refractory despite 3 days of intravenous potassium infusion. Stool studies excluded infective causes, and 24-hour urine 5-HIAA was normal. Trial of subcutaneous octreotide, titrated up to 100 mcg, led to resolution of symptoms and hypokalaemia within a day.

His fasting serum VIP levels sent prior to initiation of therapy were elevated at 211 pg/ml (normal range <86 pg/mL). Gallium-68 DOTATATE showed somatostatin-avid disease at the pancreatic head, multiple abdominopelvic lymph nodes and both liver lobes.

Our multidisciplinary team meeting determined that curative surgery was not feasible due to extensive metastases and vascular involvement. The patient remains well and asymptomatic on octreotide long-acting release during subsequent follow-ups.

CONCLUSION

This case highlights an unusual case of VIPoma, which presented with cholestatic jaundice prior to diarrhea. Strong multidisciplinary collaboration is crucial to optimize outcomes.

EP_A027

DOEGE-POTTER SYNDROME ARISING FROM AGGRESSIVE RECURRENT FIBROUS TUMOUR OF THE LUNG: A CASE REPORT

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INTRODUCTION

Doege-Potter Syndrome (DPS) is a rare paraneoplastic syndrome characterized by hypoinsulinemic hypoglycaemia. It typically arises in patients with mesenchymal tumours, particularly fibrous tumours of the lung. DPS is secondary to ectopic secretion of high-molecular-weight insulin-like growth factor (IGF)-2 that induces hypoglycemia.

CASE

We report a 56-year-old male with an underlying solitary fibrous lung tumour that was resected in 2013, which recurred in 2023 and was deemed unresectable. He was to undergo chemotherapy. However, while waiting, he presented neuroglycopenia with a capillary blood glucose of 1.9 mmol/L, reversed with glucose administration. Imaging studies revealed a large pleural-based lesion on the left with an interval increment in size, with its largest diameter at 20.6 cm and worsening mass effect. Histopathology report from CT-guided biopsy confirmed diagnosis of recurrent fibrous tumour with no malignant features. Renal and liver profiles were normal, and HbA1c was 4.3%. Paired random blood glucose was 2.8 mmol/L, with suppressed C-peptide and insulin levels of 31.81 pmol/L (NR 366.66-1466.65) and <1.39 pmol/L (NR 17.8-173), respectively. Serum IGF-1 was normal at 166.2 ng/ml (NR 54.3-194.2). Serum IGF-2 was 479 ng/ml (NR 333-967), with an IGF-2:IGF-1 ratio of 3, supporting the diagnosis of IGF-2-mediated hypoglycemia. We started him with oral prednisolone 0.5 mg/kg/day, and the hypoglycaemia improved. Unfortunately, he succumbed to respiratory failure due to advanced tumour progression. Given the clinical findings and available biochemical markers, this case is consistent with a diagnosis of non-islet cell tumour hypoglycaemia (NICTH).

CONCLUSION

This case emphasizes the association between solitary fibrous tumours of the lung and DPS, highlighting the potential for recurrence of the tumour and persistent paraneoplastic effects. Early recognition and appropriate management of DPS are crucial in improving patient outcomes, such as the commencement of corticosteroids, while awaiting definitive treatment.

EP_A028

ELDERLY WITH ABSOLUTE INSULIN DEFICIENCY IN A SENIOR CARE FACILITY: A TAILORED APPROACH

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INTRODUCTION

Managing diabetes in elderly insulin-deficient patients poses significant challenges, particularly when social support is limited.

CASE

We present an elderly female with recurrent diabetic ketoacidosis (DKA) and frequent hypoglycemic episodes. Despite various insulin regimens, she experienced unpredictable glycemic fluctuations, complicated by hypoglycemia unawareness.