Unmasking of Childhood Hypothyroidism by Disseminated Xanthomas*

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ABSTRACT. Secondary hyperlipidemia is a common laboratory finding in children with nephrotic syndrome, diabetes mellitus, and hypothyroidism. However, clinical signs of hyperlipidemia are extremely rare in childhood.

We report on an 11-year-old girl who presented with a disseminated yellow papulomatous rash on the lower limbs and yellow skin creases on the palms of her hands. Blood tests yielded an opaque serum with a triglyceride concentration of 820 mg/dL and cholesterol of 1050 mg/dL. Skin biopsy of one of the papules confirmed the diagnosis of xanthomas.

Additional examinations revealed clinical (weight gain, diminished growth rate) and biochemical primary hypothyroidism (free T4: 0.4 ng/L [normal 8–22 ng/L]; thyroid-stimulating hormone: >200 mU/L) as a consequence of Hashimoto thyroiditis (thyroid peroxidase and thyroglobulin: 4400 U/mL and >2000 U/mL, respectively; normal <60 U/mL). The patient was started on L-thyroxine, which led to a gradual decline of cholesterol and triglycerides to normal concentrations and a complete remission from the xanthomatous rash.

For the first time, this case depicts disseminated xanthomas of the skin as the presenting complaint of severe hypothyroidism.

CASE REPORT

An 11-year-old girl presented to the pediatric endocrine outpatient department of the University of Erlangen with a disseminated yellow papulomatous rash on her lower limbs and yellow skin creases of the palms of her hands (Fig 1). The rash had been developing gradually over the past 2 years. On presentation, the patient was 137.5 cm tall (standard deviation score [SDS]: –2.4; Fig 2) and had a weight of 37 kg (50th percentile). Body mass index was 19.6 (SDS + 1.8 according to 5). When the patient was 4 years old, her height had been at the 50th percentile (102 cm; diabetes mellitus, and hypothyroidism.1 Particularly in childhood, however, secondary hyperlipidemia is rarely associated with clinical signs or symptoms.4

We present a child with disseminated xanthomas and massively elevated serum lipid concentrations as a consequence of severe hypothyroidism.

ABBREVIATIONS. fT4, free T4; SDS, standard deviation score; TSH, thyroid-stimulating hormone.

With an incidence of 1 in 500, hyperlipidemia is one of the commonest congenital disorders of metabolism.1 Heterozygous type III hyperlipoproteinemia is clinically relevant, as it is frequently associated with the presence of xanthomas in adulthood.2 However, although nonspecific skin lesions may occur in childhood type III hyperbetalipoproteinemia, xanthomas are extremely uncommon.

Apart from inborn hyperlipidemia, secondary causes of elevated serum lipids have to be excluded. These diseases include the nephrotic syndrome,3 diabetes mellitus, and hypothyroidism.1 Particularly in childhood, however, secondary hyperlipidemia is rarely associated with clinical signs or symptoms.4

We present a child with disseminated xanthomas and massively elevated serum lipid concentrations as a consequence of severe hypothyroidism.

Fig 1. Abdominal wall (A) and palm of the hand (B) of an 11-year-old girl with hypothyroidism after Hashimoto thyroiditis and hyperbetalipoproteinemia. The diagnosis of xanthoma was confirmed by skin biopsy.
The patient now had a growth velocity of 9.6 cm per year (97th percentile), and her weight was 35.9 kg (reduced by 1.9 kg in 1 year). The patient’s prospective height had increased from 152 cm to 160 cm according to Bayley and Pinneau. The xanthomas had resolved completely (Fig 3).

In both parents fasting lipid concentration and thyroid function were normal.

**DISCUSSION**

This case illustrates that hypothyroidism in childhood may lead to severe hyperlipidemia with the subsequent emergence of xanthomas. Although hypothyroidism is generally regarded to be one potential cause of hyperlipidemia in childhood, childhood hypothyroidism usually presents with different symptoms and signs, among which deterioration of mental or physical strength, obesity, and a drop in growth rate appear to be the most common.

Oligosymptomatic presentation of hypothyroidism is rare in childhood but tends to become more common in the elderly patient. To our knowledge, xanthoma as the presenting complaint for hypothyroidism in children has not been reported. Even in adulthood, only 1 case of xanthoma tuberosum attributable to hypothyroidism has been published during the last 35 years.

In adulthood, xanthomatous lesions are commonly found in hyperbetalipoproteinemia (type III, according to Fredericksen). However, even in children with severe hyperbetalipoproteinemia, typical lesions usually do not appear before adolescence.

The long period before the lesions occur highlights the rarity of the present case.

There is no indication of a coexisting congenital hyperlipidemia in our patient, as has been previously reported in other patients.

**CONCLUSION**

Cutaneous xanthomas as a consequence of severe hyperlipidemia may be an extremely rare sign of childhood hypothyroidism.

**REFERENCES**


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