# Letters

**THE ARTICLE BY** Zhao and Li titled 'Eruptive xanthoma associated with hypertriglyceridaemia and diabetes' highlights an interesting case of an uncommon cutaneous presentation of severe hypertriglyceridaemia.[1] The authors' view in the article is that histopathology is 'not necessary and may be time consuming'.

Although the diagnosis of cutaneous eruptive xanthoma can be made clinically, biopsy is often performed in clinical practice. The differential diagnosis for this condition includes Langerhans cell histiocytosis, non-Langerhans cell histiocytosis, disseminated granuloma annulare and molluscum contagiosum, which have distinct appearances histologically to differentiate them.[2,3]

A punch biopsy of the skin is a simple and accessible tool that general practitioners (GPs) have at their disposal, which can aid more timely diagnosis and reduce the risk of life-threatening complications from severe hypertriglyceridaemia. Furthermore, most anatomical pathology laboratories in Australia have a reasonable turnaround time of several days to one to two weeks to return results.

Marogi et al[2] highlight the potentially fatal complication of hyperlipidaemic pancreatitis, which can result from delayed diagnosis and management of severe hypertriglyceridaemia. In Australia, wait times to see a dermatologist both in the private and public systems can be significant; therefore, GPs have a role in the diagnosis of this condition if there is clinical suspicion or in the right patient context. This is especially important as eruptive xanthomas are reversible with management of hypertriglyceridaemia.

Once the diagnosis is made, GPs can then recognise and manage the causes of hypertriglyceridaemia as part of a patient's overall preventative health strategy.[3,4]

We therefore would encourage the use of skin biopsy to aid timely provision of care for patients with suspected eruptive xanthoma.

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## Reply

Without doubt, skin biopsy and histopathological examination are useful and important tools in the diagnosis of skin diseases. But the accessibility and costs vary among different countries or regions. For example, in China, general practice medicine is less developed and skin biopsy is not accessible in general health clinics. Also, the results of skin biopsy usually take at least one to two weeks.

Eruptive xanthoma can be confidently diagnosed by dermatologists clinically, based on typical skin lesions. The biopsy is usually made to confirm the clinical diagnosis or help in differential diagnosis in some atypical cases.[1] In general clinical practice, we suggested two key points to make a first suspected diagnosis of eruptive xanthoma. The first is sudden onset of numerous yellow–red papules and associated medical history, such as obesity, alcohol abuse, uncontrolled diabetes mellitus, familial hypertriglyceridaemia, and some medications such as systemic glucocorticoid, retinoids, cyclosporine, and exogenous estrogens.[1,2] Then a serum lipids screening and glucose test can help to make the clinical diagnosis more confidently for dyslipidaemia and diabetes mellitus, which are the most commonly associated systemic metabolic disorders of eruptive xanthoma.[3,4] These laboratory tests are usually convenient and fast. If conditions permit, a skin biopsy is encouraged, but we suggested that there is no need to wait for the pathological results before proceeding with the management of systemic metabolic disorders and being aware of and preventing possible complications. The pathological results of eruptive xanthoma are confirmatory, which are characteristic but not specific to one subtype of xanthoma.[5]

Every medical decision made by clinicians is aimed at providing patients with the most timely and appropriate diagnosis and treatment, and we believe that the best choices are made during clinician consultations.

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