Severe paraneoplastic hypoglycemia secondary to a gastrointestinal stromal tumour masquerading as a stroke

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Summary

We report the case of a 70-year-old previously healthy female who presented acutely to the Accident and Emergency department with left-sided vasomotor symptoms including reduced muscle tone, weakness upon walking and slurred speech. Physical examination confirmed hemiparesis with VIIth nerve palsy and profound hepatomegaly. A random glucose was low at 1.7 mmol/l, which upon correction resolved her symptoms. In hindsight, the patient recalled having had similar episodes periodically over the past 3 months to which she did not give much attention. While hospitalized, she continued having episodes of symptomatic hypoglycaemia during most nights, requiring treatment with i.v. dextrose and/or glucagon. Blood tests including insulin and C-peptide were invariably suppressed, in correlation with low glucose. A Synacthen stimulation test was normal (Cort (0') 390 nmol/l, Cort (30') 773 nmol/l). A computed tomography scan showed multiple lobulated masses in the abdomen, liver and pelvis. An ultrasound guided biopsy of one of the pelvic masses was performed. Immunohistochemistry supported the diagnosis of a gastrointestinal stromal tumour (GIST) positive for CD34 and CD117. A diagnosis of a non islet cell tumour hypoglycaemia (NICTH) secondary to an IGF2 secreting GIST was confirmed with further biochemical investigations (IGF2 = 96.5 nmol/l; IGF2:IGF1 ratio 18.9, ULN < 10). Treatment with growth hormone resolved the patient’s hypoglycaemic symptoms and subsequent targeted therapy with Imatinib was successful in controlling disease progression over an 8-year observation period.

Learning points:

- NICTH can be a rare complication of GISTs that may manifest with severe hypoglycaemia and neuroglucopenic symptoms.
- NICTH can masquerade as other pathologies thus causing diagnostic confusion.
- Histological confirmation of GIST induced NICTH and exclusion of other conditions causing hypoglycaemia is essential.
- Mutational analysis of GISTs should be carried out in all cases as it guides treatment decision.
- Tailored management of hypoglycaemia, in this case using growth hormone and targeted cyto-reductive therapy, minimizes the risk of possible life-threatening complications.
Background

Gastrointestinal stromal tumours (GISTs) are defined as morphologically spindle cell, epithelioid, or occasionally pleomorphic mesenchymal tumours of the gastrointestinal tract. In Caucasian populations, their annual incidence is 10–15 cases per million and they are evenly distributed between genders. GIST usually express receptor tyrosine kinase KIT protein and harbour mutation of a gene that encodes for a type III receptor tyrosine kinase (either KIT or platelet-derived growth factor receptor A (PDGFRA)). Approximately 80% of GISTs harbour KIT and 5% PDGFRA mutations and ~90% are CD-117 positive. The ligand for the receptor is a stem-cell factor, which is essential for development and proliferation of a variety of cell types.

GISTs often grow asymptptomatically until they are discovered due to the appearance of signs and symptoms related to mass pressure effects, bleeding or bowel perforation. Tumour related hypoglycaemia is rare and most frequently occurs in insulinomas but can also occasionally occur in non-islet cell tumours. Non islet cell tumour hypoglycaemia (NICTH) is observed in some epithelial and mesenchymal tumours and rarely also in GISTs.

NICTH is characterised by recurrent fasting hypoglycaemia and associated with the secretion of incompletely processed precursors of insulin-like growth factor (IGF) 2 by the tumour into the circulation. These precursors consist mainly of mature IGF2 with a 21-residue carboxyl extension of the E-domain of pro-IGF2 called pro-IGF2E or ‘big’-IGF2 (1).

In this report, we present a rare case of severe NICTH due to overproduction of Insulin Growth Factor 2 (IGF2) secondary to a GIST. The importance of our case is that it raises awareness among healthcare professionals of NICTH secondary to a GIST. The importance of our case is that it due to overproduction of Insulin Growth Factor 2 (IGF2) as a rare complication of ectopic overproduction of IGF2 in patients with GISTs. This case points out challenges associated with its diagnosis and the importance of symptom control and prompt disease control with either surgery, targeted therapy or combined treatment based on staging.

Case presentation

In July 2007, a 70-year-old Caucasian retired female presented to the accident and emergency department with headache and left-sided vasomotor symptoms including reduced muscle tone, weakness and slurring of speech upon walking. Further discussion revealed that she had been suffering from similar symptoms of varying severity over the past year but that for 3 months the symptoms had been increasing in frequency and severity. She thought they were migraines and treated them unsuccessfully with paracetamol.

She had no significant previous medical history, was on no medication at the time of presentation and did not report any known allergies. Physical examination of the neurological system confirmed left hemiparesis with paresthesia and VIIth cranial nerve palsy with unilateral facial weakness and ptosis which rose initial suspicions of underlying vascular central nervous system (CNS) pathology. Abdominal examination revealed a heterogenous, hard and enlarged but painless liver. Observations included BP: 155/85 mmHg, HR: 115 bpm, T: 36.8 °C and RR: 19/min. There were no other significant findings on examination.

Investigation

Initial A&E assessment, revealed a low non-fasting venous glucose concentration of 1.7 mmol/l (30.1 mg/dl) whilst further routine biochemistry markers were normal.

Previous blood glucose levels as performed by the patient’s GP a few months earlier were unremarkable (FBG: 4.7 mmol/l – 09/2006). The patient was not overweight (BMI: 23 kg/m2) There was no family history of impaired glucose control. The patient was admitted for symptom control and further diagnostics.

During her inpatient stay, she developed frequent hypoglycaemias especially at night that required treatment with i.v. administration of dextrose and/or glucagon. Further endocrine investigations (Table 1) for insulin, C-peptide and baseline cortisol (532 mmol/l) were requested and a Synacthen test was performed which

| Investigations          | Patient’s serum | Reference range   |
|------------------------|-----------------|-------------------|
| Glucose                | 1.7 mmol/l      | 4.0–5.9 mmol/l    |
| Insulin                | <10 pmol/l      | <174 pmol/l (fasting) |
| C-peptide              | 99 pmol/l       | 170–900 pmol/l (fasting) |
| Cortisol               | 532 mmol/l      | 190–720 mmol/l (0900 h) |
| Chlorpropamide         | 0 µg/ml         | 0 µg/ml           |
| Tolazamide             | 0 µg/ml         | 0 µg/ml           |
| Tolbutamine            | 0 µg/ml         | 0 µg/ml           |
| Acetohexamide          | 0 µg/ml         | 0 µg/ml           |
| Glipizide              | 0 µg/ml         | 0 µg/ml           |
| Gliclazide             | 0 µg/ml         | 0 µg/ml           |
| IGFl                   | 5.1 nmol/l      | 6–36 nmol/l       |
| IGF2                   | 96.5 nmol/l     |                   |
| IGF2/1 ratio           | 18.9            | <10               |
| Betahydroxybutyrate    | 330 µmol/l      |                   |

Table 1 Initial evaluation for sources of hypoglycemia.
excluded longer-term onset adrenal insufficiency (serum cort (0') 390 nmol/l, (30') 773 nmol/l).

A dual phase contrast enhanced CT scan revealed multiple lobulated masses in the abdomen and pelvis. The two largest lobulated masses were located in the pelvis, measuring 14×8 cm in the axial plane, extending into the lower abdomen; and another in the suprapubic region measuring 9×11 cm. Each of these pelvic masses showed uneven enhancement, with areas of low density, either cystic or necrotic. There was another large, lobulated omental mass with similar characteristics, and multiple peritoneal and mesenteric masses of varying sizes. In addition, there were multiple poorly defined low density lesions scattered throughout the liver in keeping with secondary deposits (Fig. 1A and B).

An ultrasound guided biopsy of the largest pelvic mass (14×8 cm) was performed. Histological analysis confirmed the diagnosis of a GIST, strongly positive for proto-oncogene c-KIT CD117 and CD34 (Fig. 2A and B). Disease extent based on TNM staging was pT4N1M1 G3 (Stage IV). Based on international and national guidelines

Figure 1
Dual phase, contrast enhanced abdominal (A) and liver (B) CT scans pre-imatinib mesylate treatment. Marked with arrows is the impressive long term disease response (27/07/2007).

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(2), tissue samples were sent for mutational analysis of KIT and PDGFR variations.

The diagnosis of an NICTH secondary to an IGF2 secreting GIST was further confirmed biochemically (IGF2 96.5 nmol/l; IGF2:IGF1 ratio 18.9 (reference ratio <10)). Insulin and C Peptide levels were invariably suppressed in correlation with the profound hypoglycaemia at the time of analysis.

**Treatment**

Prior to availability of the histopathology results, treatment with diazoxide (5 mg/kg per day given 8 hourly) was provided for 5 days but failed to control her hypoglycaemic episodes as can be anticipated in subsequently confirmed NICTH, given that NICTH related hypoglycemia is not responsive to K-ATP channel activity (3).

Prednisolone 20 mg once daily in the morning was started 7 days after initial presentation and adequately controlled her symptoms allowing weaning from i.v. glucose (4) (5). To minimise steroid induced side effects, treatment with recombinant human growth hormone was added (4) (5) (6), which allowed tapering down the dose of prednisolone.

Further treatment options for GISTS include surgery or targeted cyto-reductive therapy with highly specific Imatinib mesylate, especially in the adjuvant setting and metastatic disease with focus on tumour burden reduction.

Mutational analyses indicated the presence of the common KIT exon 11 mutation. At this point, following MDT discussion targeted therapy with selective anti-PDGFRα and anti-KIT tyrosine kinase inhibitor (TKI) Imatinib mesylate was deemed as the most suitable treatment option due to the extensive disease. Treatment with the lowest 400 mg/day Imatinib mesylate dose was initiated based on the results of the mutational analysis and existing guidelines for the common KIT exon 11 mutation response to Imatinib mesylate.

**Outcome and follow-up**

Treatment with Imatinib mesylate caused rapid neuroglycopenic symptom control and allowed for further tapering of the steroid dose until discontinuation in August 2007. Therapy with human recombinant growth hormone was also discontinued as the patient stopped having hypoglycaemias within weeks after first receiving Imatinib mesylate.

Figure 3

Dual phase, contrast enhanced abdominal (A) and liver (B) CT scans post-imatinib mesylate treatment. Marked with arrows is the impressive long term disease response (15/02/2015).

Tumour burden was dramatically reduced and long term partial response was achieved (>30% tumour load shrinkage) without any signs of tumour dedifferentiation or development of gradual resistance to therapy even after 8 years following the diagnosis (Fig. 3A and B).

The patient today aged 78 years old still continues to do well on the preceding treatment and at present does not experience any hypoglycaemic episodes or related symptoms. Nevertheless, she still continues to monitor her glucose levels and has IM glucagon and support in the case of an emergency.

**Discussion**

The incidence of NICTH ranges from 2.1 to 15 per million people and is evenly distributed between genders (7) (8).
Hormone represents an alternative palliative strategy for normal 
through normal K-ATP channels. Steroids and growth 
oxide is often tried but is usually ineffective as its effect is 
various pharmacological treatments are available. Diaz-
dis 400 mg/day. 
standard dose in the most common KIT exon 11 mutation 
with KIT exon 9 mutations (800 mg/day) whereas the 
Imatinib mesylate and allows dose adjustment for patients 
less sensitive or resistant genotypes (PDGFR D842V) who 
ing the source of IGF2 excess ectopic production. 
tumour if amenable to surgical resection, thereby target-
ing glucose metabolism may contribute in explaining hypoglycaemia in GISTs (12). 
Optimal management of NICHT includes hypoglycaemia symptom control, surgical removal of the primary tumour if amenable to surgical resection, thereby targeting 
the source of IGF2 excess ectopic production. However, in extensively disseminated disease, as was the case of our patient, targeted medical treatment appears to be an effective alternative option for the treatment of GIST induced NICHT. 
Mutational analysis in GIST is crucial as it identifies 
less sensitive or resistant genotypes (PDGFR D842V) who may not benefit from therapy with the selective TKI Imitabin mesylate and allows dose adjustment for patients with KIT exon 9 mutations (800 mg/day) whereas the standard dose in the most common KIT exon 11 mutation is 400 mg/day. 
For the treatment of severe hypoglycaemic episodes, various pharmacological treatments are available. Diazoxide is often tried but is usually ineffective as its effect is through normal K-ATP channels. Steroids and growth hormone represent an alternative palliative strategy for short-term management of symptomatic hypoglycaemia. 

Treatment with Imatinib appears to be another effective option but is expensive and not always successful at managing symptoms of hypoglycaemia. Surgical resection remains the most rapid and cost-effective therapy to normalize glucose metabolism in most cases of NICHT and should be the preferable option when indicated. 

Declaration of interest 
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported. 

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Patient consent 
We confirm that a written informed consent has been obtained from the patient for publication of the submitted article and accompanying images. 

Author contribution statement 
All co-authors listed contributed substantially to the preparation of this manuscript. Permission to publish this case was given by Dr N Murthy who was the attending physician of the patient. 

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