**A Clinical Approach to Aggressive Treatment of Children with Severe Hypertriglyceridemia**

**Alejandro De La Torre, MD,** Department of Endocrinology, Cook Children’s Medical Center, Ft. Worth, TX.

**Luke Hamilton, MS,** Department of Endocrinology, Cook Children’s Medical Center, Ft. Worth, TX.

**Don P. Wilson, MD, FNLA,** Department of Endocrinology, Cook Children’s Medical Center, Ft. Worth, TX. don.wilson@cookchildrens.org

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**ABSTRACT**

Severe hypertriglyceridemia (SHTG) is uncommon in children. Those with triglyceride (TG) levels of 1,000 mg/dL or more are likely to have an underlying monogenic or polygenic disorder affecting TG metabolism. SHTG may also occur in youth who are obese and insulin resistant, those with poorly controlled diabetes, or who require medications that interfere with TG metabolism, especially in those with an underlying genetic predisposition. When present, SHTG is associated with an increased risk of acute pancreatitis and, long-term, may contribute to ASCVD-related morbid and premature mortality. In 2011 the NHLBI Expert Panel published recommendations for treatment of hypertriglyceridemia in children. Presently, however, there are no pediatric guidelines to assist clinical decision-making when aggressive therapy of SHTG might be indicated. In this chapter we review the mechanisms associated with SHTG, discuss management, follow-up, and outcomes, and suggest an approach for use of aggressive TG-lowering therapy.

**INTRODUCTION**

Severe hypertriglyceridemia is uncommon in children but is most commonly encountered in youth who are obese and insulin resistant, those who have poorly controlled diabetes, or who require medications that interfere with TG metabolism (Table 1). Although rare, individuals with monogenic disorders have serve elevations of TG, typically 1000 mg/dL or more, while those with polygenic and small-effect genetic variants that contribute to alterations in lipid and lipoprotein metabolism, particularly with secondary causes, are more common (Table 2). Such severe elevations may cause significant morbidity which occasionally may be life-threatening, necessitating aggressive TG lowering.

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| **Table 1. Common Secondary Causes of Dyslipidemia** |
| **Condition** | **Screening Tests** |
| Hypothyroidism Liver Diseases Kidney diseases Diabetes Mellitus Obesity / Insulin Resistance | Free T4, TSHCMPCMP / UACMP / UA / fasting or random glucose / HbA1cCMP / fasting glucose and insulin  |
| Medications | Steroids, retinoids, oral contraceptives, protease inhibitors |

Free T4-free thyroxine; TSH-thyroid-stimulating hormone; UA-urinalysis; CMP-Comprehensive Metabolic Profile; HbA1c-hemoglobin A1c

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| **Table 2. Estimated Prevalence of Severe Hypertriglyceridemia.** **The Copenhagen General Population Study. Modified from (15)** |
| **Subjects: >70,000 Adults****Age: >20 years** | **Polygenic\* and Small-Effect Variants** | **Can be Monogenic\*\*** |
| % Pop | 26% | 46% | 28% | 0.1% |
| TG (mg/dL) | <88 | 88-177 | 177-797 | 797-1329 |
| Severity | <--------- Mild to High --------> | <------------ Severe -----------> |
| Primary Health Risk | Increase in premature CVD | Chylomicronemia, Pancreatitis, CVD Risk Less Likely |
| \*LPL, APOA5, GCKR, APOB, LMF1, GPIHBP1, CREBH1, APOC2, APOE\*\*LPL, APOC2, APOA5, LMF1, GPIHBP1 AND GPD1 |

**PANCREATITIS**

One of the main concerns in individuals with SHTG is the development of acute pancreatitis (AP). When present AP is associated with significant morbidity which can be life-threatening. Although SHTG is a rare cause of AP in children, depending upon etiology it may be recurrent. TG-associated AP typically occurs in individuals with a pre-existing lipid abnormality, such as a monogenic disorder of TG metabolism, in those with one or more secondary risk factors (e.g., poorly controlled diabetes, alcohol use, or use of a medication that can provoke SHTG), or a combination of both. Compared to other causes, SHTG-related AP may contribute to increased severity and mortality, higher frequencies of co-morbidities and systemic complications, longer length of hospitalization and more frequent recurrence (1). In general, it is believed that a TG level of 1,000 mg/dL or more is needed to precipitate an episode of AP.

AP in children has been defined as the presence of at least 2 of the following 3 criteria (2): 1) abdominal pain compatible with pancreatic origin; 2) an amylase and/or lipase level at least 3 times the upper limits of normal (ULN); and 3) imaging suggestive of or compatible with pancreatic inflammation. Not all children with AP have abnormal levels of serum amylase and/or lipase. Furthermore, interference with assays that use colorimetric methods may cause falsely normal results when TG levels are greater than 500 mg/dL. In these circumstances, an estimate of the amylase/lipase levels can be obtained following serial dilutions of the serum. Compared to amylase, serum lipase appears to have higher specificity and sensitivity for AP. To assist in clinical-decision making, Abu-El-Haija published guidelines (3) to help categorize the severity of children with AP (Figure 1). Categorization may be a helpful clinical tool in determining how aggressively to treat SHTG in this setting.



**Figure 1. Algorithm to categorize severity of pediatric acute pancreatitis (AP) and recommended treatment of HTG. Modified from (3).**

**aPresence of at least 2 of the following 3 criteria: 1) abdominal pain compatible with pancreatic origin; 2) amylase and/or lipase at least 3 X ULN; and 3) imaging suggestive of/compatible with pancreatic inflammation. (2)**

**bCriteria of organ dysfunction as per the International Pediatric Sepsis Consensus [Modified from (16).**

**I. Cardiovascular Dysfunction**

**a. One or more of the following despite administration of isotopic IV fluid bolus > 40 mL/kg in 1 hr.**

* **Hypotension - Decrease in BP < 5th% for age or systolic BP < 2 SD below normal for age.**
* **Need for vasoactive drug to maintain BP in normal range (dopamine > 5 mcg/kg-1/mL-1 or dobutamine, epinephrine, or norepinephrine at any dose).**

**b. Two of the following:**

* **Unexplained metabolic acidosis (Base Deficit > 5 mEq/L).**
* **Increased arterial lactate > 2 X ULN.**
* **Oliguria: urine output < 0.5 mL/kg-1/hr-1.**
* **Core to peripheral temperature gap > 3° C.**

**II. Respiratory Dysfunction**

**a. One or more of the following in absence of pre-existing lung disease or cyanotic heart disease.**

* **PaO2/FIO2 < 300 in absence of cyanotic heart disease or pre-existing lung disease.**
* **PaCO2 > 65 torr or 20 mmHg over baseline PaCO2.**
* **Proven need or > 50% FIO2 to maintain saturation > 92%.**
* **Need for non-elective mechanical ventilation.**

**III. Renal Dysfunction**

* **Serum creatinine ≥ 2 X ULN for age; or**
* **2-fold increase in baseline creatinine.**

**TREATMENT OF HYPERTRIGLYCERIDE-RELATED PANCREATITIS**

**Treatment of Acute Pancreatitis**

The clinical course and treatment of SHTG-related AP in children is generally no different from that of pancreatitis of other causes (Table 3). Reduction of TG levels to well below 1,000 mg/dL generally prevents further episodes of pancreatitis.

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| **Table 3. Guidelines for Treatment of Children with Acute Pancreatitis**. Modified from (17). |
| 1. Adequate fluid resuscitation with crystalloid appears key, especially within the first 24 hours.
2. Analgesia may include opioid medications when opioid-sparing measures are inadequate.
3. Pulmonary, cardiovascular, and renal status should be closely monitored, particularly within the first 48 hours.
4. Enteral nutrition should be started as early as tolerated, whether through oral, gastric, or jejunal route.
5. There is little evidence to support the use of prophylactic antibiotics, antioxidants, probiotics, or protease inhibitors.
6. Esophagogastroduodenoscopy, endoscopic retrograde cholangiopancreatography, and endoscopic ultrasonography have limited roles in diagnosis and management.
7. Children should be carefully followed for development of early or late complications and recurrent attacks.
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Once placed NPO, patients with AP generally experience a rapid decline in TG levels, at which time a very low-fat diet can be initiated. In situations where urgent reduction in TG levels is needed, a more aggressive approach may be indicated, including use of intravenous insulin, heparin, or both (4), and TG removal (e.g., plasmapheresis, apheresis) (Table 4). A single session of plasmapheresis has been shown to lower TG levels by up to 70% (5). While apheresis can rapidly lower TG, rigorous proof of efficacy is lacking. Studies comparing technical aspects of apheresis are also limited, such as different apheresis techniques (plasma exchange vs. double-membrane filtration) and proper fluid replacement (fresh frozen plasma vs. albumin). Apheresis is expensive and not widely available. Furthermore, a large retrospective study comparing two groups of adults with HTG before and after the availability of apheresis found no benefit (6). However, the authors suggested the timing of apheresis could be a critical factor, based on other reports showing that maximal reduction in morbidity and mortality can be achieved when apheresis is used as early as possible. Comparable studies in children are not available. Randomized trials have not compared the efficacy of insulin and heparin to apheresis for the treatment of HTGP.

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| **Table 4. More Aggressive Management for Hypertriglyceridemia (18,19,20)** |
| **Method** | **Route** | **Mechanism** |
| Insulin | * Dose: 0.05-0.1/kg/hr by continuous IV infusion.
* Administer concomitant IV dextrose to avoid hypoglycemia.
* Consider use of the “2-bag” system to titrate insulin and dextrose delivery.
 | * Insulin increases lipoprotein lipase (LPL) activity which can degrade chylomicrons and thus reduce serum triglycerides.
* Intravenous insulin may be more effective than subcutaneous insulin in severe cases of HTG.
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| Heparin | * Generally, not recommended as a monotherapy.
 | * Stimulates release of endothelial LPL into circulation.
* However, use of heparin may only result in transient rise in LPL followed by increased degradation of plasma stores causing LPL deficiency.
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| Double membrane filtration or plasma exchange | * Adequate vascular access may be challenging.
* Expensive procedure; not available in all medical centers.
 | * The beneficial effect of plasmapheresis is believed to be due to a rapid decrease in TG levels.
* The effects of heparin, the removal of excessive proteases from the plasma, and replacement of consumed protease-inhibitors with new ones from donor plasma may play an additional beneficial role.
* Use of donor plasma carries risks of transfusion-related allergic reaction or infection.
* Requires transient anti-coagulation.
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Presently there are no pediatric guidelines to assist clinical decision-making when more aggressive therapy might be appropriate. In general, more aggressive TG-lowering should be considered in those who fail to response to conventional treatment and in whom there is evidence of organ dysfunction or failure (Figure 1). In addition to the parameters listed in Figure 1, given the effects of SHTG, alternated sensorium may also be an indication for aggressive TG-lowering. Although plasma exchange for treating TG-related AP was included in the 2007 Guidelines on the Use of Therapeutic Apheresis in Clinical Practice from the Apheresis, the strength of the evidence was assigned to category III (“suggestion of benefit or for which existing evidence is insufficient to establish or clarify the risk/benefit”) (7). Therefore, clinical judgement is needed in deciding when to use of more aggressive HTG-lowering treatment.

**Prevention of Future Episodes of Acute Pancreatitis**

Although lipid lowering drugs, mainly fibric acid derivatives and omega-3-fatty acids, have been shown to effectively lower TG in adults, none are FDA approved for use in children (Table 5). Published guidelines, however, suggest lipid lowering drugs should be considered in children 18 years of age or younger with persistent TG ≥ 500 mg/dL (8, 9).

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| **Table 5. Medications for Primarily Lowering Triglycerides** [Modified from (9). |
| **Medication**  | **Pediatric Dosing** | **Adult Dosing**  | **Side Effects** | **Indication / Comments**  |
| **Fibric Acid Derivatives** |
| Fenofibrate (Many generic preparations available) | Pediatric safety and efficacy not established. Not FDA approved for use in children.  | Product specific. Generally, employ full dose in the setting of normal renal function. | Skin rash, gastrointestinal (nausea, bloating, cramping) myalgia; lowers blood cyclosporine levels; potentially nephrotoxic in cyclosporine treated patients. Avoid in patients with CrCl < 30 mL/min. | Hypertriglyceridemia.Monitor renal function; avoid in the presence of severe renal function. Regular monitoring of liver function test is required. Discontinue if persistent elevation of LFTs > 3X ULN. |
| Gemfibrozil (Lopid) | Pediatric safety and efficacy not established. Not FDA approved for use in children.  | 1200 mg p.o. daily, divided BID, 30 mins before breakfast and dinner. | Potentiates warfarin action. Absorption of gemfibrozil diminished by bile acid sequestrants.  | Hypertriglyceridemia.Use with caution in patients with renal impairment, contraindicated with severe renal impairment; use contraindicated with hepatic impairment. Avoid with concurrent statin therapy. |
| **Nicotinic Acid** |
| Niacin (Multiple preparations available) | Age ≥ 10 Pediatric safety and efficacy not established. Not FDA approved for use in children. If used, suggested dose Initial: 100-250 mg/d (Max: 10 mg/kg/day) divided three times daily with meals  | Slowly titrate to max dose of intermediate release niacin (3 g/day) or slow-release niacin) 2 g/day). | Prostaglandin-mediated cutaneous flushing, headache, warm sensation, and pruritus; dry skin; nausea; vomiting; diarrhea; and myositis. | Adjunct therapy to reduce high TG. For pediatric dosing may titrate weekly by 100 mg/day or every 2 – 3 weeks by 250 mg/day. No dosing adjustment has been provided by the manufacturer for renal or hepatic impairment. Contraindicated in the presence of significant unexplained hepatic dysfunction, active liver disease, or unexplained persistent LFT elevation. |
| **Omega 3 Fatty Acids** |
| Ethyl esters(Lovaza) | Pediatric safety and efficacy not established. Not FDA approved for use in children. | 2-4 g EPA + DHA daily, divided BID | Eructation, dyspepsia. Diarrhea (7%-15%) most commonly reported. May enhance anticoagulant and antiplatelet effects of other medications. | Adjunct therapy to reduce high TG. No dosage adjustments required for impaired renal or hepatic function. Periodic monitoring of ALT and AST is recommended for patients with hepatic impairment. |
| Icosapent (Vascepa) | Pediatric safety and efficacy not established. Not FDA approved for use in children. | 2-4 g EPA daily, divided BID | Arthralgia, oropharyngeal pain |
| **Statins** |
| Multiple preparations available | Not FDA approved for use in children other than familial hypercholesterolemia. | Product specific.  | Myositis and rhabdomyolysis, primarily when given with gemfibrozil or cyclosporine; myositis is also seen with severe renal insufficiency (CrCl < 30 mL/min). | If used off label, in HTG, statins are most often used in combination with other drugs, such as fibrates, in order to achieve synergistic effects. |

Fenofibrate, a potent hypolipemic agent, is widely used in patients with hypertriglyceridemia. A moderate reversible increase in serum creatinine is a well described side effect of fenofibrate therapy, although the mechanism remains unknown (10). It does not appear to reflect an impairment of renal function, nor an alteration of tubular creatinine secretion, and is not falsely increased by dosage interference. Furthermore, a fenofibrate-induced increase of daily creatinine production is not readily explained by accelerated muscular cell lysis. Rather, it has been proposed that fenofibrate increases the metabolic production rate of creatinine (10). Although current evidence does not suggest fenofibrate is nephrotoxic, close monitoring of serum creatinine is recommended, especially in high-risk patients. Increases in serum creatinine levels ≥ 30% may suggest the need for discontinuation (11).

While over-the-counter long chain omega-3-fatty acids have variable TG-lowering effects, prescription preparations lower TG levels by 20-50%. In lipoprotein lipase deficiency states, omega-3-fatty acids may aggravate severe HTG (12).

Use of niacin, which lowers TGs 10-30%, increases HDL-C by 10-40%, and lowers LDL-C by 5-20%, is limited by common side effects, such as flushing and pruritus. In addition, it may contribute to insulin resistance, further increasing TG levels. Bile acid sequestrants may worsen HTG and are contraindicated in patients with SHTG (> 1000 mg/dL).

Several novel therapies for treatment of HTG are in development, but their clinical efficacy, cost-effectiveness, and indications, especially in children, have not yet been established.

Following recovery from the acute episode of pancreatitis, patient should be encouraged to adopt a healthy lifestyle, including a diet low in saturated fat and cholesterol, avoiding excessive carbohydrate intake, avoidance/cessation of smoking, and 30-60 minutes of moderate-to-vigorous daily physical activity. In selected cases, pharmacotherapy has been recommended to prevent pancreatitis and/or reduce risk of cardiovascular disease, although outcome data are lacking. Youth at-risk of recurrent episodes of HTG-related pancreatitis should also be encouraged to avoid use of alcohol, other medications associated with HTG, such as isotretinoin, and in girls, oral contraceptives. Tests for genetic mutations associated with pancreatitis may be informative (13, 14).

**CONCLUSION**

Aggressive TG-lowering therapy, when indicated, can rapidly lower severely elevated levels of triglycerides, potentially reducing morbidity and mortality associated with TG-related acute pancreatitis. An algorithm to categorize severity of acute pancreatitis, the presence of organ dysfunction or failure, and local pancreatic or systemic complications or exacerbations of prior co-morbid disease can assist clinical decision-making in helping to determine appropriate candidates for aggressive TG-lowering therapy.

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**REFERENCES**

1. Zhang XL, Li F, Zhen YM, Li A, Fang Y. Clinical study of 224 patients with hypertriglyceridemia pancreatitis. Chin Med J (Engl). 2015;128(15):2045–2049. [PubMed 26228216]
2. Morinville VD, Lowe ME, Ahuja M, Barth B, Bellin MD, Davis H, Durie PR, Finley B, Fishman DS, Freedman SD, Gariepy CE, Giefer MJ, Gonska T, Heyman MB, Himes R, Husain S, Kumar S, Ooi CY, Pohl JF, Schwarzenberg SJ, Troendle D, Werlin SL, Wilschanski M, Yen E, Uc A. Design and implementation of INSPPIRE. J Pediatr Gastroenterol Nutr. 2014;59(3):360–364. [PubMed 24824361]
3. Abu-El-Haija M, Kumar S, Szabo F, Werlin S, Conwell D, Banks P, Morinville VD NASPGHAN Pancreas Committee. Classification of acute pancreatitis in the pediatric population: Clinical report from the NASPGHAN Pancreas Committee. J Pediatr Gastroenterol Nutr. 2017;64(6):984-990. [PubMed: 28333771]
4. Alagozlu H, Cindoruk M, Karakan T, Unal S. Heparin and insulin in the treatment of hypertriglyceridemia-induced severe acute pancreatitis. Dig Dis Sci. 2006;51(5):931-933. [PubMed 16670939]
5. Yeh JH, Lee MF, Chiu HC. Plasmapheresis for severe lipemia: Comparison of serum-lipid clearance rates for the plasma-exchange and double-filtration variants. J Clin Apher. 2003;18(1):32-36. [PubMed 12717791]
6. Chen JH, Yeh JH, Lai HW, Liao CS. Therapeutic plasma exchange in patients with hyperlipidemic pancreatitis. World J Gastroenterol. 2004;10(15):2272-2274. [PubMed 15259080]
7. Shaz BH, Linenberger ML, Bandarenko N, Winters JL, Kim HC, Marques MB, Sarode R, Schwartz J, Weinstein R, Wirk A, Szczepiorkowski ZM. Category IV indications for therapeutic apheresis: ASFA fourth special issue. J Clin Apher. 2007;22(3):176–180. [PubMed 17377982]
8. Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents, National Heart, Lung, and Blood Institute. Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents: Summary report. Pediatrics. 2011;128 (Suppl 5):S213-S256. [PubMed: 22084329].
9. Wilson DP, McNeal C, Blackett PR. Children and adolescents step-by-step evaluation and management plan (chapter 14). In: Meyerson M, ed. Dyslipidemia: A Clinical Approach. Philadelphia: Wolters Kluwer; 2018: 213-234.
10. Hottelart C, El Esper N, Rose F, Achard JM, Fournier A. Fenofibrate increases creatininemia by increasing metabolic production of creatinine. Nephron. 2002;92(3):536-541. [PubMed 12372935]
11. Kostapanos MS, Florentin M, Elisaf MS. Fenofibrate and the kidney: an overview. Eur J Clin Invest. 2013;43(5):522-531. [PubMed 23480615]
12. Rouis M, Dugi KA, Previato L, Patterson AP, Brunzell JD, Brewer HB, Santamarina-Fojo S. Therapeutic response to medium-chain triglycerides and omega-3 fatty acids in a patient with the familial chylomicronemia syndrome. Arterioscler Thromb Vasc Biol. 1997;17(7):1400-1406. [PubMed 9261273]
13. Jap TS, Jenq SF, Wu YC, Chiu CY, Cheng HM. Mutations in the lipoprotein lipase gene as a cause of hypertriglyceridemia and pancreatitis in Taiwan. Pancreas. 2003;27(2):122-126. [PubMed 12883259]
14. Tremblay K, Dubois-Bouchard C, Brisson D, Gaudet D. Association of CTRC and SPINK1 gene variants with recurrent hospitalizations for pancreatitis or acute abdominal pain in lipoprotein lipase deficiency. Front Genet. 2014;5:90. [PubMed 24795752]
15. Hegele RA, Ginsberg HN, Chapman MJ, Nordestgaard BG, Kuivenhoven JA, Averna M, Boren J, Bruckert E, Catapano AL, Descamps OS, Hovingh GK, Humphries SE, Kovanen PT, Masana L, Pajukanta P, Parhofer KG, Raal FJ, Ray KK, Santos RD, Stalenhoef AFH, Stroes E, Taskinen M, Tybjaerg-Hansen A, Watts GF, Wiklund O, European Atherosclerosis Society Consensus Panel. The polygenic nature of hypertriglyceridaemia: Implications for definition, diagnosis, and management. Lancet Diabetes Endocrinol 2014;2(8):655-666. [PubMed 24731657]
16. Goldstein B, Giroir B, Randolph A, International Consensus Conference on Pediatric Sepsis. International pediatric sepsis consensus conference: Definitions for sepsis and organ dysfunction in pediatrics. Pediatr Crit Care Med. 2005;6(1):2-8. [PubMed 15636651]
17. Abu-El-Haija M, Kumar S, Quiros JA, Balakrishnan K, Barth B, Bitton S, Eisses JF, Foglio EJ, Fox V, Francis D, Freeman AJ, Gonska T, Grover AS, Husain SZ, Kumar R, Lapsia S, Lin T, Liu QY, Maqbool A, Sellers ZM, Szabo F, Uc A, Werlin SL, Morinville VD. Management of acute pancreatitis in the pediatric population: A clinical report from the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition Pancreas Committee. J Pediatr Gastroenterol Nutr. 2018;66(1):159-176. [PubMed 29280782]
18. Tsuang W, Navaneethan U, Ruiz L, Palascak JB, Gelrud A. Hypertriglyceridemic pancreatitis: Presentation and management. Am J Gastroenterol. 2009;104(4):984-991. [PubMed 19293788]
19. Ewald N, Kloer HU. Treatment options for severe hypertriglyceridemia (SHTG): The role of apheresis. Clin Res Cardiol Suppl. 2012;7(1):31-35. [PubMed 22528130]
20. Lennertz A, Parhofer KG, Samtleben W, Bosch T. Therapeutic plasma exchange in patients with chylomicronemia syndrome complicated by acute pancreatitis. Ther Apher. 1999;3(3):227-233. [PubMed 10427620]