



SfE BES 2023

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Submission ID

504

Title (required)

Ketoacidosis with hyperglycemia but not DKA

Abstract (required)

We present an interesting case of a 50-year-old woman with previous history of alcohol dependence, depression & oesophagitis who was brought to the emergency department by ambulance with vomiting, back pain and feeling generally unwell. Her GCS was 14/15, HR128/min, RR 32/min, BP 111/60, temperature 35.2 & CBG 11.2mmol. She reported consuming one bottle of Vodka every day. Initial venous blood gas analysis showed severe metabolic acidosis (pH 6.79, HCO₃ 3, Lactate 15, Ketone 5.7)

Urgent blood tests showed various biochemical abnormalities. The highlights of the results were severe metabolic acidosis with high osmolar gap and anion gap. The calculated serum Osmolality was 297mmol/mol & measured serum osmolality was 368 (osmolar gap 71). The anion gap was 54 which could not be completely explained by the significantly high Lactate & Ketones alone. An initial diagnosis of alcoholic ketoacidosis was made & she was treated with IV Saline & IV Dextrose after giving IV Pabrinex. She was pre-emptively started on IV Fomepizole while awaiting results of the toxicology screen.

Interestingly the capillary and serum Glucose level and ketones steeply rose after starting IV Dextrose (administration of IV Dextrose is part of standard treatment of alcoholic ketoacidosis). Patient was started on fixed rate IV Insulin infusion which led to resolution of hyperglycaemia and ketosis over the course of the next 24-36 hours. Interestingly HbA1c, Fructosamine & serial fasting plasma glucose levels were normal during the course of the long hospital admission. This meant that the hyperglycaemia during early admission was of recent onset. The initial worsening of hyperglycaemia & ketonemia with IV Dextrose infusion (which in retrospect, was not due to diabetes) was not completely understood and thought to be because of 'transient beta cell dysfunction' secondary to the severe metabolic derangement.

Imperial College London Diabetes Centre, Al Ain, UAE
University Hospitals Bristol and Weston NHS Foundation Trust, Weston-Super-Mare, United Kingdom

Gender: Male

Rahat Tauni rahat.tauni@yahoo.co.uk

West Hertfordshire Teaching Hospitals, Watford, United Kingdom

Gender: Male

Huma Humayun Khan huma.hkhan@gmail.com

Oxford Health NHS Foundation Trust, Oxford, United Kingdom

Gender: Female

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Presenting Author Email Address (required)

irfankmc@yahoo.com

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