Hypertriglyceridemia Masking Hyperglycemia

Ria Ramadoo*, Ryan Kunjal and Surujpal Teelucksingh
Department of Internal Medicine, University of the West Indies, Trinidad and Tobago

*Corresponding author: Ria Ramadoo, Medical Associates Hospital, St. Joseph, Trinidad and Tobago, Tel: + 8687502145; Fax: 00441482461097; E-mail: ruthramadoo@gmail.com

Rec date: Mar 23, 2015, Acc date: Mar 25, 2015, Pub date: Mar 27, 2015

Copyright: © 2015 Ria Ramadoo, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Clinical Image

A 42 year old female diabetic poorly compliant to therapy presented with left facial pain and classic osmotic symptoms of hyperglycemia. Clinical findings revealed dehydration and the features of a lower motor neuron lesion of the left facial nerve. Blood glucose measured by bedside glucose reflectance device (TRUEresult®) was 460 mg/dl compared with a value of 1280 mg/dl obtained on an identically timed specimen but measured by spectrophotometry (Figure 1). Plasma was noted to be markedly lipemic (Figure 2), and plasma triglyceride level was 9460 mg/dl. Glycemic control was achieved over several days with intensive insulin therapy. As plasma became less lipemic, the disparity between bedside and laboratory-derived values diminished steadily, eventually becoming identical. Blood glucose reflectance devices have revolutionized the management of diabetes but are unreliable when plasma is lipemic [1].

References