

PP-49**Hospital Sungai Buloh's Experience in Using Fixed Insulin Infusion for Diabetic Emergencies**

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INTRODUCTION

Diabetic ketoacidosis (DKA) and hyperglycemic hyperosmolar state (HHS) are diabetic emergencies that cause high mortality and morbidity. The mainstay of treatment for diabetic emergencies is insulin and fluid therapy. Various methods of insulin initiation are commenced in different healthcare settings based on their respective standard practice guidelines.

CASE

A clinical audit was carried out based on the data of patients age 12 to 80 years admitted for diabetic emergencies in Hospital Sungai Buloh for a period of 11 months (May 2018 to April 2019). All patients were commenced on the fixed insulin infusion scale regime at point of diagnosis.

Results showed that the average time of resolution of DKA/HHS of less than 24 hours was achieved by almost 87% of total patients who were admitted for diabetic emergencies from May 2018 to April 2019.

CONCLUSION

Our experience of using the fixed insulin infusion scale regime in the treatment of diabetic emergencies has shown good outcomes.

PP-50**Implications of Steroid Therapy in the Management of an Immunocompromised Patient with Severe Graves' Ophthalmopathy (GO)**

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INTRODUCTION

Severe GO is four times more common among males. Immunosuppressive therapy is aimed at combating inflammation and preserving sight. Kahaly et al found that high dose intravenous pulsed methylprednisolone for moderate to severe GO had favorable response rates compared to oral prednisolone. However, the treatment is associated with significant morbidity among diabetes, renal and liver patients. The possible complications are systemic bacterial and fungal infection, cataract, osteoporosis and hypoadrenalism.

CASE

A 42-year-old gentleman, non-smoker, with known history of diabetes, hypertension, old stroke, chronic kidney disease (CKD) stage 4 and bilateral severe non-proliferative diabetic retinopathy, presented with painful red eyes with proptosis of the left eye of 4 months' duration. Visual Acuity (VA) and clinical activity score (CAS) assessments were 6/24 and 3/7 on the right eye and 6/36 and 6/7 on the left, respectively. He had severe GO without optic nerve compression confirmed by magnetic resonance imaging. He was clinically and biochemically euthyroid. He was started on oral prednisolone but relapsed within a month. Subsequently, he was given pulsed intravenous methylprednisolone totaling 10.25 g in combination with oral cyclosporine. During this period, he developed neutropenic sepsis, herpes zoster and deterioration of CKD requiring temporary dialysis. After initial response to steroid, his condition declined to sight-threatening left GO with optic nerve compression resulting in near blindness. He underwent orbital wall decompression followed by peribulbar triamcinolone injection. While CAS improved significantly to 0/7 on both eyes, his vision did not recover, with VA 6/24 on the right and only hand movement on the left. Orbital radiotherapy was not offered due to advanced diabetic retinopathy.

CONCLUSION

This case highlights the challenges in using steroid therapy in a patient complicated by diabetes and other comorbidities in an attempt to save sight, while taking the risk of life-threatening infection and deterioration of renal function.