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.

EP_A069

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

of pheochromocytoma should be performed prior to treatment of MTC. All patients with pheochromocytoma should be adequately prepared before surgery, including blood pressure control. Patients with pheochromocytoma and MTC should be given a high index of suspicion for the diagnosis of MEN2A. Screening may include CEA, 24-hour urine metanephrine and neck ultrasound. Adrenalectomy and lifetime replacement of adrenal hormones should be given. Ideally, genetic testing for RET mutation should be done.

EP_A070

CHRONIC HYPONATREMIA: RESET OSMOSTAT, CHALLENGES IN DIAGNOSIS

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INTRODUCTION/BACKGROUND
Hyponatremia remains one of the most common electrolyte imbalances encountered. Hyponatremia has many causes, and it requires systematic investigation. SIADH is one of the most common causes. Reset osmostat is a rare and poorly recognised cause of mild to moderate hyponatraemia, with a presentation similar to SIADH.

CASE
We present the case of a 69-year-old male with a history of cerebrovascular disease who had been diagnosed with SIADH after extensive workup for chronic hyponatremia. He had been on fluid restriction and oral salt for years but with little effect on his serum sodium. Given his stable mild hyponatraemia, he was investigated for possible reset osmostat. Patient underwent an oral water loading test in daycare. He was given 1000 ml (15 ml/kg) of water to drink within 30 minutes and then monitored for 4 hours. Serum and urine osmolality, serum electrolytes and urine output were obtained at baseline, then hourly for 4 hours. Urine volume was also measured hourly.

His baseline serum sodium was 125 mmol/L, which dropped to 122 mmol/L at 2 hours, then returned to baseline (125 mmol/L) at 4 hours. The serum osmolality was 266 mOsm/kg, which dropped to 259 mOsm/kg and returned to baseline (266 mOsm/kg) after 4 hours. The urine osmolality at baseline was 233 mOsm/kg and dropped to 123 mOsm/kg midway through the test. Urine volume was greater than 300 ml/hour throughout the test, and the patient excreted more than 1000 ml of urine in total.

CONCLUSION
The results showed that the patient successfully excreted the water load, diluted his urine, and maintained serum sodium levels at the end of 4 hours. Although there is no consensus guideline, the findings in this case would be consistent with reset osmostat. Patients with reset osmostat usually do not require treatment. It is worthwhile to consider this diagnosis in a small subset of patients with a prior diagnosis of SIADH.

EP_A071

SEVERE HYPERTRIGLYCERIDEMIA-INDUCED ACUTE PANCREATITIS COMPLICATED WITH PERIPANCREATIC COLLECTION IN PREGNANCY

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INTRODUCTION/BACKGROUND
Acute pancreatitis in pregnancy is rare and may result in severe complications and high mortality. Elevated oestrogen levels and insulin resistance during pregnancy may lead to raised triglyceride levels, which can precipitate acute pancreatitis. We report a case of severe hypertriglyceridemia-induced acute pancreatitis complicated with peripancreatic abscess in a pregnant patient.

CASE
A 35-year-old female, G3P0+2 at 28 weeks period of gestation (POG), with a strong family history of dyslipidaemia, was admitted due to acute onset of epigastric pain and vomiting associated with shortness of breath for two days. She was electively intubated due to worsening metabolic acidosis. Initial blood results revealed elevated serum amylase at 840 IU/ml. Abdominal CECT demonstrated a bulky pancreas with free fluid at the peripancreatic region, suggesting acute pancreatitis. Further workup revealed severe hypertriglyceridemia of >32.1 mmol/L, and her capillary blood sugar ranged from 9 to 11 mmol/L. She was kept Nil by mouth and was initiated on an intravenous insulin infusion with dextrose solution. She had preterm labour on day 2 of admission. She was started on a low-fat diet and fenofibrate postpartum. Her triglyceride level reduced significantly and finally normalized on day 6 of admission. She was discharged well until nine days after discharge; she presented with right flank pain and low-grade fever. CT of the abdomen revealed extensive multiloculated rim-enhancing peripancreatic collection suggestive of