



Very Severe Hypertriglyceridemia (TGL ≥ 1000 mg/dL): Management - Adult - Inpatient/Ambulatory/Emergency Department Guideline Summary

Target Population: Adult patients (age ≥ 18 years) with very severe hypertriglyceridemia (triglycerides ≥ 1000 mg/dL)

Full Guideline: [Very Severe Hypertriglyceridemia \(TGL ≥ 1000 mg/dL\): Management - Adult – Inpatient/Ambulatory/Emergency Department](#)

Management of Very Severe Hypertriglyceridemia

Primary and Secondary Causes of Hypertriglyceridemia	
Primary Causes <ul style="list-style-type: none"> Familial combined hyperlipidemia Lipoprotein lipase deficiency Familial dysbetalipoproteinemia Apolipoprotein CII deficiency Apolipoprotein C-III excess Familial chylomicronemia syndrome 	Secondary Causes <ul style="list-style-type: none"> Untreated/poorly controlled diabetes mellitus Obesity High fat/high carbohydrate/high caloric diet Excessive alcohol consumption Hypothyroidism Nephrotic syndrome Pregnancy Medications (see table below)

Common drugs/medications that can raise triglycerides	
<ul style="list-style-type: none"> β-blockers Glucocorticoids Estrogens Progestins Tamoxifen Androgenic steroids Retinoids, isotretinoin Thiazide/thiazide-type diuretics 	<ul style="list-style-type: none"> Protease inhibitors Loop diuretics Tacrolimus Cyclosporine Atypical antipsychotics (e.g., clozapine, olanzapine) Valproate Alcohol

Consideration for Plasmapheresis if ACE-I Usage		
ACE-I usage	SIRS ≥ 2	SIRS = 0 or 1
No ACE-I taken in past 24 hours	Favors performing plasmapheresis	Consider plasmapheresis
ACE-I taken within past 24 hours*	Consider plasmapheresis with extra caution	Favors deferring plasmapheresis

* If plasmapheresis is performed within 24 hours of last ACE inhibitor dose, must be done in IMC or ICU setting only after multidisciplinary consultation and patient informed consent

