

Oral cinacalcet and subcutaneous calcitonin were initiated when saline diuresis failed to lower her calcium below 4 mmol/L. Calcitonin was discontinued after 2 days due to intolerance. At the 5<sup>th</sup> hospital day, serum calcium and creatinine levels decreased to 2.77 mmol/L and 103 µmol/L, respectively, with high volume intravenous saline and cinacalcet.

A multidisciplinary discussion was done and the plan was to continue oral cinacalcet and parathyroidectomy at the second trimester. Unfortunately, serial beta-hCG showed decreasing levels and transvaginal ultrasound confirmed fetal nonviability. Left inferior parathyroidectomy was then performed on the same setting at day 7 of presentation. Histopathologic examination reported giant parathyroid adenoma weighing 23 g. Her calcium level normalised and she remained normocalcemic at follow-up 5 months post-surgery.

#### CONCLUSION

Our case highlights the management challenges for hypercalcemia in pregnancy due to safety concerns on standard pharmacotherapy and surgery. Acute management of severe hypercalcemia in pregnancy requires timely multidisciplinary decisions to achieve the best outcome and minimise morbidity and mortality.

### PA-A-40

#### SEVERE HYPERTRIGLYCERIDEMIA SUCCESSFULLY TREATED WITH INSULIN INFUSION: A CASE REPORT

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#### INTRODUCTION

Patients with severe hypertriglyceridemia (HT) are at risk of developing life-threatening acute pancreatitis and cardiovascular disease. There is no standard guideline on managing severe HT in acute settings. Apheresis, heparin and insulin therapy has been utilised and reported.

#### CASE

We report a 42-year-old male who was referred to us from private healthcare for severe HT. He has hypertension and dyslipidaemia for 1 year and was prescribed with atorvastatin and fenofibrate for lipid management. He was only recently diagnosed with diabetes mellitus (DM) with HbA1c of 13%. There was no family history of hyperlipidemia or ischaemic heart disease. He did not have any abdominal pain or chest pain. On examination, there were multiple eruptive xanthomas over the extensor surface of both elbows and knees and at the Achilles tendon area.

Laboratory investigations revealed severe HT with serum triglyceride (TG) of 44.6 mmol/L and total cholesterol of 19.6 mmol/L. His blood exhibited thick and milky supernatant. Serum amylase was not elevated. Liver function test was normal. In view of severe HT, the patient was admitted and variable rate insulin infusion was started. His TG decreased progressively to 22.7 mmol/L by day 2 of admission and finally to 10.7 mmol/L by day 6 of admission. He was discharged on statin and fenofibrate together with his antihyperglycaemic medications. Screening for his family members was also done. Although there was no family history, we planned for genetic study for him soon.

#### CONCLUSION

This case showed successful therapy for severe HT with insulin infusion. It is non-invasive and cost-effective treatment option for severe HT. Rapid reduction of high TG is important to reduce risk of pancreatitis.

### PA-A-41

#### ACROMEGALY WITH SPONTANEOUS VENTRICULOSTOMY – A RARE PHENOMENON

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#### INTRODUCTION

Spontaneous ventriculostomy is a unique condition that occurs in patients with chronic obstructive hydrocephalus wherein spontaneous ventricular rupture results in communication between the ventricular system and subarachnoid space. We present a case of acromegaly who presented with spontaneous ventriculostomy on magnetic resonance imaging (MRI) of the pituitary with no prior history of neurosurgical intervention.

#### CASE

A 66-year-old male with chronic hypertension presented with long standing bilateral peripheral vision loss, worsening over the right eye for 3 months, obstructive sleep apnea symptoms and no symptoms of pituitary apoplexy. Clinically, he had classical features of acromegaly and ophthalmological assessment confirmed bitemporal hemianopia with no optic atrophy.