Adult E-Poster

(>22000 U/L at 36th-hour post-op) and stage 3 acute kidney injury (serum creatinine 360 umol/L). He was diagnosed with rhabdomyolysis and was co-managed with the nephrology team, whereby aggressive fluid replacement with diuresis was initiated. He did not require kidney replacement therapy throughout his course of recovery. On day 10 post-op, the laboratory findings normalised and the patient was discharged home fully recovered.

CONCLUSION
Postoperative rhabdomyolysis is a severe complication of bariatric surgery, which is potentially life-threatening. Creatine kinase testing should be performed in high-risk patients after bariatric surgery for timely diagnosis and interventions.

EP_A081

NON-ISLET CELL TUMOR SECONDARY TO MALIGNANT PHYLLODES TUMOR OF BREAST

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INTRODUCTION/BACKGROUND
Non-islet cell tumour-induced hypoglycaemia (NICTH) is a rare but important cause of recurrent hypoglycaemia in patients with non-pancreatic tumours. Unlike insulinomas that cause hypoglycaemia through excess insulin secretion, NICTH is associated with large mesenchymal or epithelial tumours producing high-molecular-weight insulin-like growth factor 2 (IGF-2), leading to insulin-independent hypoglycaemia. We report a case of NICTH in a patient with a malignant phyllodes tumour of the breast.

CASE
A 50-year-old female was found unresponsive at home with a blood glucose level of 2.3 mmol/L. She regained consciousness following the administration of IV glucose. She had no history of diabetes or use of glucose-lowering agents. Examination revealed a large, firm 20 × 20 cm left breast mass. Hypoglycaemia work-up showed a random glucose level of 3.0 mmol/L, C-peptide of 35 pmol/L and insulin <2.78 pmol/L, suggesting hypoinsulinaemic hypoglycaemia. IGF-1 was within the normal range. She was treated with glucocorticoids while awaiting surgery. She underwent a left mastectomy, which revealed a 16 × 12.5 × 22.5 cm 7.6-kg malignant phyllodes tumour. Histopathology examination confirmed a malignant phyllodes tumour with high mitotic activity and a high risk of recurrence. An oncology referral was made for adjuvant therapy. At one-month follow-up, she remained asymptomatic with no hypoglycemia.

CONCLUSION
NICTH should be considered in patients with large tumours presenting with hypoglycemia. Corticosteroids may help manage hypoglycaemia before surgery, which remains the definitive treatment. A multi-disciplinary approach is essential for optimal care.

EP_A082

NOCTURNAL HYPOGLYCEMIA: THE TUMOR YOU DON'T SEE, BUT YOUR BLOOD SUGAR DOES

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INTRODUCTION/BACKGROUND
Non-islet cell tumour hypoglycemia (NICTH) is a rare but potentially life-threatening complication of malignancy, often driven by tumour overproduction of insulin-like growth factor 2 (IGF-2). Diagnosis can be challenging due to non-specific symptoms and limited access to specialised assays.

CASE
We report the case of an 87-year-old female with no known medical history who presented with reduced consciousness and was found to have symptomatic hypoglycemia with capillary glucose 2.1 mmol/L. She had experienced unexplained hypoglycemic episodes over the past 3 months. During hospitalisation, she showed a pattern of nocturnal hypoglycemia that temporarily resolved with continuous dextrose infusion, fulfilling Whipple's triad. The laboratory work-up revealed low serum insulin, low C-peptide, low insulin-like growth factor, negative serum sulfonylurea screen and normal random serum cortisol. Unfortunately, IGF-2 measurement was not available. A contrast-enhanced CT (CECT) of the thorax and abdomen exposed a large left lung mass with features suggestive of malignancy. The patient was initiated on glucocorticoid therapy, which led to partial improvement, although nocturnal hypoglycemic episodes persisted. Given her advanced age and overall condition, she declined surgical intervention and opted for conservative management.

CONCLUSION
This case underscores the importance of considering NICTH in elderly patients with recurrent, unexplained