Pheochromocytoma crisis (PC) can encompass multiple organ failure, lactic acidosis, elevated temperature, encephalopathy, and hypertension and/or hypotension. Metoclopramide is a D2 receptor blocker and is known to precipitate pheochromocytoma crisis. It is commonly used in the emergency department (ED) for nausea and is often used as part of the "migraine cocktail".

**Case presentation:** 41-year-old female with primary hypothyroidism and hypertension diagnosed 5 months prior on two anti-hypertensive agents, presented to the ED with a severe headache. She recently had been placed on a Holter monitor for evaluation of episodes of palpitation/tachycardia. She was hemodynamically stable. Intravenous metoclopramide was administered as part of a "migraine cocktail". Shortly thereafter, she developed tachycardia with heart rate (HR) in the 130s, hypertension with blood pressure (BP) in the 180s/120s and proceeded to have generalized tonic-colonic seizures that lasted for 3 minutes. She was treated with lorazepam and was intubated for airway protection. Initial labs were only significant for mild leukocytosis. The urine drug screen was unrevealing. Due to the unexpected rapid clinical deterioration, computed tomography (CT) of the head, chest, abdomen, and pelvis were obtained. CT abdomen revealed a large 6.4×5.7×5.2 cm right adrenal mass. HR and BP remained elevated in the 170s and 200s/100s respectively. Given CT findings, a PC was suspected. She was started on doxazosin and labetalol. Phenoxybenzamine was later started. Biochemical testing was consistent with pheochromocytoma with elevated normetanephrine (NE) >20,000 pg/mL (<=148 pg/mL), metanephrine (M)>20,000 pg/mL (<=60 pg/mL), and total urinary metanephrines (TM) >40,000 pg/mL (<=205 pg/mL). HR and BP stabilized with treatment and the patient was subsequently extubated. She was noted to have new dysarthria and visual field deficits. Magnetic resonance imaging and CT angiography revealed findings consistent with posterior reversible encephalopathy syndrome (PRES) and acute cerebellar infarct. DOTATATE scan was negative for metastasis. She later underwent right adrenalectomy; pathology report confirmed the diagnosis of nonmalignant pheochromocytoma. Repeat NE, M, and TM 10 days post-op were unremarkable. The patient follows with endocrinology clinic outpatient and has been doing well.

**Conclusion:** Multiple cases of metoclopramide-induced pheochromocytoma crisis have been reported in the literature. These accounts indicate that the empiric use of metoclopramide for individuals presenting with headaches/nausea is not without risk especially for those with a history of hypertension and other symptoms of catecholamine excess. This case also highlights the importance of suspecting pheochromocytoma crisis in patients who develop rapid onset hypertensive crisis and other symptoms of catecholamine excess immediately after administering metoclopramide.

**Presentation:** Saturday, June 11, 2022 1:00 p.m. - 3:00 p.m.