Eruptive xanthoma

(APRIL 2015)

TO THE EDITOR: The article "Eruptive xanthoma" by Drs. Mahmoud Abdelghany and Samuel Massoud[1] described the management of a patient with severe hypertriglyceridemia associated with skin lesions. The authors noted that both metformin and statin doses were increased upon diagnosis. In addition, insulin was initiated.

The Endocrine Society guidelines note that statins have a modest triglyceride-lowering effect, typically about 10% to 15%, and may be useful to modify cardiovascular risk in patients with moderately elevated triglyceride levels.[2] In addition, they recommend fibrates as the first-line therapy for these patients, with the addition of fish oil, statins, or niacin as needed.

During the management of acute hypertriglyceridemia, the enzyme lipoprotein lipase needs to be activated to aid in the breakdown of triglycerides. This can be accomplished with therapies such as insulin,[3] fibrates, and even heparin.[4] In addition, medium-chain triglycerides (such as coconut or palm kernel) are cleared by the portal circulation, so they can be used for cooking in patients predisposed to severe hypertriglyceridemia.

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IN REPLY: In our article, we described a patient who presented with markedly elevated triglyceride and hemoglobin A_{1c}. Hypertriglyceridemia might be secondary to underlying diseases, including uncontrolled diabetes, or to inherited lipid disorders. In the optimal situation, our patient would have benefited most not only from strict control of his triglycerides and diabetes, but also from testing for inherited lipid disorders. Although insulin was initiated, he refused fibrates and genetic counseling, and he refused to be reassessed later. After 1 and 3 months, his clinical and laboratory findings had improved dramatically, deterring us from further intervention.

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Risk of falls

(MAY 2015)

TO THE EDITOR: Regarding the excellent review on reducing the risk of injurious falls in older adults,[1] I would like to inquire whether the authors believe that fall-prone patients might benefit by wearing a bicycle helmet during some or all routine activities. Bicycle helmets are comfortable and lightweight, allow air circulation, and are designed to reduce the severity of head injury sustained in a fall or collision.

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IN REPLY: The query regarding bicycle helmet use as a preventive measure in elderly people at high risk of recurrent falls is interesting. Prior to our article going to press, we reviewed the literature and found no quality studies of helmet use in preventing brain injury at home or in residential facilities. The few studies of helmet use vs no helmet use focused on sports and suggested that the benefit of current helmet design may be more limited than previously thought. Although sports helmets reduce the risk of linear impact causing death, major injury, skull fracture, and (if a facial portion is present) facial injury, there is little protection against injury from rotational forces. Concussion, a form of mild brain injury, does not appear to be reduced by helmet use in sports.[1] Additionally, 77% of soldiers hospitalized with traumatic brain injury were wearing a helmet at the time of injury.[2]

In addition to questioning the effectiveness of helmets in recurrent fallers, one has to consider the ability of a helmet to be fitted properly (for example, the fit will change after a haircut or change in hairstyle), the willingness of the individual to wear it, the ability of the patient or caregiver to attach it, and the impact of wearing a helmet on psychosocial interactions. Helmet use in a recurrent faller would have to be considered an individualized intervention amenable to caregiver and patient but without proven benefit.

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The role of sentinel lymph node biopsy after excision of melanomas

(MAY 2015)

TO THE EDITOR: I enjoyed the dermatology update in the May 2015 issue.[1] I would like to inquire about the clinical management of the patient in case 3, a 58-year-old man with biopsy-proven malignant melanoma surrounded by intense inflammatory infiltrate. The tumor was excised with standard margins, but distal metastases developed 2 years later. The depth of invasion of the primary tumor was not revealed, but could this patient have benefited from sentinel lymph node biopsy immediately after the initial excision?

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IN REPLY: Thank you for your important question. Examination of the excision specimen of the patient's primary cutaneous melanoma lesion demonstrated a Breslow depth of 1.92 mm. He did indeed undergo sentinel lymph node biopsy at the time of excision. Histologic examination of the biopsy specimen was negative for evidence of metastatic melanoma. Despite this, he obviously developed metastatic disease several years later.

As you allude to, sentinel lymph node biopsy is an important minimally invasive procedure in patients with melanoma. Morton et al[1] compared it with nodal observation and found that in patients with at least intermediate-thickness cutaneous melanoma, sentinel node biopsy significantly prolonged disease-free survival for all patients and improved melanoma-specific survival rates for patients with nodal metastases from intermediate-thickness melanomas (1.2–3.5 mm).[1] However, it remains an imperfect procedure, and a

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percentage of patients develop recurrence or metastasis despite a negative biopsy. In a recent study by Jones et al,[2] 16% of melanoma patients in a cohort with a negative sentinel node biopsy developed recurrence.[2] In these unfortunate patients, medications such as CTLA-4 inhibitors and PD-1 inhibitors now offer hope for prolonged survival.

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