is the most common, comprising about one-third of cases. This report discusses a case of acute mesentero-axial gastric volvulus likely caused by severe hypothyroidism.

CASE

A 77-year-old female with a history of degenerative spine disease, hypertension, hypothyroidism post-thyroidectomy and hyperlipidemia presented with a three-day history of abdominal pain, distension and vomiting. Clinically, her abdomen was distended and tender. Abdominal CT reported mesentero-axial gastric volvulus, and endoscopy showed a distended stomach with undigested food. Barium swallow revealed oesophageal motility disorders but no mass. Further tests showed elevated TSH levels (>51.9 mIU/L) and low free T4 (6.6 pmol/L), indicating severe hypothyroidism, likely due to missed levothyroxine (LT4) doses.

Due to her advanced age and initial presentation of sinus arrhythmia, the plan was to administer LT4 rectally with serial monitoring of TFT. The patient was prescribed a daily dose of 150 mcg (4 mcg/kg/day) of LT4, titrated up to 200 mcg daily (6 mcg/kg/day) and later switched to intravenous LT4 50 mcg daily before undergoing gastropexy. Following thyroid hormone replacement, her condition improved.

CONCLUSION

Severe hypothyroidism can impair gastrointestinal motility, and while gastrointestinal symptoms are common, gastric volvulus is rare. This case emphasises the importance of recognising thyroid dysfunction as a differential cause of gastric volvulus, particularly in patients with thyroid disorders. Early thyroid hormone replacement is essential to prevent recurrence and severe complications.

EP_A065

DEBILITATING NEUROGLYCOPENIA SECONDARY TO HIRATA DISEASE ACHIEVING REMISSION SPONTANEOUSLY

https://doi.org/10.15605/jafes.040.S1.073

Raja Azafirah RAS,[1] Siti Sanaa WA,[1] Masliza Hanuni MA,[1] Nor Amani A,[2] Saraswathy A[3]

[1]Endocrinology Unit, Medical Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia

[2]Pathology Department, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia

[3]Endocrine Unit, Specialized Diagnostic Centre, Institute for Medical Research (IMR), Kuala Lumpur, Malaysia

INTRODUCTION/BACKGROUND

Insulin Autoimmune Syndrome (IAS), also known as Hirata's disease, is a rare cause of hyperinsulinaemic hypoglycaemia. It is characterised by spontaneous hypoglycemia associated with extremely high circulating insulin levels and positive anti-insulin antibodies. Hypoglycaemic episodes usually occur in the post-prandial state and are commonly associated with other autoimmune conditions, such as Graves' disease, systemic lupus erythematosus and rheumatoid arthritis.

CASE

We report a case of a 62-year-old male with a background history of hypertension and cerebrovascular accident who presented with reduced consciousness. His capillary blood glucose levels ranged from 1.7 to 2.2 mmol/L and hypoglycaemia symptoms resolved following intravenous dextrose administration. The patient denied any consumption of oral hypoglycemic agents, exogenous insulin or traditional medications. Hypoglycaemia episodes occurred in both fasting and postprandial states. There was no weight gain to suggest insulinoma, and there were no constitutional symptoms to suggest underlying malignancy. No associated autoimmune conditions were noted. Systemic examination was unremarkable. Laboratory results revealed random blood glucose levels of 1.7 mmol/l, with marked elevation of insulin level of >6944 pmol/l and C-peptide level of 3496 pmol/l. Renal and liver profile and septic parameters were all within normal range. Insulin autoantibody (IAA) titers were elevated at 175 IU/mL (positive >20 IU/mL). Sulfonylurea levels were undetectable, and tumour markers were within normal limits. Localisation studies with CT, MRI and endoscopic ultrasound of the pancreas showed a normal pancreaticobiliary system. He was initially managed with oral prednisolone 10 mg twice daily and responded well. The dose was tapered off over two months with no recurrent episodes of hypoglycaemia afterwards.

CONCLUSION

IAS should be considered in a patient with postprandial hypoglycaemia with marked elevation of insulin levels. The diagnosis can be confirmed by elevation of insulin autoantibody titres. Most cases are self-remitting but may be managed with low-carbohydrate meals, steroids and steroid-sparing immunosuppressants.