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.

CONCLUSION
Insulin-induced peripheral neuropathy or TIDN is a rare condition. It is often misdiagnosed as other types of neuropathy, as TIDN presents similarly with diabetic peripheral neuropathy and many physicians may not be aware of this condition. The diagnosis of TIDN must be kept in mind when patients on high doses of antidiabetic agents present with severe neuropathic pain with or without autonomic dysfunction. This may be prevented by administering less aggressive therapy for sugar control.

PP-07

A TERTIARY CENTER EXPERIENCE IN USING THE 2021 IDF-DAR RISK CALCULATOR FOR PEOPLE WITH DIABETES BEFORE RAMADAN

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INTRODUCTION
Fasting during Ramadan carries considerable risks for patients with diabetes. Risk stratification identifies those at high risk for complications and guides our recommendations against fasting. Evolving from previous guidelines, the 2021 International Diabetes Federation - Diabetes and Ramadan (IDF-DAR) risk stratification system seeks to enable more personalized risk assessment by objectively evaluating 14 Ramadan-, disease- and patient-related risk variables.

METHODOLOGY
We used the new IDF-DAR risk calculator in Muslim patients with diabetes who attended usual follow-up at the diabetes clinic in Hospital Putrajaya starting five weeks prior to Ramadan 2021. Their intention to fast, baseline diabetes therapy and planned treatment adjustments for Ramadan were recorded. We also assessed the acceptance of this new tool among the attending doctors.

RESULTS
We assessed 210 patients (93.8% type 2 diabetes). Mean age was 54.6 years (range 16 to 82 years) and 59.5% were females. Majority had long-standing diabetes (69% ≥10 years), insulin-treated (69.5%) and had poor glycaemic control (57.6% with HbA1c ≥7.5%). Most were stratified into high (40.5%) and moderate risk (33.3%) categories which recommend against Ramadan fasting. Despite this, intention to fast was 98.6% and 81.2% in moderate and high risk patients, respectively. Of the 17 who opted not to fast, 94% (n=16) were assessed as high risk, 53% experienced hypoglycaemia and 35.2% had prior negative fasting experience. Attending doctors found the risk calculator to be simple and quick to administer.

CONCLUSION
The new IDF-DAR risk calculator is a comprehensive easy-to-use tool that considers numerous elements to provide a more complete and objective quantification of a patient's risk for complications during Ramadan. Intention to fast remains very high among those in high risk category. Attending doctors need to ensure appropriate recommendations against fasting are emphasized and practiced to reduce complications during Ramadan.

PP-08

SEX HORMONE DERANGEMENT IN POST-MENOPAUSAL CHRONIC LIVER DISEASE PATIENTS: A CASE SERIES

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INTRODUCTION
Healthy post-menopausal women will exhibit low estrogen, high follicle-stimulating hormone (FSH) and high luteinizing hormone (LH) levels. Abnormalities in these sex hormone levels will often trigger further investigations. Chronic liver disease is common in Malaysia, with chronic viral hepatitis as one of the most common causes. It is estimated that 1.17 percent of adult Malaysians have chronic hepatitis B (HBV) and 0.74% have chronic hepatitis C (HCV). High estrogen, low FSH and low LH are the common biochemical derangements among the patients with chronic liver disease.

RESULTS
The degree of post-menopausal sex hormone changes varied according to the degree of liver injury due to the underlying causes. In our case series, patients with higher Child-Pugh scoring and smaller liver size had higher estrogen and lower FSH and LH levels.

CONCLUSION
Sex hormone profiles for post-menopausal women with chronic liver disease show higher estrogen level with greater degree of liver cirrhosis. FSH and LH level then decrease as the degree of liver cirrhosis progresses.