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.

Treatment with antibiotics and intravenous hydrocortisone, followed by thyroxine and testosterone therapy, resulted to clinical improvement, including improvement of GCS with resolution of the prostatic abscess, visual field deficit, and erectile dysfunction. Follow-up imaging showed a decrease in the size of the sellar mass (1.5 × 1.7 × 1.5 cm), hence the neurosurgery team opted for conservative management with continued endocrine follow-up.

CONCLUSION

The importance of addressing male sexual dysfunction without stigma is highlighted by this case. Non-functioning pituitary macroadenomas commonly affect the hypothalamic-pituitary-gonadal axis, and concurrent fever may mask an underlying infection. This infection, in turn, could trigger pituitary apoplexy. Clinicians should maintain a high index of suspicion and intervene promptly in patients presenting with elevated intracranial pressure to ensure optimal outcomes.

EP_A112

A CASE OF PROLACTIN AND GROWTH HORMONE CO-SECRETING PITUITARY MACROADENOMA

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INTRODUCTION/BACKGROUND

Prolactin (PRL) and growth hormone (GH) co-secreting pituitary macroadenomas are relatively rare and exhibit a multifaceted clinical presentation. Optimal management of PRL/GH co-secreting pituitary adenomas remains clinically challenging. We report a case of a PRL/GH co-secreting pituitary macroadenoma managed with cabergoline monotherapy.

CASE

A 25-year-old male without comorbidities presented with a chronic headache for eight years. Pituitary MRI revealed a pituitary macroadenoma measuring 1.7 x 2.5 x 1.8 cm compressing the optic chiasm, with minimal extension into the right cavernous sinus and mild sellar widening. He had markedly elevated prolactin at 11,170 mIU/L and was started on Cabergoline 0.25 mg twice weekly and transferred care to our centre for further management of functioning pituitary macroadenoma. Notable physical examination findings included frontal bossing and prognathism, but no macroglossia, skin tags, or tremors were seen. A visual field assessment revealed no defects. Hormonal workup exhibited elevated GH of 4.75 µg/L (5x the upper limit of normal), IGF-1 of 418.9 ng/mL, prolactin of 3,433 mIU/mL and failure of GH suppression on OGTT, consistent with a GH and prolactin-secreting pituitary adenoma. The multidisciplinary team reached a consensus that curative surgery is not feasible due to tumor extension into the right cavernous sinus. They recommended increasing his Cabergoline dosage to 3-4 mg weekly. The patient remains asymptomatic and his prolactin level is 784 mIU/mL while on Cabergoline 3.5 mg weekly. A follow-up MRI shows a smaller pituitary lesion with resolution of the optic chiasm mass effect. Currently, the patient is not inclined to consider surgery.

CONCLUSION

Surgical intervention is typically the first-line treatment for mixed co-secreting pituitary adenomas. However, cabergoline is known to effectively normalize prolactin levels in patients with hyperprolactinemia caused by mixed adenomas. In this particular case, cabergoline monotherapy appears to be successful at controlling both tumor growth and prolactin levels.

EP_A113

EFFECTIVE MEDICAL THERAPY FOR MULTIPLE ENDOCRINE NEOPLASIA TYPE 1-ASSOCIATED METASTATIC VIPoma

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INTRODUCTION/BACKGROUND

Pancreatic islet cell tumors occur in 40% of MEN 1 patients. VIPoma is a rare functioning pancreatic neuroendocrine tumor characterized by excessive secretion of vasoactive intestinal peptide (VIP), with an annual incidence of fewer than 1 in 10 million in the general population. Most cases are sporadic, but about 5% are linked to multiple endocrine neoplasia type 1 (MEN 1) syndrome. We describe a patient with MEN 1 associated metastatic VIPoma.

CASE

A 56-year-old female was first diagnosed with a benign insulinoma in 2005 and underwent successful laparoscopic tumor excision. There was no prior or family history of endocrine tumors. In 2019, she developed intermittent abdominal pain and chronic diarrhea which progressed over a 3-year period.