at 28 weeks of gestation. During her third trimester, she required basal bolus insulin regimen with adjustment of acarbose dose. Throughout the pregnancy, the patient's blood glucose and fetal well-being were closely monitored and her glucose levels remained well-controlled. She delivered at 37 weeks of gestation, and both mother and baby were discharged in good health.

CONCLUSION

Acarbose may be a valuable addition to the treatment plan for pregnant women experiencing postprandial hypoglycemia, particularly when conventional treatments such as insulin therapy and dietary modification are inadequate. Although further research is needed to establish the safety and efficacy of acarbose in pregnancy, this case suggests that acarbose could be an effective and safe option for managing postprandial hypoglycemia in diabetic pregnancies.

EP_A110

UNMASKING ATYPICAL FEMORAL FRACTURES IN OSTEOPOROSIS: A CASE SERIES OF HIGH-RISK PATIENTS

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INTRODUCTION/BACKGROUND

Atypical femoral fractures (AFFs) are rare but serious complications associated with long-term antiresorptive therapy for osteoporosis. These fractures often occur in the femoral diaphysis, particularly in the subtrochanteric or mid-shaft regions, and may arise without trauma or with minimal trauma. Corticosteroid use and other comorbidities, such as chronic inflammation, further increase the risk of AFFs in susceptible individuals.

CASE

We report three cases of AFFs in female patients aged 61 to 75 years. The mean duration of bisphosphonate use prior to AFF was 5 years and 8 months. Two out of three patients had a history of chronic glucocorticoid use and one had rheumatoid arthritis who was on methotrexate. Only one patient had prodromal thigh pain. All patients presented with complete AFF and one patient with contralateral incomplete AFF. Most complete AFFs were sustained from a simple fall while one case was atraumatic. All complete AFFs were treated with intramedullary nailing and recovered well postoperatively. The patient with contralateral incomplete AFF was counselled for prophylactic surgical intervention which she declined. Anti-osteoporotic treatment was switched from bisphosphonate to anabolic agents following surgery.

CONCLUSION

Early recognition of AFFs and proactive intervention can prevent further fractures. Clinicians should consider drug holidays or switching therapies for patients on long-term bisphosphonates, especially those with additional risk factors, to optimize bone health.

EP_A111

CULTURAL SILENCE: UNVEILING PITUITARY APOPLEXY IN A MAN WITH CHRONIC ERECTILE DYSFUNCTION AND COEXISTING PROSTATIC ABSCESS

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INTRODUCTION/BACKGROUND

Pituitary apoplexy is an endocrine emergency caused by hemorrhage or infarction within a pituitary tumor, resulting in acute pituitary dysfunction. Triggers can include major surgeries, angiography, intracranial hypertension, or distant infections. In this case, fever and signs of increased intracranial pressure revealed a previously undiagnosed pituitary macroadenoma, initially presenting as chronic erectile dysfunction, which ultimately led to a diagnosis of pituitary apoplexy.

CASE

A 43-year-old male with obstructive sleep apnoea presented with acute fever, vomiting, headache, postural dizziness, and lethargy. He had long standing erectile dysfunction, previously uninvestigated. Initially treated for gastroenteritis, he was drowsy (Glasgow Coma Scale, GCS: Eye 3, Verbal 4, Motor 6), with left temporal hemianopia but no signs of meningism or focal neurological deficits.

Laboratory tests showed leukocytosis (12 × 10^9/L) predominantly neutrophilia, elevated C-reactive protein (105 mg/L), hyponatremia (125 mmol/L), hypokalemia (3 mmol/L) and negative blood cultures. Abdominal ultrasonography revealed a small prostatic abscess. Neuroimaging (CT brain and MRI pituitary) confirmed a pituitary macroadenoma (2.0 × 2.9 × 3.7 cm) with hemorrhagic apoplexy compressing the optic chiasm. Hormonal evaluation showed secondary hypogonadism, hypocortisolism, and hypothyroidism.