Adrenal CT revealed a right adrenal lesion measuring 5.1 x 5 x 5.7 cm with plain HU +24. The patient underwent an uneventful right open adrenalectomy and was hospitalized for 4 days. Histopathology confirmed right adrenal pheochromocytoma measuring 6 x 5 x 5.5 cm with no capsular breach. Postoperatively, blood pressure was controlled on one antihypertensive with normal 24-hour urinary metanephrine and normetanephrine.

CONCLUSION

Screening for elderly pheochromocytoma should not be missed and these patients should be managed in high-volume endocrine surgery centres to minimize operative complication rates.

EP_A009

PRIMARY ADRENAL LYMPHOMA WITH PRIMARY ADRENAL INSUFFICIENCY: A CASE REPORT

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INTRODUCTION/BACKGROUND

Primary adrenal lymphoma is a rare form of lymphoma and affects bilateral adrenal glands in most cases. This condition is often associated with adrenal insufficiency. We hereby report a case of bilateral primary adrenal lymphoma presenting with adrenal insufficiency in our centre.

CASE

A 58-year-old male with underlying hypertension presented with a 3-month history of dull lower abdominal pain, nausea, anorexia, postural giddiness, tiredness and weight loss of 5 kg. He denied any history of fever or night sweats.

At presentation, his blood pressure was 116/70 mmHg despite not taking his three antihypertensive medications for the past few days. Abdominal examination revealed bilateral flank fullness. Blood investigations showed hyponatraemia and hyperkalaemia. On clinical suspicion, early morning cortisol was sent and came back at 322 nmol/L, which was considered low in an ill patient. He was managed as adrenal insufficiency and was started on hydrocortisone replacement. Subsequently, a computed tomography (CT) of the thorax, abdomen and pelvis with adrenal protocol was performed which revealed bilateral suprarenal masses with locoregional invasion.

Further workup showed elevated Lactate Dehydrogenase (LDH). Tuberculosis workup and fungal culture and sensitivity were all negative.

Biopsy and histopathological examination of the left suprarenal lesion revealed diffuse large B-cell lymphoma. Chemotherapy was initiated during the admission. Unfortunately, his stay was complicated with septic shock secondary to pneumonia post-induction of chemotherapy. He completed a 10-day course of antibiotics and inotropes were weaned off prior to discharge. He was advised to follow up for reassessment prior to commencing the subsequent chemotherapy cycles.

CONCLUSION

Primary adrenal lymphoma is rare. However, this diagnosis should be considered in a patient presenting with bilateral adrenal masses and adrenal insufficiency. In such cases, an early adrenal biopsy is crucial to confirm the diagnosis.

EP_A010

USE OF PLASMAPHERESIS IN THE MANAGEMENT OF SEVERE HYPERTRIGLYCERIDEMIA IN A PATIENT PRESENTING WITH DKA AND NSTEMI: A CASE REPORT

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INTRODUCTION/BACKGROUND

Severe hypertriglyceridemia is defined as triglyceride level >11.3 mmol/L and is associated with significant morbidities including pancreatitis and atherosclerotic cardiovascular disease. A commonly acquired cause is insulin resistance associated with obesity and type 2 diabetes.

CASE

We report a case of a 49-year-old male with underlying diabetes mellitus, fatty liver and class II obesity (BMI 37) who was admitted for severe diabetic ketoacidosis

complicated with severe hypertriglyceridemia. His lipid profile was as follows: triglyceride 129.6 mmol/L, total cholesterol 24.5 mmol/L and HDL 2.90 mmol/L, with his plasma having a milky appearance. His HbA1c was 12.5%.

He was admitted to the Intensive Care Unit and was started on fixed-rate insulin infusion and intravenous fluids. He was kept nil by mouth and given pharmacotherapy (statin and fenofibrate). He had no evidence of acute pancreatitis, however, required dialysis for oliguric acute kidney injury. He later suffered from non-ST elevation myocardial infarction with transaminitis requiring discontinuation of lipid-lowering drugs. His repeated triglyceride level remained elevated at 45.2 mmol/L on day 4 of admission. He underwent one session of plasmapheresis uneventfully, with a significant reduction in triglyceride to 5.7 mmol/L. Before discharge, his treatment for DM was intensified and lipid-lowering therapy was re-commenced following normalization of liver enzymes.

Further history revealed his dietary habits consisted of a calorie-dense, high glycaemic load diet (estimated 3417 kcal/day, carbohydrates 50% of total calorie intake, protein 14.6% and fats 35%). He had no significant family history nor stigmata of hyperlipidaemia.

CONCLUSION
Despite the availability of effective lipid-lowering drugs, plasmapheresis remains a treatment option in severe hypertriglyceridemia, particularly in patients unresponsive or intolerant to pharmacotherapy. The rapid reduction of plasma triglyceride through plasmapheresis is effective in preventing hypertriglyceridemia-associated complications and can improve clinical outcomes in critically ill patients.

EP_A011

CONFRONTING THE CHALLENGE OF DIABETIC CYSTOPATHY WITH ESBL KLEBSIELLA PNEUMONIAE UROSEPSIS: A COMPLEX CLINICAL CONUNDRUM

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INTRODUCTION/BACKGROUND
The multisystemic nature of diabetes mellitus (DM) also affects the bladder causing diabetic cystopathy (DC), especially in middle-aged or elderly patients with long-standing poorly controlled disease, and it carries an increased risk of urinary tract infections (UTI).

CASE
A 54-year-old female with a background of poorly controlled DM Type 2 (HbA1c 14%) and multiple target organ damage including HF, IHD and retinopathy, presented with chronic urinary frequency and a 3-day history of fever and dysuria. Upon arrival at the hospital, she was in septic shock. Investigations revealed leukocytosis with CRP of 104 mg/L and procalcitonin of 2.24ng/ml. Her urinalysis revealed UTI, but the urine culture was negative. Subsequently, blood culture revealed growth of extended-spectrum beta-lactamase (ESBL) *Klebsiella pneumoniae*. Abdominal ultrasound revealed thickened and trabeculated urinary bladder wall. She was referred to urology and uroflow done showed a low average flow of 7.7ml/s and a high post-void residual of 180 ml suggestive of DC. In the ward, she improved after receiving intravenous Ceftriaxone for 3 days followed by Augmentin for 14 days.

The pathogenesis of DC is multifactorial. It may be secondary to autonomic neuropathy beginning with impaired bladder sensation and progressing to impaired contractility and urinary retention. Other theories involve alterations in detrusor muscle physiology and urothelial dysfunction. Those patients may be asymptomatic or may have variable voiding complaints such as overactive bladder, urge incontinence and overflow incontinence. Urodynamic evaluation is the cornerstone of diagnosis characterized by lower flow rates and higher post-void residual volumes. Patients with DM are at an increased risk of developing UTI due to impaired immune function and poor metabolic control aggravated by DC which can be further complicated by the emergence of resistant pathogens and lead to poor outcomes.

CONCLUSION
Proper management of DM is crucial in preventing complications such as DC and improving overall health outcomes.

EP_A012

USE OF SGLT2 INHIBITOR IN ALPELISIB-INDUCED HYPERGLYCAEMIA

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INTRODUCTION/BACKGROUND
Hormone receptor-positive (HR+) and human epidermal growth factor receptor 2-negative (HER2-) breast cancer constitutes the most common form of breast cancer. Forty percent of patients with HR+/HER2- breast cancer have