Results: Nov. 2009-2010, in the hospital's department of internal medicine, we provided 3 training sessions (15 lessons), followed by a coaching period, to 78 interns. Quantitative evaluation: 85 patients (56.4% M), average age 72.7±9.6 years, blood sugar a D3 in the target (4-8.5 mmol/l) 44.6%, average blood sugar 8.5±1.8 mmol/l, hypoglycemias 0.9%, average length of stay 9.7±5.4j. Qualitative evaluation: choice of the relevant therapeutic plan in the majority of cases, about 90% of the interns have integrated the elements of balance of insulin therapy, consider that this formation had a positive impact on their management, are more confident in their capability and have a better feeling of self-efficiency. The chosen pedagogical methods facilitated the transfer of competences and the global satisfaction level reaches 90%.

Conclusion: The development of the medical staff training program, based on the reflexive and participative approach, with the introduction of a new insulin therapy protocol, allows a significant improvement of hyperglycemia's management. Our project is part of a global approach aiming at giving the beneficiaries a systemic vision of diabetes.

P315

An unusual case of Kwashiorkor in an adult 25-year-old pancreoprivic diabetic swiss woman
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Malnutrition, comprising protein-energy malnutrition and micronutrient deficiencies, is well known to be a major health burden in developing countries. Here, we report a rare case of a 25-year-old pancreatoprivic insulin-dependent diabetic Swiss woman with Kwashiorkor who was hemipancreatectomized as a neonate due to nesidioblastosis, and refused to inject insulin for a period of over the five most recent years. When administered to the hospital because of a bowel volvulus, that was surgically treated, the patient rejected further medical treatment. Within three weeks after operation the patient developed massive anasarca and diarrhea and returned to our department. Clinical, laboratory and further diagnostic examinations revealed a severe case of Kwashiorkor with hypoproteinemic edema, anaemia, diminished coagulation, fatty degeneration of the liver, myocardial insufficiency, atrophy and oedematos swelling of the small bowel's mucosa, chronic hypovolemia, muscular dystrophy, increased susceptibility for infections, delayed wound healing, and for the first time seizures.

We successfully treated an urosepsis that was initially observed and implemented a careful rehydration with supply of electrolytes and micronutrients, and corrected the blood glucose level. In addition, we furnished a diet according to the WHO guidelines of severe malnutrition. Under this therapy regimen the patient recovered substantially but refused again further medical treatment and left the hospital against all medical advices.

We review the pathophysiology of kwashiorkor and present a severe case of kwashiorkor in a developed country. This case strengthens the importance of insulin therapy and pancreatic enzymes for the development of kwashiorkor.

P316

Addison's crisis caused by bilateral adrenal haemorrhage
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Introduction: In the majority of cases Addison's crisis occurs in pre-existing primary adrenal insufficiency (Addison's disease). However, bilateral adrenal hemorrhage with subsequent bilateral adrenal necrosis can lead to Addison's crisis without pre-existing adrenal disease. Major risk factors are anticoagulant/heparin therapy, coagulopathy or hypercoagulable states, thromboembolic disease, physical trauma and gram-negative septicemia (Waterhouse-Friderichsen syndrome). Even cases of idiopathic adrenal hemorrhage have been reported.

Methods: Case report

Results: A 61-year-old female patient presented with acute generalized abdominal pain, fever (38.8°C), hypotension and tachycardia (85/60 mmHg, 110 bpm) without septicemia. Myelodysplastic syndrome with moderate thrombocytopenia (80 G/l) was diagnosed 3 weeks earlier (without specific therapy). International normalized Ratio (INR) and activated partial thromboplastin time were normal, no electrolyte dysbalance was documented. Contrast-enhanced computed tomography and magnetic resonance imaging findings were indicative of adrenal hemorrhage without evidence for a space-occupying lesion. Treatment with high-dose intravenous hydrocortisone (Solucortef® 100 mg bolus,