Adult E-Poster

EP_A124

METASTATIC PULMONARY NEUROENDOCRINE NEOPLASM WITH CARCINOID SYNDROME COMPLICATED BY BOWEL PERFORATION

https://doi.org/10.15605/jafes.040.S1.132

Yong Ming Khoo, Wee Jing Teo, Zi Yang Lian, Zanariah Binti Hussein
Institut Endokrin, Hospital Putrajaya, Putrajaya, Malaysia

INTRODUCTION/BACKGROUND
Carcinoid syndrome (CS) results from hormone-secreting neuroendocrine neoplasms (NENs) releasing bioactive substances into systemic circulation. NENs are most commonly found in the gastrointestinal tract and less frequently in the lungs. CS develops in about 19% of patients with NENs, with 20% presenting with distant metastases. Rarely, mesenteric fibrosis in CS can lead to ischemia and perforation.

We present a case of metastatic bronchial NEN with CS, complicated with bowel perforation and subsequent death.

CASE
A 46-year-old male with previous history of spinal surgery for a post-traumatic compression fracture presented with gradual bilateral lower limb weakness and back pain, followed by chronic diarrhea and significant weight loss. Spinal MRI revealed extensive metastatic bone disease. Oesophagogastroduodenoscopy (OGDS) and colonoscopy were unremarkable; however, CT imaging identified a solitary endobronchial mass in the left lower lobe (3.1 x 2.6 x 2.8 cm), associated with left hilar lymphadenopathy and liver metastases.

Biopsy of the lung mass revealed a grade 1 neuroendocrine tumor (Ki67 1%). Urinary 5-hydroxyindolacetic acid (5-HIAA) levels were markedly elevated at 854.6 µmol/day. Gallium-68 DOTATATE PET-CT demonstrated somatostatin receptor-avid disease involving the left lung, with mediastinal nodes, liver and extensive skeletal metastasis. A diagnosis of CS was established based on clinical presentation, elevated 5-HIAA, imaging, and histopathology.

The patient was initiated on octreotide, a somatostatin analogue. However, he struggled to come to terms with the diagnosis and self-discharged against medical advice. He was later readmitted with severe hypokalemia, acute kidney injury, metabolic acidosis and acute abdomen. CT imaging revealed pneumoperitoneum consistent with a perforated duodenum. Due to hemodynamic instability, surgical intervention was not feasible, and palliative care was given.

CONCLUSION
This case illustrates a rare and potentially fatal complication of CS, underscoring the importance of early diagnosis and prompt treatment. Maintaining a high index of suspicion is crucial for timely identification of CS.

EP_A125

TRAPPED IN THE HYPOGLYCEMIA LOOP: A RARE CASE OF RAPIDLY PROGRESSIVE METASTATIC INSULINOMA

https://doi.org/10.15605/jafes.040.S1.133

Zi Yang Lian, Chin Voon Tong, Zanariah Hussein
Institut Endokrin, Hospital Putrajaya, Putrajaya, Malaysia

INTRODUCTION/BACKGROUND
Malignant insulinomas are rare and account for approximately 10-15% of all insulinomas. Most metastatic insulinomas are not curable with surgery alone and necessitate a multimodal approach encompassing medical, locoregional, targeted, systemic, and supportive therapies. The optimal treatment sequence should be individualized to each patient.

CASE
A 21-year-old male presented with a one-month history of recurrent hypoglycemic episodes characterized by neuroglycopenic symptoms. Subsequent evaluation confirmed endogenous hyperinsulinemic hypoglycemia. Computed tomography (CT) imaging revealed a 2.1 x 2.0 x 1.8 cm lesion in the pancreatic tail, multiple liver lesions in both lobes (largest measuring 3.8 x 4.1 x 4.1 cm), and intra-abdominal lymphadenopathy (largest measuring 1.1 x 1.8 cm). Gallium-68 (Ga-68) DOTATATE PET/CT and fluorine-18 fluorodeoxyglucose (18F-FDG) PET/CT demonstrated predominantly somatostatin receptor-avid disease.

Following multidisciplinary team discussion, the tumor was deemed inoperable. Medical management was rapidly escalated, involving diazoxide, hydrochlorothiazide, corticosteroids, octreotide followed by pasireotide, and dextrose infusion, guided by continuous glucose monitoring. Endoscopic ultrasound-guided fine needle biopsy (EUS-FNB) of the pancreatic tail lesion revealed a high-grade, well-differentiated neuroendocrine tumor (Ki67 50%, G3).

While awaiting access to systemic therapies, including everolimus, peptide receptor radionuclide therapy (PRRT), and chemotherapy, the patient underwent radiofrequency ablation (RFA) of the pancreatic tail lesion and transarterial embolization (TAE) of the hepatic lesions. However,