Secondary infection with *Streptococcus pyogenes* can trigger acute poststreptococcal glomerulonephritis and rheumatic fever.5,6 The exact pathogenic mechanism associated with the organisms isolated in skin lesions with secondary infection has not yet been determined. In our case, the pathogenic role of *S aureus* was clear, as it was isolated in the blood, the pleural fluid, and the skin lesion. Thus the parasite entered the epidermis through a break in the skin leading to bacteremia and the consequent empyema.

Early diagnosis of scabies is essential in order to initiate appropriate treatment with a scabicide. Similarly, secondary bacterial infection must be managed through local or, occasionally, systemic antibiotics, and pus must be drained from abscesses in order to avoid complications that could potentially endanger the life of the patient.

**References**


**Eruptive Xanthomas After Onset of Diabetes Mellitus**

G. Villalón,a J. M. Martín,a C. Monteagudo,b V. Alonso,a E. Montesinos,a and E. Jordáa

aServicio de Dermatología and bServicio de Anatomía Patológica, Hospital Clínico Universitario de Valencia, Spain

**To the Editor:**

We recently treated a 33-year-old man who was admitted to our hospital with abdominal pain accompanied by nausea, vomiting, and hyperglycemia that had begun 4 days earlier and reflected the onset of diabetes mellitus. The patient had a history of hypertension diagnosed in the last 3 months, predominantly abdominal obesity, with a body mass index of 31.5 kg/m², severe alcoholism, and hypercholesterolemia diagnosed a year ago. He was receiving dietary treatment. The patient’s father had type 2 diabetes mellitus that began in his thirties.

The patient reported polyuria, polydipsia, and polyphagia for the last 3 weeks, along with weight loss of 10 kg. Around that time, he began to develop erythematous papules of 1 to 4 mm in diameter on his back, and these turned yellow within a few days. Some of the lesions had a peripheral halo and were accompanied by mild pruritus. The lesions were initially distributed on the back but later spread to the arms and legs, buttocks, and in particular, the sacral region (Figure 1).

Laboratory analysis during admission revealed the following: glucose, 257 mg/dL; total cholesterol, 418 mg/dL; triglycerides, 853 mg/dL; high-density lipoprotein cholesterol, 32 mg/dL; low-density lipoprotein cholesterol, 218 mg/dL; direct bilirubin, 0.1 mg/gL; indirect bilirubin, 6.1 mg/dL; aspartate aminotransferase, 18 mU/mL; alanine aminotransferase, 20 mU/mL; γ-glutamyltransferase, 66 mU/mL; lactate dehydrogenase, 398 mU/mL; and alkaline phosphatase, 230 mU/mL. Gasometric analysis of venous blood revealed slight metabolic acidosis. Thyroid function, insulinemia, and C-peptide concentrations were within normal ranges and analysis of anti-islet cell antibodies was negative.

Abdominal ultrasound revealed diffuse hepatic steatosis with hepatomegaly. Histology of the skin lesions (Figure 2) revealed infiltration of the superficial and middle dermis by uniform polygonal mononuclear macrophages with a foamy cytoplasm, with a tendency toward perivascular aggregation and without accompanying

**Figure 1.** Multiple yellow papules with a peripheral erythematous halo on the back of the arm and the back.

**Figure 2.** Macrophages loaded with intracellular lipids (foam cells) (hematoxylin-eosin, ×400).
lymphocytes. There were no notable changes in the epidermis.

Following stabilization of the patient, treatment was initiated with a diabetic diet, insulin therapy, fenofibrate 160 mg/d in slow-release tablets, and metformin 850 mg every 12 hours.

A month and a half later, after the patient had lost weight, done regular physical exercise, and received medical treatment, the lesions had remitted, though some had left residual hypertrophic scars. Blood glucose and triglycerides had returned to almost normal levels (glucose, 111 mg/dL; triglycerides, 163 mg/dL).

Eruptive xanthomas are yellow or orange papules measuring only a few millimeters in diameter and generally associated with any processes that involve absorption of carbohydrates, as well as reduction of weight and regular physical exercise, particularly in patients with insulin resistance.9

In summary, eruptive xanthomas may be associated with diabetic dyslipidemia, not just with hypertriglyceridemia, and with a complete accompanying metabolic syndrome that may require urgent medical treatment.

References