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.

## Adult E-Poster

A 65-year-old frail Chinese female with poor social support and underlying medical conditions such as diabetes mellitus (DM), hypertension and dyslipidemia, was first admitted due to loss of consciousness at home. She was diagnosed with DKA secondary to pneumonia. After stabilization, she was transferred back to a district hospital. Despite trials of multiple insulin regimens -basal-bolus, basal insulin plus sulfonylurea and premixed insulin, she continued to experience multiple episodes of hyperglycemia and hypoglycemia. Laboratory findings showed a low/undetectable C-peptide level, confirming insulin deficiency. After discussion with endocrinologists, she was transitioned to a basal-bolus regimen with s/c Toujeo 10 u OM and s/c Novorapid 6 u tds, leading to improved glycemic control but still unpredictable glycemic readings.

Given her planned placement in a nursing home, carbohydrate counting was impractical. Instead, we collaborated with a dietitian and elderly home nursing staff to implement a structured meal-based insulin dosing strategy based on her total daily insulin requirement (0.4 units/kg/day), insulin sensitivity ratio (1 unit: 3 mmol/l), and insulin-to-carbohydrate ratio (1 unit per 14g CHO). This approach significantly stabilized her blood sugar, preventing further hypoglycemia and DKA episodes.

**CONCLUSION**

This case underscores the complexity of insulin management in elderly patients with insulin deficiency. Rather than carbohydrate counting, a structured meal-based insulin regimen proved to be a viable solution in a nursing home setting, ensuring safe and effective glycemic control.

## EP_A029

### THE SILENT REMODELER: A CASE OF PAGET'S DISEASE OF THE BONE

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**INTRODUCTION/BACKGROUND**

Paget's disease of bone (PDB) is a metabolic bone disorder characterized by excessive osteoclastic activity, leading to abnormal bone remodeling. PDB is often underdiagnosed, particularly among Southeast Asians and individuals under 40 years old. We report a rare case of PDB in a 48-year-old Malaysian woman presenting with severe complications.

**CASE**

The patient, with a history of hypertension, developed progressive shortness of breath and reduced effort tolerance over a week. She had a five-year history of bilateral hip and knee pain, which led her to change jobs from cashier to babysitter. Over two years, she became increasingly stooped and required a walking stick for support. She also reported bilateral hearing impairment for a week and had unintentional weight loss of 15 kg over two years. There was no family history of bone disorders, trauma, or consanguinity.

On examination, she had frontal bossing, interdental spacing, pectus carinatum, bilateral leg bowing and muscle wasting. Biochemical tests showed markedly elevated alkaline phosphatase (1073 U/L) with normal serum calcium and phosphate levels. Serum parathyroid levels were significantly raised (250 pmol/L). She had acute kidney injury (eGFR 27.5 mL/min/1.73 $m^2$) with metabolic acidosis. Imaging revealed bowing of the femur, diploic widening and cotton wool appearance of the skull, severe kyphoscoliosis with possibility of restrictive lung disease, bilateral staghorn calculi and severe pulmonary hypertension with high output cardiac failure.

Given the late-stage presentation, she was given IV zoledronic acid (3 mg) and analgesics but succumbed to her illness after eight days of hospitalization.

**CONCLUSION**

This case highlights the need for clinicians to be aware of PDB, especially in rare populations. A high index of suspicion in those with characteristic clinical, biochemical and radiological features is essential, as early diagnosis and treatment can improve quality of life and survival.