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.

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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