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Fasting hypoglycaemia due to insulinoma in pregnancy

Sir,

Insulinomas are rare and even more so in pregnancy. We present one such case in an African woman.

A 30 year old school teacher presented with irrational behaviour for 6 months and drowsiness and automatism for 3 days. She had been on treatment for generalized epilepsy for 6 months. She was normotensive with a gravid uterus (16 weeks size) and only a trace of albuminuria; the uterine findings were consistent with her dates and confirmed by ultrasound. On admission, the seizures persisted and appeared more frequent on fasting. During an attack, a low blood glucose value (0.7 mmol/l) was observed – a pattern repeated on subsequent occasions with fasting and random values in the range < 0.3–3.7 mmol/l, corresponding once with an elevated fasting plasma insulin level of 26.5 mU/l (normal 5–15), and usually responding to intravenous glucose. A diagnosis of insulinoma in pregnancy was therefore made. Treatment consisted of continuous 5% and bolus 50% glucose infusions and frequent meals (3–4 hourly). Definitive surgery was not attempted because of the patient's poor physical state. Six weeks into her admission, she spontaneously aborted a fresh stillbirth but died 2 weeks later. At autopsy, there was a grey-white nodule (5 mm diameter) in the body of the pancreas consistent with an insulinoma.

This presentation with a seizure disorder is usual in insulinomas¹ and may result in a mistaken diagnosis of epilepsy. The rapid downhill course in our patient was probably related to the increased demands of pregnancy. Hyperinsulinaemia despite hypoglycaemia and seizures responding to glucose intake verified Whipple's triad and an amended insulin/glucose ratio² of > 2000 µU/mg confirmed insulinoma. We allowed pregnancy to advance with specialist obstetric supervision and serial ultrasound assessment of fetal growth since insulinoma should normally not be an indication for induced abortion especially as babies born to such mothers suffer no deleterious effects as long as corrective partial pancreatectomy is undertaken during the first trimester of pregnancy.³ The latter option was not available to us because our patient was in a poor physical state and hence a poor anaesthetic risk.

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Intestinal ischaemia associated with phaeochromocytoma

Sir,

We were interested to read the case report of Carr *et al.*¹ of intestinal ischaemia in phaeochromocytoma. We have recently seen a patient with malignant phaeochromocytoma who presented with dissecting aortic aneurysm and a distended abdomen, with no bowel sounds and absolute constipation. She was too ill to contemplate surgery and was therefore managed with increased doses of oral phenoxybenzamine and propranolol to control blood pressure and pulse rate. She remained uncomfortable and distended for several days despite large doses of oral sennosides, lactulose and enemas. Abdominal X-ray showed massive large bowel distention with gas and faecal loading in the right hemicolon. With passage of a flatus tube and large doses of docusate sodium, lactulose and sennosides the abdomen became less distended and subsequently normal bowel action returned.

Pseudo-obstruction has been described in phaeochromocytoma^{2,3} and intravenous phentolamine has been found to be effective in reversing the alpha-mediated impairment of acetylcholine release from nerve terminals in the gut.⁴ Although small bowel ischaemia can occur in phaeochromocytoma the possibility of pseudo-obstruction needs to be considered before embarking on surgery.

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