appropriate fluid management, her sodium levels gradually normalized.

CONCLUSION

This case highlights a rare but clinically significant adverse effect of zoledronic acid therapy. Hypocalcemia remains the more commonly expected metabolic complication. A few cases of hyponatremia associated with severe diarrhea or vomiting following zoledronic acid administration have been reported in the literature. However, our patient did not exhibit such gastrointestinal symptoms. Although the exact mechanism by which zoledronic acid contributes to hyponatremia remains unclear, early recognition is crucial to prevent potential complications.

EP_A131

A SEPTIC MASQUERADE: MULTIFOCAL SEPTIC ARTHRITIS REVEALING DISSEMINATED MELIOIDOSIS IN A YOUNG PATIENT WITH TYPE 1 DIABETES

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INTRODUCTION/BACKGROUND

Melioidosis, caused by *Burkholderia pseudomallei*, is a potentially fatal infection endemic to Southeast Asia and northern Australia. While often linked to type 2 diabetes mellitus, disseminated melioidosis in patients with type 1 diabetes mellitus (T1DM) is exceedingly rare, more so if with musculoskeletal involvement. We report a case of disseminated melioidosis presenting with multifocal septic arthritis, a thigh abscess, pulmonary infection, and splenic microabscesses in an adolescent with T1DM, highlighting the need for heightened vigilance in endemic regions.

CASE

An 18-year-old Indian female with T1DM since age of 13 (HbA1c 10.3%), on insulin aspart and detemir, presented with five weeks of fever, one week of painful left thigh swelling, and three days of cough. She was admitted with severe diabetic ketoacidosis and was empirically treated with intravenous ampicillin-sulbactam. Ultrasound of the left thigh revealed an abscess, which was drained; pus culture was positive for *Burkholderia pseudomallei*. Antibiotics were escalated to intravenous ceftazidime and trimethoprim-sulfamethoxazole.

Despite treatment, she remained febrile and required intubation on day eight of admission due to respiratory compromise. Blood and respiratory cultures also isolated *Burkholderia pseudomallei*. Computed tomography of the thorax, abdomen, and pelvis showed pulmonary infection (patchy ground-glass opacities, bilateral consolidation, minimal pleural effusion) and splenic microabscesses. Joint ultrasound revealed bilateral knee effusions and a complex right ankle effusion. Emergency arthrotomies and washouts of all affected joints yielded the same organism.

Her fever resolved with marked clinical improvement following complete source clearance. She was discharged ambulatory after six weeks of intravenous ceftazidime and a five-month oral eradication course, with optimized glycemic control. Follow-up imaging confirmed resolution of all lesions.

CONCLUSION

This case highlights that the aggressive and atypical presentation of disseminated melioidosis in T1DM may delay diagnosis. Persistent fever in endemic areas warrants prompt reevaluation. Early antibiotic escalation, timely surgical intervention, and multidisciplinary care were keys to recovery.

EP_A132

A CASE SERIES OF THREE CHINESE-MALAYSIAN PATIENTS WITH VARIED CHARACTERISTICS OF LATENT AUTOIMMUNE DIABETES IN ADULT (LADA)

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INTRODUCTION/BACKGROUND

Latent autoimmune diabetes in adults (LADA) is an autoimmune diabetes typically present in adulthood with initial insulin independence and positive anti-glutamic acid decarboxylase (GAD) antibodies. Most progress to insulin dependence within six months of diagnosis.

We present three Chinese-Malaysian patients with LADA, each demonstrating varied presentations and management, all culminating in diabetic complications.

CASE

Case 1. A 53-year-old lean male with a 22-year history of presumed Type 2 Diabetes Mellitus (T2DM), initially

managed with oral agents for ten years and later transitioned to premixed insulin, presented with recurrent diabetic ketoacidosis (DKA). His first DKA was at 51 and subsequently required titration of insulin therapy during follow-up. Two years later, he experienced another DKA episode. Autoimmune testing revealed high-titer anti-GAD antibodies, confirming LADA.

Case 2. A 68-year-old male with a 15-year history of presumed T2DM presented with recurrent DKA following insulin interruption and initiation of an SGLT2 inhibitor. Initially managed with two oral agents, he experienced progressive glycemic deterioration after eight years, necessitating insulin therapy. He was positive for anti-GAD antibodies, confirming the diagnosis of LADA.

Case 3. A 71-year-old female with a three-year history of presumed T2DM was initiated on premixed insulin alongside oral agents due to poor glycemic control. Despite this, she experienced recurrent DKA, triggered by brief interruptions in insulin therapy. This raised suspicion for LADA despite her advanced age. Autoantibody was positive for anti-GAD antibodies, confirming the diagnosis.

CONCLUSION

These cases highlight the variable and delayed presentation of LADA, which is frequently misclassified as T2DM. A higher rate of LADA is observed amongst the ethnic Chinese population in Malaysia, mirroring the high prevalence amongst T2DM patients in China. Features such as early treatment failure, recurrent DKA and insulin sensitivity in Chinese ethnicity should raise clinical suspicion, as timely antibody testing is crucial for accurate diagnosis and management.

EP_A133

MACROPROLACTINOMA IN A POST-MENOPAUSAL WOMAN: A RARE CASE REPORT

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INTRODUCTION/BACKGROUND

Prolactinoma is a type of benign pituitary tumor that secretes prolactin derived from lactotropes and constitutes 50% of all pituitary adenomas. Microprolactinoma (diameter <10 mm) is the more common type and rarely develops into macroprolactinoma (diameter ≥10 mm). Prolactinomas are predominantly diagnosed in premenopausal women and postmenopausal cases are uncommon, often presenting with atypical symptoms.

CASE

A 63-year-old woman came to M Djamil General Hospital with complaints of narrowed visual fields and recurrent headaches. The patient had no history of malignancy. She had not menstruated for 15 years. There were no signs or symptoms of endocrine disorders. Laboratory tests revealed neutropenia (30%) and lymphocytosis (52%). Pituitary hormone examination showed the following results: prolactin level of 42.78 uIU/mL (normal range: 5.13–26.53), luteinizing hormone level of 3.65 uIU/mL (normal range: 0.58–14), follicle-stimulating hormone level of 23.98 uIU/mL (normal range: 1.38–5.47), and thyroid-stimulating hormone level of 3.75 uIU/mL (normal range: 0.25–5). An MRI scan of the head revealed an intrasellar tumor extending into the suprasellar region, suggestive of a pituitary macroadenoma, measuring approximately 42.61 x 28.06 x 45.1 mm, along with bilateral maxillary sinusitis. The patient was started on low-dose bromocriptine therapy at 0.625 mg orally once daily, with regular monitoring of treatment response. After three months of therapy, prolactin levels decreased significantly to <0.6 uIU/mL. A follow-up MRI scan was performed six months after therapy, revealing a reduction in tumor size (36.7 x 22.8 x 45 mm).

CONCLUSION

Prolactinoma diagnosed in postmenopausal women is less common due to hormonal changes. The absence of typical hyperprolactinemia symptoms due to the cessation of ovarian function makes the diagnosis challenging