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INTRACRANIAL HYPERTENSION – A RARE BUT IMPORTANT CAUSE OF HEADACHE IN A YOUNG FEMALE WITH CUSHING'S DISEASE

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INTRODUCTION

Intracranial hypertension during the course of diagnosis and treatment in Cushing's disease is rare. However, it carries significant morbidity. Headache and visual disturbance in patients with Cushing's disease should alarm the physician of the diagnosis. Treatment options include carbonic anhydrase, loop diuretics and serial lumbar puncture as temporary measures for alleviating symptoms and preserve vision.

RESULTS

A 21-year-old female presented with symptoms of weight gain, intermittent headache, blurring of vision, and bilateral leg swelling. Her blood pressure was 140/88 mmHg, BMI was 34.5 kg/m^2. She had abdominal striae. There was no proximal myopathy. Visual confrontation and acuity were normal. Diagnosis of Cushing's disease was confirmed with unsuppressed cortisol [426 nmol/L] post low-dose dexamethasone suppression test and elevated serum ACTH [14.7 pmol/L]. Pituitary MRI showed a 0.7 x 0.9 x 0.6 cm left pituitary microadenoma without evidence of optic chiasm compression or hydrocephalus. Baseline visual acuity and Humphrey visual field assessment were normal. At three months after initiation of oral ketoconazole 200 mg twice daily, she complained of worsening headache and blurring of vision. Funduscopy showed bilateral papilledema. Bjerrum's chart examination showed bilateral enlargement of physiologic blind spots. Repeat pituitary MRI did not show any new significant findings. Lumbar puncture demonstrated marked increase in the opening pressure above 50 cmH_20. Examination of the cerebrospinal fluid was normal. Oral acetazolamide 500 mg twice daily was commenced, however, this was complicated by hypotension and metabolic acidosis. Ketoconazole was re-introduced with careful titration and symptoms of worsening headache and vision were no longer observed. The patient subsequently underwent trans-sphenoidal surgery and is currently in remission.

CONCLUSION

Symptoms of headache and visual disturbance should prompt the physician to exclude intracranial hypertension in patients with Cushing's disease in order to institute correct treatment and preserve vision.

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GLYCEMIC CONTROL AND BODY WEIGHT EFFECTS OF 25 MG FULL TABLET VERSUS 12.5 MG HALF TABLET EMPAGLIFLOZIN IN THE TREATMENT OF TYPE 2 DIABETES (T2D): A SINGLE CENTRE EXPERIENCE

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INTRODUCTION

Empagliflozin is the most commonly available sodium-glucose co-transporter-2 (SGLT2) inhibitor in government hospitals. Benefits of empagliflozin has been proven in randomized controlled trials and adopted into international and local T2D practice guidelines. However, prescription of empagliflozin is still limited by cost. Although halving the tablet of empagliflozin is not recommended, there is no clear evidence against this practice. We aimed to compare the effect of full-tablet empagliflozin (25 mg) and half-tablet empagliflozin (12.5 mg) in the treatment of patients with T2D.

METHODOLOGY

This is a cross-sectional study conducted in Hospital Sultan Haji Ahmad Shah (HoSHAS). Prior to 2019, patients with T2D in HoSHAS have been prescribed with full-tablet empagliflozin (25 mg) while after 2019, new patients have been initiated with half-tablet empagliflozin (12.5 mg) due to limited resources. All actively treated patients were included in the study. Electronic medical records were reviewed for patient demographic and clinical parameters such as HbA1c, body weight and insulin treatment at treatment initiation and latest follow-up.

RESULTS

66 patients were on active empagliflozin treatment, with mean age of 50.36 years old and diabetes duration of 10.8 years. Almost two-thirds of the patients were male and treated with half-tablet empagliflozin (12.5 mg). The mean duration of SGLT2 treatment was 10.9 months. Full-tablet (25 mg) vs. half-tablet (12.5 mg) empagliflozin treatment did not show any significant difference in HbA1c reduction (1.10% vs 0.91%, p=0.724) and weight reduction (3.38 kg vs 2.27 kg, p=0.595). 43.7% of patients were on concomitant insulin treatment. 15.2% of patients had reduction in total insulin daily dose. 4.5% of patients were able to discontinue insulin. Full-tablet and half-tablet empagliflozin had comparable effects on insulin dose reductions.

CONCLUSION

This study suggested that the unconventional practice of using half tablet of empagliflozin had comparable results to full-tablet treatment and can be an option in management of T2D where there are limited resources.