A dermatologic presentation of pancreatitis

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A 40-year-old adopted obese Caucasian male with a past medical history of type 2 diabetes, hypertension, and seizures presented to an Emergency Department with a one-day history of sharp epigastric pain accompanied by nausea and emesis. Dermatologic examination of his arms (**Figure A**) and legs (**Figure B**) was consistent with widespread cutaneous xanthomas secondary to hypertriglyceridemia. Venous and arterial (**Figure C**) blood samples appearing lipemic were obtained. His lipase level was 1,470 U/L and his triglyceride level was 13,563 mg/dL. CT imaging (**Figures D** and **E**) was consistent with necrotizing pancreatitis. He required admission to the Intensive Care Unit (ICU) for resuscitation, bowel rest, and supportive care. He underwent emergent plasmaphoresis with the goal of triglyceride reduction. (1) Hypertriglyceridemia is the third most common cause of pancreatitis (after alcohol abuse and gallstones) and is usually seen with triglyceride levels greater than 1000 mg/dL. (2) Patients may have a genetic predisposition such as type V hyperlipidemia and/or may have coexisting secondary causes of hypertriglyceridemia such as alcohol abuse, poorly controlled diabetes, obesity or rapid weight gain, hypothyroidism, uremia, nephritic syndrome, or third trimester pregnancy. (2) Management strategies include supportive care, early initiation of lipid lowering agents, tight glycemic control, plasma exchange, plasmaphoresis, and the use of heparin and insulin to stimulate lipoprotein lipase and chylomicron degradation (although data is limited for all of these strategies). (3) The patient's prolonged ICU course was complicated by abdominal compartment syndrome, respiratory failure requiring tracheostomy, renal failure requiring renal replacement therapy (limiting the ability to use fibrates), and a partial pancreatic necrosectomy.

Reference

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Figure A-E