CASE
A 37-year-old male with type 2 diabetes mellitus, hypertension, dyslipidemia, and morbid obesity (body mass index 60 kg/m²) was referred for bariatric surgery. Preoperatively, he was initiated on subcutaneous semaglutide 1 mg weekly for weight optimization, resulting in weight loss from 178 to 127 kg. His hemoglobin A1c was 9.5%. He subsequently underwent laparoscopic proximal jejunal bypass sleeve gastrectomy on 5 November 2025.

Two weeks postoperatively, he reported lethargy and was clinically found to be dehydrated, following poor tolerance of nourishing fluids and inadequate caloric intake. Capillary blood glucose was 7.6 mmol/L. Investigations revealed metabolic acidosis with markedly elevated serum ketones (4.9 mmol/L), consistent with ketoacidosis. He was commenced on an intravenous insulin infusion and aggressive IV fluid resuscitation. Attempts to discontinue insulin infusion resulted in recurrent ketoacidosis, attributed to poor tolerance of nourishing fluids. Following multidisciplinary input involving endocrinologists, a diabetes educator, and a dietitian, he was able to tolerate enteral nutritional supplementation. Insulin infusion was successfully discontinued, and he was discharged on a basal bolus subcutaneous insulin regimen.

CONCLUSION
Ketoacidosis following bariatric surgery is an underrecognized complication and may occur even in patients with type 2 diabetes mellitus and relatively normal blood glucose levels. Contributing factors included prolonged caloric deprivation, rapid weight loss, post-surgical catabolic state, and relative insulin deficiency. Recently used glucagon-like peptide-1 receptor agonist may have further suppressed appetite, compounding postoperative nutritional intolerance. The involvement of a multidisciplinary team, including endocrinologists, a dietician, diabetic educators, and surgical teams, is essential to optimize outcomes and prevent severe complications.

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STARVATION KETOACIDOSIS SECONDARY TO RETATRUTIDE-INDUCED GASTROPARESIS: A CASE REPORT

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INTRODUCTION
Retatrutide is an investigational triple agonist targeting glucagon-like peptide-1, glucose-dependent insulinotropic polypeptide, and glucagon receptors. Early clinical trials have demonstrated promising weight loss effects. Gastrointestinal side effects are common and dose-dependent; however, severe complications such as gastroparesis leading to starvation ketoacidosis are rarely reported. Increasing public interest in emerging anti-obesity pharmacotherapies has led to unsupervised access to investigational medications through unregulated channels. We report a case of starvation ketoacidosis associated with retatrutide-induced gastroparesis following unsupervised use of medication obtained from unregulated sources.

CASE
A 39-year-old female healthcare worker with prediabetes (hemoglobin A1c 5.7%), class I obesity (body mass index 31.2 kg/m²), and endometriosis presented with persistent vomiting and diarrhea. She reported using retatrutide for weight loss, initially obtained from an informal source, although the authenticity and origin of the medication could not be verified. She self-titrated retatrutide over 7 weeks, escalating from 1 mg twice weekly to 6 mg weekly, with only mild nausea. Subsequently, she purchased the medication from another unverified online source. Following this change, she developed worsening nausea at the 6 mg weekly dose, prompting a dose reduction to 5 mg weekly. Two days after the most recent dose, she developed intractable vomiting and diarrhea. On presentation, she was clinically dehydrated. Venous blood gas revealed metabolic acidosis (pH 7.33, bicarbonate 18.8 mmol/L) with elevated serum ketones (4.5 mmol/L) and normal lactate (1.2 mmol/L). Blood glucose was 4.5 mmol/L, and serum amylase was normal. She was treated with intravenous fluids, fixed-rate insulin infusion, and antiemetics. Ketoacidosis resolved by day 3, with improvement of gastrointestinal symptoms by day 5.

CONCLUSION
This case highlights a serious complication associated with retatrutide and underscores the risks of unsupervised use of investigational weight-loss therapies obtained from unregulated sources. It also emphasizes pharmacovigilance as emerging antiobesity therapies become widely used. Careful dose titration, close clinical monitoring, and use within regulated medical channels are essential for patient safety.