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.

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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.