

PP-M-10

HYPOGLYCEMIA RESOLUTION AFTER A BIOCHEMICALLY CONFIRMED, HISTOLOGY-NEGATIVE PANCREATIC INSULINOMA SURGERY: A CASE REPORT

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CASE

A 50-year-old 80-kg Filipino female presented with blank stares and hypoglycemia resolving after intravenous glucose infusion. A 72-hour fast revealed hypoglycemia (43.90 mg/dL) and elevated serum C-peptide (5.90 ng/mL) and serum insulin (60.86 μ IU/mL) after 14 hours, confirming hyperinsulinemic hypoglycemia. Abdominal CT showed a 1.4 x 1.3 x 1.3 cm exophytic, isodense nodule along the inferior margin of the pancreatic body. Endoscopic ultrasound also revealed a 1.0 x 1.7 cm hypoechoic pancreatic nodule. She underwent a distal pancreatectomy. Investigation of unresolved hypoglycemia revealed a persistent pancreatic nodule, prompting extended pancreatectomy with intraoperative ultrasound guidance. Post-operatively, hypoglycemia no longer recurred. Histopathology revealed benign pancreatic tissue with fat necrosis, hemorrhage and microcalcifications. Six months postoperatively, she had 21% weight loss. No pancreatic nodule was visualized on repeat CT. The negative histopathologic findings may be due to the early stages of insulinoma or the beginning of hyperplasia. Post-operative weight loss may indicate successful insulinoma resection.

KEYWORDS

insulinoma, hypoglycemia, hyperinsulinemia, 72-hour fast

PP-M-11

EXPERIENCE OF SEVERE HYPERTRIGLYCERIDEMIA MANAGEMENT IN A TERTIARY CENTRE: A CASE SERIES

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CASE

Severe hypertriglyceridemia is defined by levels typically >10 mmol/L. It is often caused by uncontrolled diabetes mellitus, obesity, metabolic syndrome, chronic liver disease, excessive alcohol consumption, and genetic disorders. It is a risk factor for coronary artery disease and acute pancreatitis. We report successful inpatient reduction of severe hypertriglyceridemia in five individuals with intravenous insulin infusion, lipid-lowering oral agents and restriction of dietary carbohydrate and fat intake. More than half of them had underlying diabetes mellitus and triglyceride levels >30 mmol/L on admission. Insulin treatment was given for at least seven days. A lower rate of 0.05 unit/kg per hour insulin infusion and dextrose infusion was initiated for the patient without diabetes. None of them had severe hypoglycemia reported during their stay. They were discharged with triglyceride levels less than 10 mmol/L and subsequently followed up in our centre.

KEYWORDS

diabetes mellitus, severe hypertriglyceridemia, insulin infusion, inpatient