another episode of massive PR bleeding 2 days later, patient underwent under-running of bleeding rectal tumor with 2 haemostatic suture applied. For rectal adenocarcinoma treatment, in view of high risk massive bleeding and local disease, patient underwent 25 radiotherapy and chemotherapy. *Discussion*: Treatment of the underlying malignancy is advocated as a possible curative measure. However, immunosuppressive therapy is recommended for those patients who fail treatment of the primary tumour, or for those who present acutely with bleeding or are unable to receive chemotherapy.

HT073 Vaccine-induce thrombotic thrombocytopenia (VITT) manifested as massive and complete portal venous thrombosis & splenic hypoperfusion: First Malaysian case

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Introduction: VITT is a rare complication of adenoviral vaccine administration. It presents with thrombocytopenia & thrombosis in varies site, especially in cerebral veins and pulmonary embolism. Complete Portal venous thrombosis have been reported rarely. *Case report*: This is 34-year-old Indian man, presented with symptoms of abdominal discomfort on day 6 post 1st vaccine injection but was presented to emergency on day 15 with severe abdominal pain and haemodynamic compromise. The imaging showed complete portal venous thrombosis and obstruction with hypoperfusion of spleen and bowel ischaemia. Severe thrombocytopenia and segmental pulmonary emboli were detected. Anti-platelet factor 4 (aPF-4) was sent upon making clinical diagnosis of VITT. Without waiting for the report, prompt treatment initiated with Therapeutic Plasma Exchange, Fondaparinux, Immunoglobulin and Intravenous Steroid. Patient developed upper & lower gastrointestinal bleeding during the treatment. The treatments modalities persevered with help of intensive care service and necessary blood transfusion. Patient survived, and was on tapering dose of oral steroid for 10 weeks and completed 3 months of anticoagulation. Test aPF-4 antibody came back as positive. *Discussion*: This case illustrated the importance of history & clinical diagnosis to prompt the initiation of specific treatment in VITT i.e the plasma exchange which altered the course of event for unexpected side effects from necessary vaccine in this healthy & young patient.

HT074 Devastating complication of pregnancy: A case of recurrent post-partum thrombotic thrombocytopenic purpura

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Introduction: Thrombotic thrombocytopenic purpura (TTP) is a rare disorder which also uncommon in pregnancy. Absence of functional ADAMTS-13 leads to ultra large VWF multimers' formation hence bind spontaneously to platelets to form aggregates within the arterial and capillary microvessels (microthrombi) inducing tissue ischemia, platelet consumption, and microangiopathic haemolytic anaemia. Here, we report a case of recurrent TTP, which occurred in her 2 consecutives post-partum period. *Case report*: A 37-year-old lady, Para 2 with underlying chronic hypertension and history of gestational Diabetes Mellitus, presented with recurrent episodes of anaemic symptoms at postpartum period in 2020 (day 8) and 2021 (day 9). She had severe anaemia and thrombocytopenia with morphological finding of microangiopathic haemolytic anaemia. She was treated as thrombotic thrombocytopenic purpura (TTP) with commencement of plasma exchange and steroid in 2020 and Rituximab were added in 2021. ADAMTS 13 showed absence of activity with presence of inhibitor. She had been investigated for autoimmune disease but did not fulfil SLICC criteria for diagnosis of SLE. *Discussion*: This case illustrated recurrent acquired post-partum TTP. It is one of causes of thrombotic microangiopathic anaemia (TMA) in which the commonest causes are pre-eclampsia, eclampsia and HELLP syndrome. Pregnancy is a known risk factor for acquired TTP, in which auto-antibodies against ADAMTS 13 inactivate or bind ADAMTS13. Risk of recurrence TTP is about 45% in acquired pregnancy associated TTP. Specific proteins found in the placental circulation serve as antigens that trigger maternal antibody production against ADAMTS-13 is the proposed mechanism.

HT075 Pulmonary embolism as uncommon presentation for primary antiphospholipid syndrome in young male

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Introduction: Antiphospholipid syndrome (APS) is an autoimmune disease and it is uncommon in paediatric population with even gender distribution. Primary APS (PAPS) occurs in isolation with commonest presentation of arterial thrombosis, in contrast to venous thrombosis in secondary APS (SAPS). Systemic lupus erythematosus (SLE) is frequently associated with SAPS. Here is a case of 15-year-old boy, presented with pulmonary embolism which led to the diagnosis of primary APS. *Case report*: An active 15-year-old boy presented with acute exertional dyspnoea. He was hypoxic, requiring oxygenation support. Computed tomography (CT) thorax shows extensive bilateral pulmonary embolism. Coagulation profile revealed isolated prolong activated partial thrombin time (aPTT). Mixing study indicated presence of coagulation inhibitor. APS diagnosis made by presence of triple positivity of antiphospholipid antibodies. Autoimmune disease screenings were negative except for positive p-antineutrophilic cytoplasmic antibody (p-ANCA), without clinical evidence of vasculitis. His final diagnosis

is primary APS with pulmonary embolism and currently treated with warfarin. *Discussion*: Antiphospholipid syndrome is uncommon in paediatric population. In contrast to adult APS, gender distribution is even and for PAPS, common manifestation is arterial thrombosis compared to venous thrombosis in SAPS. Based on largest paediatric APS registry, commonest venous thromboembolism is deep vein thrombosis (DVT). Pulmonary embolism in context of PAPS is an unusual presentation. High index of suspicion is crucial in children presenting with thrombotic events with no risk factor. Follow-up care is important as few cases of PAPS diagnosis are revised to SAPS with subsequent diagnosis of SLE.

HT076 4-factor prothrombin complex concentrates (PCC): The preferred option in overwarfarinised patients with upper gastrointestinal haemorrhage

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Introduction: Octaplex® is a 4-factor prothrombin complex concentrate (PCC) containing vitamin K-dependent coagulation factors (Factor II, VII, IX, and X) and inhibitory proteins C and S. It is indicated for the management of life-threatening bleeding in patients with overwarfarinisation. Here we highlight the importance of the early provision of PCC in an overwarfarinised patient with a massive upper gastrointestinal haemorrhage. *Case Report*: A 71-year-old man with non-valvular atrial fibrillation on warfarin presented to the emergency department with per rectal bleeding for 2 days. He was hypotensive on arrival and clinical examination revealed fresh melaena and pallor. His blood investigation showed a haemoglobin of 7.5g/dL from a baseline of 13g/dL, platelet count of 140 x 10^9/L, and a deranged prothrombin time (PT) of 60.2 seconds with an international normalized ratio (INR) of 5.72. Two units of packed red blood cells and four units of fresh frozen plasma (FFP) failed to normalize the deranged coagulation profile and ongoing bleeding. A single dose of 2000 IU 4-factor PCC Octaplex® (30 IU/kg) was subsequently administered intravenously with vitamin K at 10mg resulting in an immediate correction of INR (1.15) and haemodynamic stability. An upper endoscopic examination demonstrated a Forrest IIA pre-pyloric gastric ulcer. A repeated endoscopy 2 weeks later revealed a healed gastric ulcer, and he was safely restarted on anticoagulation therapy. *Discussion*: Our case corroborated with evidence that early administration of 4-factor PCC is crucial in overwarfarinised patients with major bleeding to minimize transfusion requirements and allow lifesaving procedures to be carried out.

HT077 Case of acquired haemophilia following COVID-19 vaccine in the elderly: Lesson for prompt and accurate diagnosis

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Introduction: Acquired haemophilia A (AHA) occurs due to the development of autoantibodies directed against clotting factor VIII (FVIII). This disease is observed among the elderly. with a mortality rate approaching 20%. Accurate diagnosis and prompt treatment of AHA has been shown to reduce its bleeding mortality risk. *Case report*: An 80-year-old developed multiple bruises 2 weeks after his first dose of the COVID-19 vaccine. Diagnosis was delayed due to his cognitive impairment and low clinical suspicion. This led to a representation with worsening ecchymosis, a left thigh haematoma and symptomatic anaemia. Laboratory testing revealed an isolated prolongation of the activated partial thromboplastin time, which remained uncorrected in the mixing test. Further testing confirmed the presence of factor VIII inhibitors and low FVIII titres of 6.7%. He responded to treatment with intravenous methylprednisolone and recombinant activated FVII. *Discussion*: Interestingly, most cases of AHA following COVID-19 vaccination involved elderly patients with multiple comorbidities. All presented with bleeding within 1–3 weeks after receiving the mRNA vaccine. The pathophysiology remains to be elucidated but vaccines are known to stimulate autoantibody production via pre-existing B cells. Given the patient's cognitive impairment and frailty, a comprehensive geriatric assessment (CGA) from the outset might have facilitated an earlier diagnosis. In spite of guideline recommendation to initiate immunosuppressive therapy, clinicians should individualise the use of IST among frail patients as IST-related morbidity may outweighs the risk of fatal bleeding in AHA. Despite a temporal association between the COVID-19 vaccine and AHA, a cause-and-effect relationship has not been established and further study is warranted.

HT078 Two case reports of paediatric May-Thurner Syndrome with extensive lower extremity deep vein thrombosis requiring pharmaco-mechanical thrombectomy/thrombolysis

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Introduction: May–Thurner Syndrome (MTS) is an anatomic variant resulting in compression of the left iliac vein by the overlying right common iliac artery against the lumbar vertebrae. MTS increases the incidence of left-sided lower extremity deep vein thrombosis (DVT). Data on management and outcomes of paediatric MTS cases with DVT is limited. We present two case reports of paediatric MTS with DVT, as well as their management and outcomes. *Case Reports*: Both cases were adolescents who presented with acute left lower limb DVT with one having pulmonary embolism. MTS was diagnosed on various imaging investigations including ultrasound doppler, CT and MRI scans. Both cases had concomitant thrombophilia –