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Intractable Hypoglycaemia with Hyperlactatemia in a Newly Diagnosed Patient with Diffuse Large B-Cell Lymphoma Requiring Mega Dose Glucose Infusion

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INTRODUCTION
Hypoglycaemia is an extremely rare complications in lymphoma. We report a case of intractable hypoglycaemia with hyperlactatemia in a non-diabetic retroviral disease patient with newly diagnosed Diffuse Large B-Cell Lymphoma (DLBCL) requiring extremely high glucose infusion to maintain euglycaemia.

CASE
A 27-year-old man with underlying retroviral disease presented with fever and constitutional symptoms associated with left axillary lymphadenopathy for 2 months. Excisional biopsy of the left axillary lymph node confirmed DLBCL. CT staging of the thorax, abdomen and pelvis showed enlarged nodal groups on both sides of the diaphragm. There were no lesions involving both adrenal glands, the liver, and the pancreas on the CT scan. During hospitalisation, he developed persistent hypoglycemia with capillary blood glucose of 2.7-3.9 mmol/l. His renal and liver functions were normal. Serum insulin, c-peptide levels sent during severe hypoglycaemia were normal. Serum cortisol and thyroid studies were normal with low IGF-I. Despite maintenance with dextrose 10% and 20% infusion, the hypoglycaemia persisted necessitating frequent boluses of dextrose 50% (D50%) that was successively converted to a continuous infusion via central venous access. Ensuring that central venous catheter was functioning at all times, the D50% infusion rate was up-titrated to a maximum steady rate of 210 mls/hr using pure D50%; equivalent to glucose 105 g/hr to maintain capillary blood glucose above 4.0 mmol/L. We noticed the patient's serum lactate level persistently elevated despite no evidence of tissue hypoperfusion and hypoxia. Concomitant oral glucocorticoids were introduced whilst on D50% infusion with subsequent reduction of D50% requirement. The patient remained in euglycaemia state while on glucocorticoid after successful tapering off of D50% and initiation of chemotherapy.

CONCLUSION
This rare case of intractable hypoglycaemia illustrate the need to treat hypoglycaemia aggressively. Glucocorticoids and chemotherapy had maintained euglycaemia in this patient.

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Autoimmune Polyglandular Syndrome Type II in a Patient presenting with Gynaecological Symptom: A Case Report

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INTRODUCTION
Autoimmune polyglandular syndromes (APS) are rare endocrinopathies characterized by the coexistence of at least two endocrine gland insufficiencies that are based on autoimmune mechanisms.

We report a 45-year-old lady who was diagnosed as APS-2 following a presentation of menorrhagia.

CASE
A 45-year-old lady with underlying primary hypothyroidism on thyroxine replacement, presented with menorrhagia. Further history revealed significant weight loss, lethargy, loss of appetite, alopecia and skin darkening over the ears. On examination, blood pressure was 110/59 mmHg, hyperpigmentation was found at buccal mucosa, palmar creases, trunks and extremities. Gynaecological assessment revealed no abnormalities. Initial blood investigations showed pancytopenia, normal electrolytes and normal thyroid function test. She was treated as symptomatic anaemia secondary to abnormal uterine bleeding and received blood transfusion. Subsequently, she became confused, disoriented and had pre-syncopal attack. The clinical suspicion of Addison's disease was raised after review of her clinical profile. The raised ACTH (260.0 pmol/L) and short synacthen test (0 min cortisol 69.4 nmol/L, 30 minutes 78.2 nmol/L, 60 minutes 69.8 nmol/L) confirmed the suspicion of primary adrenal insufficiency. Serum Dehydroepiandrosterone sulphate was <0.14 umol/L. Plasma aldosterone and renin was sent concurrently. Patient had mixed iron and vitamin B12 deficiency and was treated accordingly. The aetiology of the primary adrenal insufficiency was postulated to be autoimmune origin. Further evaluation including Computer tomography of the adrenal glands; anti-parietal cell antibodies and anti- 21-OH antibodies were planned. Patient showed marked improvement in symptoms after initiation of hydrocortisone replacement and discharged in stable condition.

CONCLUSION
This case highlights the significance of a timely diagnosis and appropriate treatment of APS-2. Physicians need to sharpen their awareness of the potentially serious and life-threatening consequences.