A Case of Subacute Thyroiditis Presented as the Cause of Fever of Unknown Origin

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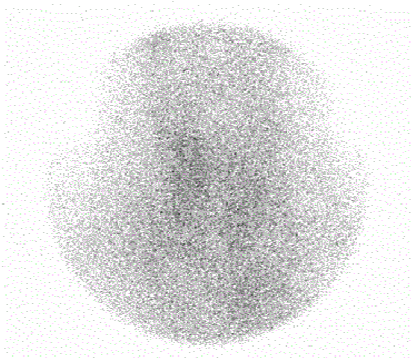
Abstract Fever of unknown origin (FUO) is not infrequently a diagnostic dilemma for clinicians. Common infectious causes include endocarditis and abscesses in adults, and noninfectious causes include neoplasm and certain collagen vascular disease. Endocrine causes of FUO are rare. The only endocrine disorder likely to present as an FUO is subacute thyroiditis. Subacute thyroiditis usually occurs in women in middle age with a viral prodrome, neck tenderness, classic symptoms of thyrotoxicosis, and elevated erythrocyte sedimentation rate. The patient may have abrupt onset of fevers and chills with complaints of thyroid pain or only low-grade fevers with poorly characterized anterior neck pain. We present a case of FUO in a 48 year old female who had one month of fever and neck pain. Despite an extensive evaluation, the patient had persistent fever and no source was found with the exception of subacute thyroiditis. The fever resolved from the second day of low dose steroid (10 mg of prednisolone per day) administration. This case illustrates when fever is of unknown origin, subacute thyroiditis should be considered.

Key Words: Fever of unknown origin, Subacute thyroiditis



A Case of ACTH-independent Cushing's Syndrome with Bilateral Cortisol-Secreting Adenomas

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A 48-year-old woman was incidentally found to have bilateral adrenal masses, 2.8 cm in right, 2.3 cm and 1.7cm in left, on abdominal computed tomography (CT). Her medical history was notable for hypertension that had not been controlled recently with carvediol, at a dose of 25 mg daily. She presented with signs and symptoms of suspected Cushing's syndrome. The diagnosis of ACTH-independent Cushing's syndrome was given through basal and dynamic hormone tests. Adrenal vein sampling (AVS) was performed to localize a functioning adrenal cortical mass. AVS results were consistent with hypersecretion of cortisol from both adrenal glands, with a cortisol lateralization ratio of 1.1. At bilateral laparoscopic adrenalectomy, bilateral ACTH-independent adrenal adenomas were found. Her signs and symptoms of Cushing's syndrome were improved after surgery just as the blood pressure was normalized. She was started on replacement therapy with glucocorticoids and mineralocorticoids. This case suggests the useful role of adrenal vein sampling for appropriate diagnosis and treatment in the patient with ACTH independent Cushing's syndrome with bilateral adrenal masses.