Adult E-Poster

CASE
A 49-year-old man presented with recurrent hypoglycemia. During his first clinical consult, a computed tomography (CT) scan of the pancreas was done and showed normal findings. Prolonged fasting test was consistent with endogenous hyperinsulinemic hypoglycemia. He was later referred to our center. In further history, he revealed that his symptoms started 10 days after taking Bionerv. A mixed meal test showed fasting hypoglycemia with late postprandial hypoglycemia, and markedly elevated serum insulin levels. His IAA was positive, and his sulfonylurea screen was negative. A diagnosis of ALA-induced IAS was made. Despite stopping ALA and dietary modifications, his symptoms persisted, requiring diazoxide and prednisolone. The patient was monitored with continuous glucose monitoring (CGM), which revealed episodes of alternating hyper and hypoglycemia.

A 69-year-old man with a history of thyrotoxicosis presented with symptoms of hypoglycemia. Prolonged fasting confirmed endogenous hyperinsulinemia. Abdominal CT and endoscopic ultrasound (EUS) were normal, while Galium-68 DOTOTATE imaging showed mild uptake at a 10 mm pancreatic tail nodule. He was suspected of having insulinoma and was referred to us for further assessment. Further history revealed that the symptoms started after 1 week of taking Bionerv. His IAA was positive. In view of the temporal relationship with ALA, an IAS diagnosis was made. Symptoms improved after discontinuation of ALA, dietary modification and medical therapy. His CGM showed predominant hyperglycemia with late evening hypoglycemia.

CONCLUSION
Although ALA is generally safe, emerging case reports demonstrate its potential to trigger IAS. Detailed drug history and clinical suspicion is crucial to avoid the misdiagnosis of insulinoma and unnecessary interventions.

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OBSTRUCTIVE JAUNDICE FOLLOWING MIBG THERAPY IN MALIGNANT PHEOCHROMOCYTOMA: A CASE REPORT

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INTRODUCTION/BACKGROUND
Malignant pheochromocytoma is a rare neuroendocrine tumor with potential for local invasion and distant metastasis. In inoperable cases, nonsurgical options include I-131 metaiodobenzylguanidine (MIBG) therapy. MIBG-related complications may occur, especially in patients with bulky or anatomically complex tumors. We describe a case of post-MIBG ascending cholangitis due to tumor-related biliary obstruction.

CASE
A 49-year-old Kadazan Muslim female with hypertension, type 2 diabetes, dyslipidaemia, and previous strokes was diagnosed in August 2022 with inoperable malignant right adrenal pheochromocytoma. She presented with right hypochondriac pain, weight loss, palpitations, diaphoresis, and postural hypotension. Imaging revealed a right suprarenal mass (6.3 × 4.9 × 7.5 cm) invading the inferior vena cava and right renal vein. Elevated urine normetanephrine and positive DOTATATE, FDG-PET, and MIBG scans confirmed a functional tumor. Due to high surgical risk, she declined surgery and underwent right adrenal artery embolization with stable disease on follow-up. In July 2024, she received high-dose I-131 MIBG therapy (211 mCi) for palliative intent. Eight days post-therapy, she developed fever and jaundice. Imaging revealed intrahepatic biliary dilatation secondary to tumor compression at the porta hepatis. She was diagnosed with ascending cholangitis complicated with gram-negative sepsis and thrombocytopenia. She was managed with intravenous antibiotics, biliary stenting and supportive care.

CONCLUSION
Obstructive jaundice is a rare but serious complication following MIBG therapy. In this case, tumor compression near the porta hepatis likely exacerbated by post-therapy inflammation or necrosis, led to biliary obstruction. Although preoperative biliary stenting is standard in pancreaticobiliary malignancies, its use in neuroendocrine tumors, including pheochromocytoma, is not well defined. This case supports the potential role of pre-emptive biliary decompression in select high-risk patients undergoing MIBG therapy. Multidisciplinary planning is essential for risk stratification and outcome optimization.