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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Dinda Putri Sofiani,[1] Eva Decroli,[2] Dinda Aprilia,[2] Alexander Kam,[2] Yanne Pradwi Efendi,[2] Syafril Syahbuddin[2]

[1]*Department of Internal Medicine, Faculty of Medicine, Andalas University, M Djamil General Hospital, Padang, Indonesia*

[2]*Division of Endocrinology, Metabolic, and Diabetes, Department of Internal Medicine, Faculty of Medicine, Andalas University, M Djamil General Hospital, Padang, Indonesia*

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

and often delayed. Despite their size and invasiveness, macroprolactinomas in postmenopausal women generally respond well to treatment with dopamine agonists.

EP_A134

CHARCOT ARTHROPATHY IN A CONTROLLED DIABETIC PATIENT: A CASE REPORT

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Dinda Putri Sofiani,[1] Eva Decroli,[2] Dinda Aprilia,[2] Alexander Kam,[2] Yanne Pradwi Efendi,[2] Syafril Syahbuddin,[2] Asyumaredha Asril Silan[3]

[1]*Department of Internal Medicine, Faculty of Medicine, Andalas University, M Djamil General Hospital, Padang, Indonesia*
[2]*Division of Endocrinology, Metabolic, and Diabetes, Department of Internal Medicine, Faculty of Medicine, Andalas University, M Djamil General Hospital, Padang, Indonesia*
[3]*Division of Orthopedic Surgery, Department of Surgery, Faculty of Medicine, Andalas University, M Djamil General Hospital, Padang, Indonesia*

INTRODUCTION/BACKGROUND

Charcot arthropathy is a severe complication of diabetes which is often diagnosed late, characterized by a red, warm, and swollen foot with bone abnormalities on imaging. Most studies report elevated HbA1c as a risk factor in Charcot patients, but there are rare cases with normal HbA1c. If not promptly diagnosed and treated, the condition can lead to deformity, foot ulcers, amputation, and death.

CASE

A 54-year-old male came to M Djamil General Hospital with complaints of ulcers around the right ankle. The patient has a history of diabetes mellitus (13 years). We found deformity with ulcers and pus in the right ankle joint. We did several examinations to confirm the diagnosis. The laboratory results are random blood glucose 152 mg/dL; fasting blood glucose 65 mg/dL; two-hours postprandial glucose 111 mg/dL; HbA1c 7.0%. CT scan of the lower extremities found osteomyelitis of the tarsal bones with cellulitis; histopathology found chronic and acute inflammation with granulation tissue. The working diagnosis was Charcot arthropathy of the right distal tibia Brodsky Type 3A, and Type 2 Diabetes Mellitus. We performed immobilization, external fixation, sequestrectomy and boot casting and controlled glycemia with medical nutrition therapy and rapid acting insulin for perioperative management. We used antibiotics and analgesics to treat infection and pain. The results were good and the patient was advised to use ankle foot orthosis.

CONCLUSION

This is a rare case report of Charcot arthropathy in a patient with normal HbA1c. This condition may be associated with rapid HbA1c normalization, which can trigger acute episodes, and the duration of diabetes. Clinicians should assess glycemic history and neuropathic risk factors. Target HbA1c between 7.0 – 8.0% during treatment can facilitate wound healing without increasing mortality.

EP_A135

SEVERE HYPOTHYROIDISM-INDUCED RHABDOMYOLYSIS IN THE ABSENCE OF A TRIGGERING FACTOR

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Mohamed Haris Bin Mohamed Azmi,[1] Nur 'Aini Eddy Warman,[1,2] Mohd Hazrriq Awang,[1,2] Nor Aisyah Zainordin,[1,2] Aimi Fadilah Mohamad,[1,2] Fatimah Zaherah Mohamed,[1,2] Rohana Abdul Ghani[1,2]

[1]*Endocrine Unit, Department of Int Medicine, Hospital Al-Sultan Abdullah, UiTM, Selangor, Malaysia*
[2]*Endocrine Unit, Department of Int Medicine, Faculty of Medicine UiTM, Selangor, Malaysia*

INTRODUCTION/BACKGROUND

Thyroid disorders are among the most common endocrine diseases globally, with hypothyroidism affecting approximately 3.4% of the Malaysian population. Muscle-related symptoms, such as fatigue, cramps, and myalgia are frequently observed in hypothyroidism and usually present with mild to moderate elevations of the muscle enzymes. However, rhabdomyolysis due to hypothyroidism, particularly in the absence of other apparent causes, is rare and is more frequently associated with Hashimoto's thyroiditis. The exact mechanism remains unclear, but it is hypothesized that hypothyroidism disrupts muscle metabolism, leading to prolonged oxidative damage and subsequently rhabdomyolysis.

CASE

We report a case of a 32-year-old male with no prior medical history who presented with one month of weight gain and lethargy, associated with facial puffiness for 2 weeks. He denied systemic symptoms, strenuous activity, trauma, alcohol use, or recent medications. No family history of thyroid or autoimmune disease was noted. Examination showed mild facial puffiness, no muscle weakness, and normal reflexes. Laboratory investigations revealed elevated creatinine kinase (CK) levels of 2,527 U/L (55-170), aspartate transaminase (AST) of 130.3 U/L (8-33), alanine transaminase (ALT) of 118.1 U/L (7-56) and acute kidney injury with urea 7.3 mmol/L (7-12), creatinine 182 μmol/L,