85%), 14% from bone (N: 14-68%), 13% from the intestine (N: <18%). As the patient was asymptomatic and had normal liver function, the hepatologist decided to monitor her biochemically and clinically.

CONCLUSION
Patients with elevated ALP should be thoroughly investigated and examined to rule out the common treatable causes. In cases of isolated raised ALP, isoenzyme electrophoresis could identify the source with the highest accuracy.

EP_A068

LIPOPROTEIN CHAOS

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INTRODUCTION/BACKGROUND
Hypertriglyceridemia pertains to blood triglyceride values greater than 2.0 mmol/L. Familial combined hyperlipidaemia, residual dyslipidaemia in well-controlled Type 2 DM and familial hypoalphalipoproteinemia are common hereditary disorders associated with hypertriglyceridemia.

CASE A
A 30-year-old female with Type 2 DM, admitted for uncontrolled DM and hypertriglyceridemia, with the following laboratory results: TG of 82.9 mmol/L (0.0-1.7 mmol/L). T Cholesterol (TC) of 14.97 mmol/L (0.0-5.2 mmol/L), non-HDL 14.48 mmol/L, LDL unmeasurable (0.0-1.95 mmol/L). She was initiated on insulin infusion, with target glucose of 8-10 mmol/L, medium chain TG (MCT) Oil 5 mls TDS, Rosuvastatin 20 mg ON, T. Fenofibrate 145 mg OD, Omega-3 1500 mg TDS. TG level decreased from 82 mmol/L to 2.7 mmol/L within one week and remained low during follow-up.

CASE B
A 48-year-old male with no comorbidities presented with left-sided weakness and facial asymmetry. He was treated as a case of cerebrovascular accident. He was incidentally noted to have hypertriglyceridemia of 11.5 mmol/L. TCl and LDL of 17.6 mmol/L and 11.7 mmol/L, respectively. Insulin infusion was initiated with fenofibrate 145 mg OD, atorvastatin 80 mg ON and Omega 3 capsules- 1 g 3 times daily. Upon discharge, his TC level was 6.3 mmol/L with TG of 4.8 mmol/L and LDL of 3.4 mmol/L. TG levels were 3.75 mmol/L during his follow-up visit with the same treatment.

CASE C
A 30-year-old female was diagnosed with hypertriglyceridemia and type 2 diabetes mellitus in the young. On admission, TC was 8.63 mmol/L, TG >12.4 mmol/L, LDL (lipaemic sample), non-HDL 8.11 mmol/L. She was initiated with insulin infusion, T. Fenofibrate 145 mg OD and Omega-3 FFA 2 g TDS. She was co-managed with a dietitian for a low TG diet with the addition of MCT oil of 8 ml BD, reduced to 5 ml BD due to intolerance. TG levels remained >12.4 mmol. After 48 hours, oral niacin 500 mg OD was added. During follow-up, TG level reduced to 3.64 mmol/L, with TC of 3.54 mmol/L and LDL of 0.82 mmol/L.

CONCLUSION
Management of hypertriglyceridemia is somewhat debatable, with some familial cases requiring plasma exchange. However, in the 3 case reports presented above, management was successful with insulin infusion, omega 3 FFA, MCT oil and statins.

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MEN2A

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INTRODUCTION/BACKGROUND
Multiple endocrine neoplasia (MEN) 2A is a rare inherited syndrome with manifestations depending on the specific RET mutation. Classical MEN2A is characterised by medullary thyroid cancer (MTC), pheochromocytoma and primary parathyroid hyperplasia.

CASE
We report a case of a 43-year-old female whose initial presentation was left flank pain, with an ultrasound showing hydronephrosis. CT scan showed a bilateral adrenal mass (>4 cm) with central necrosis. Her serum CEA and 24-hour urine metanephrine were markedly elevated. She did not present with the classical triad of pheochromocytoma. She then underwent bilateral adrenalectomy with histopathologic examination confirming pheochromocytoma. Postoperatively, she was started on fludrocortisone and hydrocortisone. A neck ultrasound was done, revealing a TR5 thyroid nodule. FNAC was done, and results showed medullary thyroid carcinoma. She was scheduled for a total thyroidectomy.

CONCLUSION
Patients with MEN might present with atypical symptoms with no positive family history. The diagnosis of pheochromocytoma will lead the clinician to investigate further to rule out MEN2A. Although MTC is usually the first manifestation of MEN2A, our patient did not present with related symptoms. Definitive treatment