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## A Case Presentation: Sleeve Gastrectomy with Transit Bipartition as a Treatment of Type 2 Diabetes Mellitus Applied for the First Time to a Bulgarian Citizen

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Sleeve gastrectomy (SG) with transit bipartition (TB) was applied to a Bulgarian patient for the first time and no other case presentation was found in the literature using this treatment method in Bulgaria. Our aim is to introduce and disseminate this procedure in our country for the treatment of patients with type 2 diabetes mellitus (T2DM).

A 40-year-old gentlemen, height 176 cm, weight 115 kg (BMI: 37.2 kg/m$^2$), presented with a 3-year history of T2DM. His grandmother has T2DM. First, he was admitted in a hospital in Sofia. His Hba1C level was 9.31 % and blood glucose was 16 mmol/L. He was on treatment with metformin 850 mg morning and evening 2 times daily. Patient complaints were polyuria, polyphagia, weakness, and headache. He was informed about metabolic surgery and he referred to the clinic in Istanbul willingly to have a surgical operation.

In May 2016, he underwent laparoscopic SG with TB in İstanbul. The patient recovery was successful, and 16 kg weight loss was observed in 4 months. Hba1C value was observed in normal range -6 %. He is not on any drug treatment for his T2DM.

Surgical treatment options for diabetes mellitus are available nowadays to treat patients with obesity. The ABCD score, which comprise age, BMI, C-peptide level, and duration of T2DM (years) was reported as useful in predicting the success of T2DM treatment using metabolic surgery. SG with TB operations are getting more popular, but in our country, this is the first case of a patient treated with SG + TB.SG + TB is a simple procedure that results in rapid weight loss and remission or major improvement of comorbidities. As a conclusion of this case report, TB is an excellent complement to SG.

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## Incidentally Detected Monogenic Diabetes Case

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We present our case to emphasize that monogenic diabetes should be considered in young patients having positive family history and whom diabetes could not be classified.

A 25-year-old female was referred to our clinic due to elevated blood glucose. The patient had no symptoms of hyperglycemia. She had no chronic illness and did not take any medication. Her 55-year-old mother has been followed for uncomplicated diabetes for 16 years with oral antidiabetics, and her 75-year-old grandmother had uncomplicated diabetes for 30 years treated with basal insulin. On physical examination, vital signs were stable, height 168 cm, body weight 70 kg, BMI 24.8 kg/m$^2$. Systemic examination was normal, and no findings of insulin resistance were present.

Laboratory findings revealed that fasting plasma glucose (FPG) was 140 mg/dL, postprandial plasma glucose 178 mg/dL, and HbA1C 7.2 %. Blood count and biochemical parameters were normal. Fasting C-peptide was 2.32 ng/mL, urine ketone negative, anti-GAD, ICA, and anti-insulin antibodies were negative. We recommended life-style modifications and metformin treatment. Then, considering the patient age, family history of diabetes, absence of insulin resistance, negative autoantibodies, and normal body mass index, we performed genetic analysis for maturity-onset diabetes of the young (MODY). Heterozygous mutation of p.R191W (c.571C > T) was detected in glucokinase gene, and diagnosis of MODY type 2 was confirmed. She was followed with life-style modifications without metformin. FPG and glucose tolerance test results of siblings of the patient were normal. Genetic screening was recommended for the family.

It may be difficult to determine the type of diabetes in young patients. In suspected cases, genetic analysis may help to establish the definite diagnosis of MODY.

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## A Rare Cause of Insulin-Dependent Diabetes: Two Siblings with Walcott-Rallison Syndrome

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Wolcott-Rallison syndrome (WRS) is a rare autosomal recessive disorder characterized by neonatal or early infancy onset insulin-dependent diabetes and epiphyseal dysplasia. Other frequent multisystem manifestations include recurrent hepatitis, renal dysfunction, failure to thrive, developmental delay, neutropenia, and hypothyroidism. Herein, we reported two siblings with WRS.

**Case 1:** A 14-month-old male infant was brought to the hospital for feeding difficulty and vomiting and was diagnosed as diabetic ketoacidosis. He developed liver and renal failure after admission and was managed appropriately. Later on, physical examination showed growth failure and skeletal abnormalities, as well as dysmorphic features. Because of accompanying diabetes and skeletal abnormalities, WRS was suspected and the diagnosis was confirmed by genetic analysis which revealed a homozygous