

The Reply

We thank Fritzsche et al for their comments and report of an intriguing rare subset of a rare tumor; however, their final conclusion may not be quite accurate.

Hypoglycemia in an adult patient without diabetes mellitus is an uncommon occurrence.

Elderly medical inpatients are an exception, because in this group hypoglycemia is associated most strongly with sepsis or critical illness, may occur in up to 5.2% of patients, and was identified as an independent predictor of mortality.^{1,2}

Only 71 hypoglycemic episodes were identified in a retrospective study of 37,898 new admissions (0.19%) and the major causes were end-stage kidney or liver disease, sepsis and alcohol,³ although comorbidities were common.

When other potential etiologies which are not rare (such as drugs, postprandial, or after gastric bypass surgery) also are considered, the statement “hypoglycemia in nondiabetic patients should raise the suspicion of a rare cause such as solitary fibrous tumors of the pleura” needs rephrasing.

More so, because several important characteristics are common to non-islet cell tumors associated with hypoglycemia.

First, mostly they are of mesenchymal origin (mesothelioma, solitary fibrous tumors of the pleura, sarcomas,

etc) although a few cases of carcinomas and hematological malignancies have been reported.

Second, the mechanism is the production of incompletely processed insulin-like growth factor-2 or “big”-IGF-2 by the tumor cells causing severe hypoglycemia with suppressed insulin and C-peptide levels; and finally, the tumors are generally large and clinically obvious when hypoglycemia occurs.⁴ Thus, a hypoglycemic episode in a nondiabetic patient has several potential and more common causes before a hitherto unsuspected tumor such as the Doeg-Potter syndrome can be considered.

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