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## Adrenal (Excluding Mineralocorticoids)

***7648***

### *Bilateral Adrenal Hemorrhage After Laminectomy: A Rare Complication*

*Michelle-Ashley Rizk, MD, Sapna Sharma, MD, Hafiza Qadeer, MD, Rubina Paudel, MD, and Chheki Sherpa, MD*
Tower Health/Reading Hospital, Reading, PA, USA

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**Introduction:** Bilateral Adrenal Hemorrhage (BAH) is an exceedingly uncommon complication of laminectomy, with few cases reported in the literature. In patients with history of any surgical procedure who present with unexplained symptoms of abdominal pain, back pain, hypotension, fever, confusion, or electrolyte abnormalities especially hyponatremia, acute adrenal insufficiency (AI) should be highly suspected. We herein describe a case of BAH following laminectomy. Clinical Case: 63-year-old male with past medical history of hypertriglyceridemia was admitted for post traumatic L1 burst fracture and was treated with T11-L3 fusion and T12-L3 laminectomy. The patient had normal bilateral adrenal glands after the fall on CT thoracic/lumbar spine imaging. The course was complicated by thrombocytopenia initially thought to be induced by therapeutic heparin since heparin antibody was positive. Serotonin-release assay returned negative weeks later ruling out heparin induced thrombocytopenia. Two weeks later, he developed unexplained tachycardia and CT angiogram was done which showed segmental pulmonary embolism and bilateral adrenal nodules measuring at least 3.9 cm on right side and 3.3 cm on left side. He was treated with Eliquis and was discharged home. Two weeks later, he was readmitted with weight loss of 30 lbs, weakness and altered mental status. His vital signs were significant for hypotension and tachycardia. Initial work up showed profound hyponatremia (sodium 121 mEq/L), hyperkalemia (potassium 6.1 mEq/L), hypoglycemia (Glucose 58 mg/dL), hypercalcemia (calcium 11.7 mg/dL) and acute kidney injury (creatinine 2.58 mg/dL). Repeat CT scan of chest/abdomen/pelvis without contrast showed bilateral hyperdense 4 cm adrenal mass/hematoma. Since initial CT of thorax/spine done after the fall showed normal adrenal glands, the new bilateral hyperdense adrenal masses noted post procedure is suggestive of adrenal hemorrhage/hematoma. Undetectable cortisol and high ACTH confirmed AI. Patient was treated with stress dose hydrocortisone followed by slow taper. MRI of pituitary gland showed partial empty Sella however since ACTH was high, empty sella was only an incidental finding and not the cause of AI. He is maintained on hydrocortisone 15 mg in the morning and 5 mg in the evening plus fludrocortisone 0.1 mg daily. His fatigue has improved, he is gaining weight and electrolytes are normal. Conclusions: This case report emphasizes the significance of timely diagnosis and management of BAH, which leads to primary AI. BAH is a rare complication following laminectomy. Clinicians should be aware of this possibility and consider it in the differential diagnosis of postoperative abdominal pain and electrolyte abnormalities, especially hyponatremia. Timely recognition and high index of suspicion should prompt empiric glucocorticoid replacement to decrease mortality.

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