a 2.3 cm pancreatic mass. Echocardiography showed moderate tricuspid regurgitation with an enlarged right atrium. A provisional diagnosis of carcinoid syndrome secondary to pancreatic NET with liver metastases was made. A multidisciplinary team decision was made to terminate the pregnancy to allow further evaluation and treatment. Computed tomography of the thorax, abdomen and pelvis confirmed the pancreatic head lesion with liver metastasis. Biochemistry showed elevated 24-hour urinary 5-hydroxyindoleacetic acid and serum chromogranin A, confirming the diagnosis of carcinoid syndrome. Histopathology of the biopsied pancreatic mass was consistent with grade 2 NET with a Ki-67 of 3-4%. Gallium-68 DOTATE and fluorodeoxyglucose positron emission tomography demonstrated concordant disease involving the pancreatic head, liver, lymph nodes and bone. The tumour was deemed inoperable and the patient was commenced on somatostatin analogue, followed by peptide receptor radionuclide therapy given the predominant Gallium-68 DOTATE-avid disease.

CONCLUSION

This case highlights the delay in diagnosis of carcinoid syndrome due to the lack of awareness of NET, leading to a heavy, inoperable tumor burden with guarded prognosis. A concerted effort is required to educate all healthcare providers on NET to minimise delay in diagnosis and improve patient outcomes.

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HABBATUS SAUDA OIL-INDUCED SEVERE HYPERTRIGLYCERIDEMIA IN A PATIENT WITH DIABETES MELLITUS

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INTRODUCTION/BACKGROUND

Hypertriglyceridemia (HTG) is a significant risk factor for cardiovascular disease, pancreatitis, and metabolic complications, particularly in patients with multiple comorbidities. While herbal supplements like Habbatus Sauda (*Nigella sativa*) oil are often used for their purported health benefits, emerging reports suggest potential adverse metabolic effects. This case highlights severe HTG potentially triggered by Habbatus Sauda oil in a patient with T2DM, dyslipidaemia and psoriatic arthritis (PsoA).

CASE

A 50-year-old Malay male, a research officer, presented with poorly controlled diabetes (HbA1c: 11%), dyslipidemia and severe HTG. He had a five- to six-year history of T2DM, previously on oral hypoglycemic agents (OHA) but discontinued, along with hypertension and PsoA managed with methotrexate (MTX). His triglyceride (TG) levels fluctuated significantly (2.1 → 13 → 8 mmol/L), with worsening levels temporally associated with the consumption of Habbatus Sauda oil. No other dietary or medication changes could fully explain the lipid surge.

The patient was advised to discontinue Habbatus Sauda oil and implement strict lifestyle modifications. Pharmacological interventions included metformin XR, gliclazide MR, vildagliptin, dapagliflozin (self-purchased), fenofibrate and atorvastatin. Despite adherence challenges, TG levels improved from 13 mmol/L to 8 mmol/L following supplement cessation and medication optimization. Hyperkalemia (K: 6.0 mmol/L) was incidentally detected, requiring urgent potassium-lowering therapy. The patient remained resistant to injectable anti-diabetic therapy and exhibited inconsistent compliance with diet and medications.

CONCLUSION

This case highlights a potential link between Habbatus Sauda oil and worsening hypertriglyceridemia, underscoring the need for vigilance in patients with pre-existing metabolic disorders. While herbal supplements are widely perceived as beneficial, they may have unintended metabolic consequences, particularly in high-risk individuals. Clinicians should actively inquire about supplement use when evaluating unexplained dyslipidemia and provide comprehensive patient education on adherence and supplement safety. A multidisciplinary approach is essential to optimizing long-term cardiovascular and metabolic outcomes.