CONCLUSION
Although rare, symptoms of diabetes insipidus in patients with malignancy should alert the physician for the possibility of pituitary metastasis. Failure to consider this diagnosis can lead to delay in treatment and complications.

PP-03

DIABETES INSIPIDUS MASQUERADING PITUITARY ADENOMA

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INTRODUCTION
Central diabetes insipidus (CDI) is rare with a prevalence of 1 in 25000, most commonly due to pituitary surgery or trauma (50%) and hypophysitis (15%). We reported a rare case of CDI masquerading as a pituitary adenoma.

RESULTS
A 54-year-old woman with diabetes mellitus presented with generalised seizure. She had polyuria >3L/day and polydipsia for 6 months. She had no menses since age 45, and no history of postpartum complications. Galactorrhoea, increased weight/shoe size, changes in facial appearance, headache, blurring of vision, postural dizziness and hypothyroid symptoms were absent. She was obese (body mass index 49 kg/m$^{2)}$, with BP 124/62, HR 62, and no postural hypotension. There were no abdominal striae, proximal myopathy, frontal bossing, spade-like hands nor bitemporal hemianopia. She had hypernatraemia (152mmol/L), high serum osmolality (320 mOsm/kg) and low urine osmolality (80 mOsm/kg). Urine osmolality increased to 340 mOsm/kg after desmopressin. She had central hypocortisolism (cortisol 14 nmol/L, ACTH 22 pg/mL), central hypothyroidism (fT4 7.1 pmol/L, TSH 0.58 mIU/L), hyperprolactinaemia (3387 mIU/L, 3974 mIU/L post-dilution) and secondary hypogonadism (oestradiol 232 pmol/L, LH <0.1 IU/L, FSH 1.4 IU/L). Random morning GH was 0.1 ng/mL. IGF-1 was not sent as there was no clinical suspicion of acromegaly. Pituitary MRI showed a well-defined enhancing sellar mass with suprasellar extension measuring 1.3 cm x 1.4 cm x 1.6 cm, suggestive of a pituitary macroadenoma with central necrosis and loss of posterior pituitary brightness on plain T1 MRI. The adenoma was removed via transsphenoidal surgery, and histopathology showed pituitary adenoma which stained positive for GH and prolactin. There was no evidence of hypophysitis on histology.

CONCLUSION
Pituitary adenomas rarely present as CDI. In few reports, all had concurrent hypophysitis on histopathology (1-4). Our patient had biochemically confirmed CDI and radiologic findings suggestive of adenoma and hypophysitis. However, histopathology only showed pituitary adenoma with no evidence of hypophysitis.

PP-04

HYPOGLYCEMIA AWARENESS AND MANAGEMENT STUDY (HAMS) – A RETROSPECTIVE REVIEW OF HYPOGLYCEMIA KNOWLEDGE AMONG HEALTH CARE PROVIDERS IN A SINGLE CENTER

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INTRODUCTION
Knowledge on management of hypoglycemia is essential for all healthcare providers (HCP). Poor management of hypoglycemia will lead to catastrophic consequences. The objective of this study is to evaluate the level of knowledge on hypoglycemia among HCP in Hospital Melaka.

METHODOLOGY
This was a retrospective review on level of hypoglycemia knowledge among HCP from various departments. All HCP who attended a Hypoglycemia Roadshow in Hospital Melaka in November 2019 were given an assessment which consisted of 10 questions to evaluate their knowledge on diagnosis, complications and management of hypoglycemia.

RESULTS
There were 422 participants consisting of 308 doctors and 114 non-doctors. The level of knowledge was divided into low (0-3 points), moderate (4-6) and high (7-10). High scores were seen in 56.16% (n= 237); the rest achieved moderate (35.31%, n=149) and low (8.53%, n=36) scores. We compared the level of knowledge between doctors and non-doctors: 41.94% of doctors achieved high scores as compared to 14.22% of non-doctors. However, this was not statistically significant (p=0.115). HCP from the medical department performed better with 28.67% achieving high scores compared to 27.49% in those from non-medical departments (p=0.00) Numerically, junior HCP (<5 years working experience) performed better with 40.76% obtaining high scores compared to their senior counterparts (≥5 years), with only 15.4% obtaining high scores. (p=0.331)

CONCLUSION

More than half of the participants had good knowledge on hypoglycemia. Continuing refresher education is important for HCP from all departments regardless of seniority.

PP-05

PEPTIDE RECEPTOR RADIONUCLIDE THERAPY INDUCED CARCINOID CRISIS: A CASE REPORT AND REVIEW OF LITERATURE

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INTRODUCTION

Peptide receptor radionuclide therapy (PRRT) is a therapeutic option in inoperable or metastatic neuroendocrine tumors (NET). PRRT is promising in prolonging survival and delaying disease progression in patients with advanced bronchopulmonary carcinoid. However, it may lead to worsening of carcinoid symptoms or even precipitate carcinoid crises.

RESULTS

A 62-year-old man with underlying advanced lung carcinoid tumor developed carcinoid crisis after receiving PRRT. The carcinoid crisis was successfully treated with intravenous octreotide infusion. Several prophylactic measures were taken to prevent PRRT- induced carcinoid crisis. Pre-medications included corticosteroid, a selective 5-HT3 receptor antagonist, parenteral ranitidine and chlorpheniramine for H1 and H2 antagonism, respectively, to prevent the release of the mediators from tumor tissue and/or blocking their effects on target organs. Octreotide infusion was given at 50 µg/hour. Despite measures, he developed carcinoid crisis manifesting as hypotension, tachycardia, multiple episodes of intense diarrhea and flushing at 10 hours post-PRRT. He was immediately resuscitated with crystalloid. Octreotide infusion was increased up to 125 µg/hour. Bridging therapy with long acting somatostatin analogue, lanreotide, was also started. The carcinoid crisis resolved with treatment. Octreotide infusion was tapered by 25 µg hourly and then stopped 24 hours after PRRT.

CONCLUSION

Carcinoid crisis usually occurs during the first PRRT cycle, either during the infusion or 12 to 48 hours after. Acute tumor lysis mediated by radiation cellular damage, resulting in sudden release of supraphysiologic amounts of hormonally active substances, leads to profound carcinoid symptoms. Emotional stress is also contributory. Lastly, administration of amino acids such as lysine and/or arginine as a renal protective measure may play a role in the pathophysiology of PRRT-induced carcinoid crisis, as these may be used as substrates for the synthesis of vasoactive hormones by the carcinoid cells.

PP-06

A CASE OF INSULIN-INDUCED PERIPHERAL NEUROPATHY

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INTRODUCTION

Insulin-induced peripheral neuropathy, known as treatment-induced diabetic neuropathy (TIDN), is an uncommon treatment-induced neuropathic pain and/or autonomic dysfunction that occurs in patients after a rapid improvement in glycaemic control.

RESULTS

We report a patient with underlying type 1 DM who developed TIDN after rapid improvement in glycaemic control following admission for diabetic ketoacidosis. He developed severe neuropathic pain and autonomic dysfunction manifesting as severe postural hypotension resulting in postural giddiness and unsteady gait. He was initially managed as diabetic neuropathic pain. Despite the high dosage of analgesics, pain did not improve, and postural giddiness also persisted. His HbA1C decreased from 17.5% to 7.4% in two months. The diagnosis of TIDN was made after considering the rapid reduction in HbA1c and his clinical presentation of pain and autonomic dysfunction that were not alleviated with the treatment plan for diabetic neuropathy. The patient's insulin dosage was reduced and glycaemic targets were relaxed. Two weeks after the adjustment of medications, his condition improved tremendously.