomography (CT) taken after anti biotherapy was completed: Bilateral pulmonary infiltration and nodular cavitory lesions were evaluated as ANCA-associated vasculitis and 500 mg cyclophosphamide treatment was given and methylprednisolone was continued as a sustained dose

of 0.5 mg/kg. The patient was taken into the 2 HD program per week and discharged.

**Conclusions** The relationship between COVID-19 disease and acute kidney injury is well known, but the number of cases in which COVID-19 and ANCA-associated vasculitis coexistence are rare in the literature. It is possible to make a differential diagnosis with detailed anamnesis, physical examination, imaging findings, laboratory parameters, and especially in selected cases, kidney biopsy. In this case, we wanted to emphasize that AAV should be kept in mind in the etiology of AKI developed after COVID-19 and appropriate treatment should be started without wasting time.

## PP021

**Drug Eruptions with Cases: Fixed Drug Eruption and DRESS Syndrome**

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**Background** Adverse drug reactions are undesirable side effects of routinely used or newly started drugs, and the skin is the organ where these side effects are most commonly seen. Cutaneous drug reactions (CDR) are common and usually occur with mild and self-limiting lesions, and some of its severe forms can be life-threatening. The drug groups to often cause drug reaction for the skin are non-steroidal anti inflammatory drugs (NSAIDs), antibiotics and anticonvulsants. In our study two immunological drug reaction cases are presented. One with a mild and localized fixed drug eruption, and the other one with a more severe and generalized DRESS syndrome.

**Case Report** The first case was a 56-year-old female patient with a diagnosis of ankylosing spondylitis. She stated that she was using diclofenac sodium. The patient applied to the dermatology outpatient clinic with a sharply defined, hyperpigmented macular-looking lesion on the dorsal aspect of the left hand. She stated that for the last year, similar lesions appeared in the same area from time to time, and it was a more vivid purple color when it first appeared and the color became brownish over time, also it was accompanied by complaints such as itching and burning. For the patient, fixed drug eruption was considered due to diclofenac sodium drug use history and lesion characteristics. The second case, a 35-year-old female

patient, started treatment of carbamazepine 400 mg/day with the diagnosis of epilepsy 1 month ago. The patient applied to the hospital with the complaint of widespread erythematous maculopapular rash on the body and itching, which started 3 days ago and is becoming increasingly severe. Bilateral cervical lymphadenopathy was detected in lymph node examination. According to the laboratory evaluation; in liver function tests more than 10 times increase was observed. The patient was evaluated as DRESS syndrome with clinical and laboratory findings.

**Conclusions** As a result, physicians of all branches should be familiar with cutaneous drug reactions that they may encounter frequently in their daily practice for early diagnosis and treatment. When cutaneous drug reactions are suspected, it is necessary to approach the patient holistically and systematically.

PP022

### Methotrexate Toxicity in a Hemodialysis Patient: A Case Report

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**Background** Methotrexate (MTX) is widely used in the treatment of various malignancies and chronic inflammatory diseases. It is an antimetabolite agent that impairs DNA synthesis by competitively inhibiting the dihydrofolate reductase enzyme. Side effects such as nausea, stomatitis, myelosuppression, hepatic, renal and pulmonary toxicity may occur due to high doses of MTX, decreased elimination and polypharmacy. Since the primary excretion site (90%) is the kidneys, toxicity may develop by accumulation in cases with impaired renal function. Here, we presented a case who is in the hemodialysis (HD) program and developed pancytopenia and mucositis as a result of using low-dose MTX for the treatment of psoriasis.

**Case Report** A 30-year-old female patient presented to the emergency department with complaints of abdominal pain and bloody diarrhea. She has chronic renal failure, psoriasis and hypertension diagnoses secondary to membranoproliferative glomerulonephritis, and she is

also included in routine HD. The drugs she was using were ramipril, amlodipine, carvedilol, doxazosin and moxonidine. In the patient who was started MTX 7.5 mg/week subcutaneously by dermatology for the treatment of psoriasis two weeks ago, diarrhea started four days after the first dose. After the second MTX administration, diarrhea increased and severe diffuse abdominal pain developed two days later. On physical examination: Plaques in the oral mucosa, there were crusty ulcerations on the lips, widespread erythematous plaques in the body, widespread tenderness in the abdomen, voluntary defense and rebound, other system examinations were normal. Abdominal CT Angiography performed to exclude surgical emergencies showed diffuse edematous wall thickening, increased mucosal staining, and prominent valvulae in colonic loops, ascending colon, and cecum. In the laboratory examination, leukocyte was 1,910/mm<sup>3</sup>, neutrophil 1,360/mm<sup>3</sup>, hemoglobin 8.7 g/dL, platelet 76,000/mm<sup>3</sup>, CRP 207 mg/L, vitamin B12 level 125 ng/L. Blood MTX level was 0.03 mcmmol/L. Blood CMV-DNA PCR was negative. No parasite was detected in the stool. Bone marrow biopsy was performed when one atypical cell was seen in the peripheral smear. In the bone marrow imprint material, an increase and pause in early myeloid elements were observed. Although the serum MTX level was low due to the serum half-life of MTX of 6-8 hours, MTX toxicity was considered due to the recent MTX treatment, pancytopenia and mucositis, and hospitalization was made. Total parenteral nutrition was started due to folic acid 3x50 mg, granulocyte colony stimulating factor 5 mcg/kg/day, vitamin B12 replacement and oral inability due to mucositis. Upon the deepening of pancytopenia, erythrocyte and thrombocyte suspensions were replaced. He recovered from neutropenia on the 8th day of his hospitalization. The patient's routine HD program was continued. Ciprofloxacin and metronidazole treatment was completed in 10 days. After 15 days of hospitalization, the patient's clinical improvement was discharged.

**Conclusions** Tight binding to plasma proteins and accumulation of metabolites in the cell is one of the reasons why MTX is not sufficiently removed by dialysis. While MTX treatment is not recommended in HD patients under normal conditions, it can be applied by reducing the dose, especially in malignant diseases that do not have an alternative treatment. In this case, MTX was started for the treatment of psoriasis because there was no response to secukinumab; It has been emphasized that toxicity may develop even with the use of low-dose MTX in HD patients.



## PP023

**Primary Mediastinal Large B-Cell Lymphoma: A Case Report**<sup>1</sup>Ömer Candar, <sup>1</sup>Fahir Özkalemkas, <sup>1</sup>VildanÖzkocaman, <sup>1</sup>Sinem Çubukçu, <sup>1</sup>Tuba Ersal<sup>1</sup>Bursa Uludag University, Department of Internal Medicine, Division of Hematology, Bursa, Turkey

**Background** Primary mediastinal large B-cell lymphoma (PMLBCL) is a rare tumour in the world. Non-Hodgkin lymphomas (NHL) 2%-3% diffuse large B-cell lymphomas (DLBCL) 6%-10% constitutes. We reported a 19-year-old male patient diagnosed with primary mediastinal large B-cell lymphoma.

**Case Report** 19-year-old male patient with no known disease, night sweats that started for about 1 month, weight loss (25 kilograms in 1 month), cough, and a palpable mass in the neck on thorax tomography performed with packed lymph filling the anterior mediastinum and reaching both cervical subzones. When nodules (bulky mass) were detected, a tru-cut biopsy was performed by the thoracic surgeon, and the patient was referred to us when PMLBCL was received as a result of the material sent to pathology. PET-CT was taken for staging and bone marrow biopsy was performed on the patient. The patient, who was accepted as stage 2B, was started on rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP) treatment. Inadequate response after four cycles of R-CHOP was considered as refractory disease and the patient was given 2 cycles of R-DHAP (rituximab, dexamethasone, cytarabine, cisplatin) as salvage therapy. During these treatments, a tracheal stent was inserted by the thoracic surgeon due to tracheal compression. When the cervical lymph nodes progressed 72 hours after the end of the treatment, the patient was consulted to the radiation oncology department and four sessions of radiotherapy were given. The patient was started on a targeted PD-1 blocker, nivolumab, together with brentuximab, an anti-CD30 monoclonal antibody, for at least four cycles, once every three weeks. Three courses of treatment were given. It was learned that the patient died due to sudden respiratory arrest while he was at home in the seventh month of his illness.

**Conclusions** The disease is a rare, aggressive lymphoma with good prognostic features, which is usually seen at a young age and present with the presence of mass disease. R-CHOP treatment is the most commonly

used chemotherapy protocol and it has been reported that radiotherapy has a positive effect on the prognosis in selected cases. In resistant patients, autologous stem cell transplantation can be progressed after the chemotherapy.

## PP024

**Pityriasis Rosea After Pfizer-BioNTech Covid-19 Vaccine: A Case Report**<sup>1</sup>Seyma Handan Akyön, <sup>2</sup>Yeser Genç<sup>1</sup>Health Sciences University, Ankara City Hospital, Clinic of Family Medicine, Ankara, Turkey<sup>2</sup>Ankara City Hospital, Clinic of Dermatology, Ankara, Turkey

**Background** Vaccines against SARS-CoV-2 are being developed and implemented at a rapid pace. With COVID-19 vaccine applications; some skin side effects can be seen. Examples of these are local skin reactions at the injection site, urticaria, maculopapular rash, and pityriasis rosea-like reactions. Pityriasis rosea-like eruptions (PR-LE) may be seen after vaccination or as a drug reaction. Although pityriasis rosea can rarely be seen due to chickenpox, tuberculosis, influenza, HPV, poliomyelitis, diphtheria, pneumococcus, tetanus, hepatitis B vaccines, there are also cases of pityriasis rosea after COVID-19 vaccine. In this study, a case of pityriasis rosea developing after Pfizer-BioNTech COVID-19 vaccine was presented.

**Case Report** The case was a 31-year-old woman with no known comorbidity and regular medications. The patient, 5 days after the administration of the 3rd dose of Pfizer-BioNTech mRNA COVID-19 vaccine, described the lesions on her back as 2x3 cm in diameter, oval, sharply limited, pale erythematous, in the form of a herald patch with pitriatic scales observed in the periphery. The patient was evaluated to have pityriasis rosea due to the medallion plaque presence, rash and the distribution character of the rash, and the absence of symptoms other than itching, therefore the patient was given topical steroid therapy.

**Conclusions** Today, like with many vaccines, there are also cases of pityriasis rosea developing after COVID-19 vaccines. Further studies on tissue and serological examination are needed to establish a causal link between PR/PR-LE and COVID-19 vaccines.



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