of a 24-year-old primigravida with HoFH who underwent LA and successfully delivered her baby at 35 weeks age of gestation.

CASE
A 24-year-old female diagnosed with HoFH at 7 years old, presented at 7 weeks pregnancy with hyperemesis gravidarum. She previously required regular plasma exchange from the age of 8 but subsequently defaulted treatment at 16 years old. Clinical examination revealed widespread multiple xanthomata over both hands, feet and elbows. Her baseline total cholesterol was 15 mmol/L and LDL-C was 13.2 mmol/L. She was initiated on bi-weekly plasma exchange. However, she developed intradialytic hypotension complicated by fistula failure following a second exchange, which necessitate double filtration plasmapheresis (DFPP), which is more specific for lipid apheresis. The LDL-C levels were reduced by an average of 46% following each treatment. Her pregnancy was complicated by two hospitalisations for suspected Acute Coronary Syndrome. Cardiology referral was made for re-assessment of coronary arteries. Fortunately, echocardiography and dobutamine stress test both showed normal findings. At 35 weeks of gestation, the patient successfully delivered a healthy baby boy weighing 1.6 kg via emergency caesarean section for foetal complication with good Apgar score.

CONCLUSION
This case demonstrated a favourable pregnancy outcome when LA along with good multidisciplinary support was utilized in a pregnant patient with HoFH.

EP_A034

THE USE OF THERAPEUTIC PLASMA EXCHANGE IN A PATIENT WITH RECURRENT SEVERE HYPERTRIGLYCERIDEMIA-INDUCED ACUTE PANCREATITIS

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INTRODUCTION/BACKGROUND
Severe hypertriglyceridemia (HTG)-induced acute pancreatitis is defined by clinical, laboratory and radiographic evidence of acute pancreatitis with triglyceride (TG) levels of >11.2 mmol/L in the absence of other causative factors. We report a case of therapeutic plasma exchange (TPE) used in recurrent severe HTG-induced acute pancreatitis who failed conventional treatment.

CASE
The patient is a 28-year-old female with poorly controlled Type 2 diabetes mellitus diagnosed 4 years ago with HbA1c range of 10-13% despite on Insulin Actrapid 30 u three times daily, Insulin glargine 36 u daily and Metformin 1g twice daily. Her TG levels remained elevated despite being on daily 145 mg of Fenofibrate, 40 mg of Rosuvastatin, and 4 gm of Omega-3-free fatty acid. Xanthelasma, tuberous or tendon xanthomata were absent. She denied a family history of hypertriglyceridemia. She was non-alcoholic and her thyroid screen was normal. Obesity and poor compliance with lifestyle changes and medications alongside poorly controlled diabetes contributed to severe hypertriglyceridemia. She had recurrent admissions for severe HTG-induced acute pancreatitis within the past 2 years. During each admission, she was given supportive treatment including fasting with bowel rest, analgesia, intravenous hydration, and insulin infusion. She failed to respond to conservative measures and required TPE for 3 of her 6 admissions. Her TG level was >64 mmol/L during these 3 admissions with persistent severe abdominal pain lasting more than 48-72 hours despite fentanyl infusion. Fresh frozen plasma was used as replacement fluid during each TPE session. TG levels dropped by 80-85% after a single TPE with TG levels on discharge decreased to a range of 2.3-5.5 mmol/L.

CONCLUSION
This case highlights the potential utility of TPE during acute pancreatitis by rapidly decreasing TG levels and reducing inflammatory cytokines. However, the TPE effect is transient and the patient requires adequate lipid-lowering treatment to achieve lasting effects.

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HEPATOMA-ASSOCIATED NON-ISLET CELL TUMOR HYPOGLYCEMIA: A CASE REPORT

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INTRODUCTION/BACKGROUND
Non-islet cell tumour hypoglycaemia (NICTH) is a rare condition due to excessive secretion of insulin-like growth factor-2 (IGF-2) or pro-IGF-2. NICTH is commonly associated with hepatocellular carcinomas.

CASE
We reviewed case notes, investigation results, imaging studies and discussed treatment options based on literature review.