analysis, with 51.8% (n = 56) receiving sleeve gastrectomy (SG), 42.6% (n = 46) Roux-en-Y gastric bypass (RYGB), and 5.6% (n = 6) sleeve-plus procedure. The mean age was 41.79 years, with 81.5% females. 56.5% had hypertension, 33.6% diabetes mellitus, 38.9% obstructive sleep apnea, and 38% dyslipidaemia. The mean preoperative weight was 122.08 kg and mean BMI was 47.85 kg/m². Overall, 49.1% (n = 53) of patients achieved successful weight loss in 12 months, with percentage distribution as follows: 45.3% had RYGB, 47.2% had SG, and 7.5% had sleeve-plus procedure. At 12 months, 66.7% (n = 4) of sleeve-plus patients, 52.2% (n = 24) of RYGB patients, and 44.6% (n = 25) of SG patients had successful weight loss. However, no significant difference in success rates was observed among the three surgical procedures ($p = 0.484$). No other factor significantly impacted the outcome of successful weight loss.

CONCLUSION

Bariatric surgery effectively facilitates weight loss, with nearly half of patients achieving successful weight loss at 12 months. While the sleeve-plus procedure showed the highest success rate, differences among procedures were not statistically significant.

EP_A212

OUTCOMES OF RADIOACTIVE IODINE THERAPY IN HYPERTHYROID PATIENTS ON EXISTING STEROID THERAPY: A RETROSPECTIVE STUDY

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INTRODUCTION

Radioactive iodine (RAI) is a common and effective treatment for hyperthyroidism. Corticosteroids are sometimes given as adjunct therapy for hyperthyroidism, or as treatment for thyroid eye disease (TED). Data is lacking on whether pre-existing steroid therapy affects the efficacy of RAI.

METHODOLOGY

We performed a retrospective review of thyrotoxic patients attending our clinic who underwent RAI between Dec 2017 and June 2024 and identified patients who were on corticosteroid therapy prior to RAI. Parameters including age, gender, diagnosis, steroid dosage, fT4, RAI treatment episodes and remission were evaluated. For patients who underwent multiple RAI treatments, only the first RAI treatment was evaluated. Remission was defined as euthyroid or hypothyroid status at least 6 months post-RAI, without the need for additional RAI treatment. Chi-squared test was performed to compare the remission rate with or without prior steroids.

RESULT

Four hundred fifty-two patients underwent RAI, 17 were on steroids. For the steroid group, the mean age was 41.8 ± 9.8 years. Graves' was the predominant diagnosis (76.5%). Mean fT4 pre-RAI was 18.4 ± 9.7 pmol/L, and mean prednisolone dose was 23.8 ± 9.3 mg. Indications for steroids included TED (41.2%), antithyroid drug allergy (17.6%), refractory Graves' (11.8%), agranulocytosis (11.8%), other autoimmune diseases (11.8%) and liver injury (5.9%). Patients with TED were often commenced on steroid therapy for two weeks pre-RAI.

Mean RAI dose was 20.2 ± 4.5 mCi for the steroid group and 17.8 ± 4.3 mCi for the non-steroid group ($p = 0.028$). Remission rate after first RAI treatment was 58.8% in the steroid group vs 73.6% in the non-steroid group. ($\chi^2 = 3.5$, $p = 0.06$)

CONCLUSION

We did not find any statistically significant difference in the post-RAI remission rates between the steroid and non-steroid groups. However, there was a trend towards reduced response to RAI in the steroid group. The study was limited by the small number of patients on steroids, and the difference in RAI doses used between groups. Analysis of a larger number of patients is warranted.

EP_A213

ALDOSTERONE-RENIN RATIO: ASSESSING APPROPRIATENESS IN DIAGNOSTIC PRACTICE

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INTRODUCTION

Clinical guidelines recommend the aldosterone-renin ratio (ARR) as a screening tool for primary aldosteronism (PA); however, results may be influenced by pre-analytical factors such as posture, timing, salt intake, and medications.

METHODOLOGY

We conducted a retrospective evaluation of ARR requests at University Malaya Medical Centre from August 2022 to August 2024. The study aimed to determine testing indications, review interfering medications, and assess test

outcomes using data extracted from the laboratory and hospital information systems (LIS and HIS).

RESULT

Out of 882 ARR cases, 428 were reviewed. Excluded cases included those with patients aged over 70 or under 16, tests taken outside UMMC, incomplete data, and patients who chose follow-up elsewhere or underwent 4-hour post-saline suppression tests. The cohort consisted of 47.4% females (203) and 52.6% males (225). Confirmed primary aldosteronism (PA) was identified in 13.1% of ARR cases on two antihypertensives, 9.6% on three, and 10.5% on four or more antihypertensives, compared to 0.9% in those not on treatment. PA was also more frequent among those with adrenal incidentalomas (10.1% vs. 4.3%) and those with hypokalemia (20.0% vs. 1.5%). A total of 333 ARR tests were performed in patients taking concomitant medications known to interfere with ARR results. Additionally, 113 ARR tests (26.4%) were performed without concomitant potassium measurements, among which 4 cases with confirmed PA were identified. While ARR testing is recommended to be performed in the morning, this protocol was not consistently followed in our cohort. Of the 428 ARR tests conducted, 24 (5.6%) were confirmed to have primary aldosteronism (PA).

CONCLUSION

Our findings highlight the variability in ARR testing practices, particularly regarding the timing of tests and the influence of interfering medications. The results underscore the importance of adhering to clinical guidelines to optimize the diagnostic accuracy of ARR testing for primary aldosteronism.

EP_A214

FINDINGS OF GLYCAEMIC CONTROL AND OTHER PARAMETERS AFTER INSULIN DEINTENSIFICATION EXERCISE AMID INSULIN SUPPLY INADEQUACY IN A TERTIARY CARE CENTRE

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INTRODUCTION

Our country has recently experienced a period of human insulin supply challenges which prompted different centres all over the country to come up with plans to reduce insulin usage while avoiding diabetes management failure. An assessment after adhering to this plan is necessary to decide the efficacy and safety of such actions.

METHODOLOGY

We reviewed the records of patients with Type 2 Diabetes Mellitus managed under the diabetes clinic Hospital Tengku Ampuan Afzan, Kuantan from July 2024 to November 2024. These patients underwent insulin deintensification based on the Pahang insulin deintensification guideline 2024. Their weight, fasting blood sugar (FBS), HbA1c and total daily insulin dose were recorded at baseline and subsequent follow-up. Data were compared and analysed using Microsoft Excel 2024 and IBM SPSS Statistics Data Editor Version 23.

RESULT

Nine patients were included. They had a median diabetes duration of 12 (1-21) years. Mean HbA1c was 9.6 (±2.6)% and median total daily insulin dose (TDD) was 28 (10-86) units. After a median follow-up duration of 4 (3-9) months, there was an improvement in mean HbA1c to 8.6 (±1.6) % while TDD dropped by 42.8%. There was no improvement in FBS. Patients' weight also dropped by 4%. None of the patients were admitted for diabetic ketoacidosis but two of them had episodes of mild hypoglycaemia after initiation of sulphonylureas.

CONCLUSION

While insulin remains the most potent treatment in resolving hyperglycaemia in Type 2 DM, in some patients, there is always a risk of over-insulinisation which may sometimes impair their supply. Despite being limited due to small sample size and short duration of follow-up, these findings provide a glimpse into the potential benefits in glycaemic control by optimising use of oral glucose lowering drugs subsequently reducing the reliance on insulin. However, cautious use of sulphonylurea is vital as some patients may still have normal insulin reserves.