

## Adult E-Poster

### CONCLUSION

This case highlights a rare presentation of SIR with prominent dermatological manifestations mimicking acromegaly. This phenotype of insulin-mediated pseudo-acromegaly is thought to arise from a selective post-receptor insulin signaling defect, where metabolic pathways are impaired while mitogenic signaling remains relatively intact. Recognizing these atypical dermatologic clues is vital for early identification of insulin resistance syndromes, enabling timely diagnosis and appropriate intervention.

## EP\_A117

### MASQUERADING INSULINOMA: A RARE CASE OF ENDOCRINE TUMOR AND COMPLEX CLINICAL PRESENTATION

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#### INTRODUCTION/BACKGROUND

Recurrent hypoglycemia poses a diagnostic challenge, particularly when multiple endocrine disorders are present. Adrenal insufficiency, characterized by deficient cortisol production, impairs glucose homeostasis by reducing gluconeogenesis and increasing insulin sensitivity. Insulinoma, a rare pancreatic  $\beta$ -cell tumor, causes unregulated insulin secretion, leading to symptomatic hypoglycemia. Diagnosis relies on Whipple's triad and specific biochemical markers, including elevated insulin, C-peptide, and proinsulin levels during fasting. The concurrent presence of insulinoma and adrenal insufficiency is rare and requires a high index of suspicion.

#### CASE

A 54-year-old male with type 2 diabetes (on metformin), obstructive sleep apnea, and a history of traditional medicine use presented with recurrent dizziness and documented hypoglycemia. Examination and electrolytes were unremarkable. A short Synacthen test showed an inadequate cortisol response, confirming adrenal insufficiency. He was started on oral hydrocortisone, with subsequent stabilization of glucose levels and was discharged.

Three months later, he presented again with symptomatic hypoglycemia (as low as 1.2 mmol/L) despite compliance with medications. Biochemical tests revealed elevated insulin (296 pmol/L) and C-peptide (2,595 pmol/L), suggesting endogenous hyperinsulinemia. A 72-hour fast confirmed persistent hypoglycemia with inappropriately high insulin and C-peptide levels. CT imaging showed a distal pancreatic lesion consistent with insulinoma and

he then underwent distal pancreatectomy. Hypoglycemia resolved after surgery. He remains stable on hydrocortisone (10 mg three times daily).

Cortisol deficiency initially explained the patient's hypoglycemia, which improved with steroid therapy. However, persistent episodes prompted further workup, revealing an insulinoma. Surgical removal resulted in resolution, confirming the dual etiology of his hypoglycemia.

### CONCLUSION

This case highlights the rare coexistence of insulinoma and adrenal insufficiency. Cortisol deficiency can obscure insulinoma symptoms, emphasizing the need for a thorough and systematic diagnostic approach to recurrent hypoglycemia.

## EP\_A118

### GROWTH RETARDATION THERAPY IN PATIENTS WITH MARFAN SYNDROME: A CASE REPORT AND LITERATURE REVIEW

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#### INTRODUCTION/BACKGROUND

Marfan syndrome is an autosomal dominant disorder affecting connective tissues, with an incidence of 2-3 per 100,000 individuals. It involves mutations of the gene coding for fibrillin-1, and is characterized by ocular, cardiovascular, and skeletal manifestations. Excessive linear growth and tall stature are common features, which may lead to aortic dilatation, scoliosis, and social adjustment problems. Hence, height control treatment is considered in some patients.

#### CASE

We report the case of a 15-year-old male who was referred to the Endocrine clinic for possible growth-reductive therapy. His height was 198 cm (97<sup>th</sup> percentile) and his weight was 69.5 kg (50<sup>th</sup> percentile). He experienced rapid growth starting at age 7; however, he did not receive any treatment for height reduction. Physical examination revealed a high-arched palate, a systolic murmur at the mitral area, arachnodactyly, and mild upper thoracic scoliosis. An echocardiogram showed mild dilation of the left atrium and left ventricle, mild to moderate mitral regurgitation, and mitral valve prolapse. His aortic root was not dilated.

He maintains a normal social life, although he occasionally feels excluded due to limitations on physical activities resulting from loose ligaments. A review of available

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treatment options indicated that estrogen-based therapies have demonstrated efficacy in females when initiated before age 11, while the use of testosterone or high-dose estrogen in males remains less well-studied. Given the patient's advanced pubertal status (Tanner stage V) and chronological age, therapy was considered unlikely to be effective. Nevertheless, a shared decision-making process emphasizing supportive management, monitoring, and counseling was undertaken with the patient and his family.

### CONCLUSION

The case highlighted the importance of early identification and timely referral for growth-reductive therapy in patients with Marfan Syndrome. Height reduction strategy has been promising, however data is limited with relatively small sample size, with inconclusive evidence on growth-suppressing therapies among male patients.

## EP\_A119

### EXPLORING HYPERGLYCEMIA-RELATED SEIZURES: A CASE SERIES

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### INTRODUCTION/BACKGROUND

Hyperglycemia-related seizures, though rare, represent a serious complication of uncontrolled diabetes, often occurring in the context of Hyperosmolar Hyperglycaemic State (HHS). We present a retrospective case series detailing the clinical characteristics, metabolic parameters and outcomes of patients admitted with hyperglycemia-related seizures.

### CASE

Seven patients (4 females, 3 males) were included, with a median age of 64 years (range 16–76). All except one, a known defaulter, were on insulin therapy. Glycemic control was poor, with a median HbA1c of 9.9% (range 7.4 – 19.8). Random blood glucose levels at presentation ranged from 15 to 48.8 mmol/L. Serum sodium ranged from 120 to 150 mmol/L and serum osmolality ranged from 292.2 to 361.1 mOsm/kg. Three had HHS and one had overlapping diabetic ketoacidosis. Generalised tonic-clonic (GTC) seizures were the most common presentation (n = 6), while one had focal seizures.

Only one patient had a prior history of stroke; none had known epilepsy. Three patients required intubation for airway protection. Potential confounders included

dementia (n = 2), hypertensive crisis (n = 1), liver cirrhosis (n = 2, including one with history of substance abuse) and sepsis (n = 1). Brain CT most commonly showed cerebral atrophy with small vessel disease (n = 4); two had concurrent multifocal infarct. Two EEGs were performed, showing no epileptiform changes. Most patients achieved seizure control following normalization of blood glucose. Three patients were started on antiepileptic medications, and two of these patients were discharged on the same medications. The mortality rate was high, with three deaths occurring during the study period. One of these patients developed a total anterior circulation infarct.

### CONCLUSION

Our findings suggest that GTC seizures are more prevalent in patients with severe hyperglycemia. The absence of epileptiform activity on EEG supports a metabolic etiology. Early recognition, aggressive glycemic management and comprehensive post-discharge follow-up are important. These measures may improve neurological outcomes and reduce the high mortality associated with this complication.

## EP\_A120

### PRIMARY ALDOSTERONISM IN PREGNANCY: A CASE REPORT

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### INTRODUCTION/BACKGROUND

Primary aldosteronism (PA) in pregnancy is a rare and potentially severe disorder that poses significant challenges for diagnosis and treatment. Compared to essential hypertension, PA is associated with increased risks of preterm delivery, fetal growth restriction, and preeclampsia due to hypertension and hypokalemia.

### CASE

We present a 34-year-old primigravida with confirmed PA of ten years duration marked by recurrent episodes of hypokalemia and hypertensive urgency. Despite the initiation of mineralocorticoid receptor antagonist (MRA) treatment, the patient's blood pressure remained poorly controlled, and the patient also had irregular follow-up. She presented at 8 weeks of gestation with uncontrolled hypertension. She required multiple antihypertensive medications with maximal doses as pregnancy progressed, including methyldopa, labetalol, and nifedipine, but BP control remained suboptimal. Imaging revealed a left adrenal nodule, leading to retroperitoneoscopic adrenal-