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

hypoglycemia, particularly when occurring nocturnally. IGF-2 overproduction, typically by large mesenchymal or epithelial tumours, is the underlying reason behind these events. Although surgical resection of the tumour remains the definitive treatment, glucocorticoids and frequent glucose supplementation are used in conservative management.

EP_A083

MEN TYPE 2B SYNDROME IN A NORMOTENSIVE YOUNG FEMALE WITH INCIDENTALLY DISCOVERED PHAEOCHROMOCYTOMA

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INTRODUCTION/BACKGROUND
Phaeochromocytomas (PC) account for up to 5-25% of adrenal incidentalomas. Some PC patients, especially those with an adrenal incidentaloma, are asymptomatic and have normal blood pressure. The frequency of incidentally discovered normotensive phaeochromocytomas is increasing owing to better accessibility of imaging procedures. These tumours may be linked to certain genetic syndromes, such as Multiple Endocrine Neoplasia (MEN) type 2B, a rare condition caused by the RET proto-oncogene mutation, and includes a range of clinical manifestations such as phaeochromocytomas, medullary thyroid carcinoma and mucosal neuromas.

CASE
A 34-year-old female who had undergone total thyroidectomy for medullary thyroid carcinoma (MTC) was referred for an incidental right adrenal mass from CT staging. She had no paroxysms of headache or palpitations, no family history of MTC, pheochromocytoma and MEN-related diseases. She was normotensive. Physical examinations revealed mucosal neuromas on the tongue, buccal mucosa, lips, and eyelids. No marfanoid habitus present. Laboratory results showed normal serum calcium (2.57 mmol/L), but a 24-hour urine metanephrine was four times the upper limit of normal, along with borderline elevation of normetanephrines. The adrenal CT revealed an indeterminate right adrenal mass measuring 2 x 2 x 3 cm with peripheral calcifications suggesting pheochromocytoma. Left lymph node and carotid sheath biopsy were reported as features consistent with ganglioneuroma. The patient is scheduled for a right retroperitoneoscopic adrenalectomy. The unifying clinical presentations are consistent with MEN 2B Syndrome. However, genetic panel testing was not done due to financial constraints.

CONCLUSION
This case underscores the importance of considering genetic syndromes, such as MEN type 2B, in patients with incidental findings of pheochromocytomas, even when the patient is normotensive. Early diagnosis and genetic testing can help guide management, including surveillance for other tumours associated with MEN type 2B and early intervention. Further research is needed to explore the clinical presentation of pheochromocytomas in normotensive patients.

EP_A084

PSEUDOACROMEGALY IN A PATIENT WITH PACHYDERMOPERIOSTOSIS

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INTRODUCTION/BACKGROUND
Patients who are clinically suspected of acromegaly are usually referred to an endocrinologist. Biochemical evaluation is necessary to confirm the presence of an abnormality in the growth hormone (GH) axis. There are some conditions with physical features mimicking acromegaly in the absence of GH excess. Given the heterogeneity of conditions that can cause pseudoacromegaly, this posed a diagnostic challenge.

CASE
A 32-year-old male was referred to the Endocrine clinic for evaluation of suspected acromegaly. He had an incidental finding of pancytopenia and chronic excessive sweating when he presented to his General Practitioner. Following this, he was diagnosed with myelofibrosis by a haematologist. He reported having large hands and feet since his teens. He was also referred to a dermatologist for generalised skin thickening and itchiness and treated for photodermatitis.

Clinically, he has clubbing of the fingers of his hands and feet and furrowing of skin on his forehead but no other phenotypical features of acromegaly. Biochemically, IGF-1 and GH levels were normal.