hologic features (2). The skin overlying pilomatricoma sometimes can be atrophic. It is supposed that this atrophic appearance is related to the loss of elastic fibres, and dermal oedema (1). In the aetiopathogenesis, it is suggested that the cause of the bullous appearence of the tumour is obstruction of lymphatics, and congestion by lymphatic fluid (1, 2, 5).

In addition, some authors suggest that the tumour cells can produce elastinolytic enzymes. These lytic products cause disruption of collagen fibres and destruction and dilation of lymphatic vessels (2, 5). After these processes, the dermis is filled with lymphatic fluid (2). Since the lesions do not regress spontaneously, treatment is surgical (1). Our patient had all the features of a typical bullous pilomatricoma. Additionally, in the history of the patient, there was hepatitis A vaccination to the same region with the bullous lesion and thereafter a severe inflammation developed in the vaccination area. Therefore, we thought that both the pricking trauma of vaccination and inflammation caused by the vaccine might be the trigger of the aforementioned mechanisms. To our best knowledge, the case is the first bullous pilomatricoma which developed after the hepatitis A vaccination. Our case is being reported to draw attention to this rare entity and a probable aetiopathogenetic association with hepatitis A vaccine and bullous pilomatricoma.

Keywords: Bullous, hepatitis A, pilomatricoma, tumour, vaccination

B Tas[1], E Tas[2], M Sar[3]
From: [1]Bagcilar Training and Research Hospital, Department of Dermatology, [2]Dumlupınar Universty, Kütahya Evliya Celebi Training and Research Hospital, Department of Gastroenterology and [3]Bagcilar Training and Research Hospital, Department of Pathology, Istanbul, Turkey.

Correspondence: Dr B Tas, Ataköy 7–8, Kısım, Martı sitesi, Martı 14/105, Ataköy, Istanbul, Turkey. F ax 90-2124404040; e-mail: betulavc@yahoo.com

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Can Isotretinoin Induce Articular Symptoms in SAPHO Syndrome?

The Editor,

Sir,

A 28-year old man visited his doctor because of hip pain (worse on the left side) and low back pain (worse with immobility/at night and better with activity) for the last 10 days. He stated that he had used oral isotretinoin for acneiform lesions for two weeks, and his complaints had ensued thereafter. He added that he had experienced a similar history with isotretinoin treatment when he was 20 years old as well. On physical examination, bilateral hip joint movements and lumbar flexion were painful. He also had limited range of motion in his left hip. Sacroiliac joints, sternum and sternoclavicular joints were painful with palpation. Gaenslen's and Mennel tests were positive, bilaterally. He had antalgic gait on the left side. He had severe nodulocystic acne with abcesses on his face, neck and back. C-reactive protein level was 1.87 mg/dL (N: 0–0.8 mg/dL). Laboratory tests including erythrocyte sedimentation rate, liver and kidney function tests and Brucella Rose Bengal test were all within normal limits. Radiographs were unremarkable. Magnetic resonance imaging (MRI) showed bilateral sacroiliitis (Fig. 1). Bone scintigraphy was consistent with bull's head sign (Fig. 2).

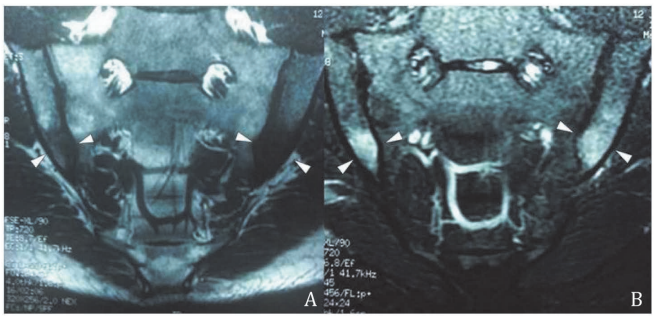

Fig. 1: Magnetic resonance imaging demonstrating bilateral sacroiliitis (white arrowhead) on T1-weighted **(A)** and T-2 weighted **(B)** axial views.

Eventually, the patient was diagnosed with SAPHO (synovitis, acne, pustulosis, hyperostosis and osteitis) syndrome possibly induced by isotretinoin treatment. Isotretinoin was stopped and the patient was treated with indomethacin 75 mg/d. There was marked improvement in his complaints (except for acne) in the second month of follow-up.

SAPHO syndrome is a chronic inflammatory disorder with findings of synovitis, acne, pustulosis, hyperostosis and

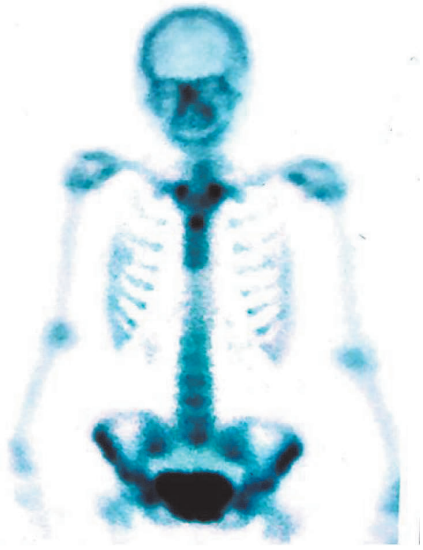

Fig. 2: Tc-99m bone scintigraphy showing increased uptake in manubrium sterni and bilateral costoclavicular joints (bull's head sign) and bilateral sacroiliac joints.

sterile osteitis. To the best of our knowledge, isotretinoin was documented as a provoking factor for articular symptoms in SAPHO only in one case (1). Likewise, we herein present a case where SAPHO was precipitated with isotretinoin for acne treatment.

SAPHO syndrome can be seen in all ages and it occurs with equal frequency in both genders. Although the exact aetiopathogenesis is yet unclear, it is supposed to be related to environmental, immunologic and genetic factors (2). The diagnosis of SAPHO is based on the exclusion of other causes (infectious discitis/osteomyelitis, malignancy, seronegative spondyloarthritis) with the presence of one of the following four items: (a) acne concomitant with bone involvement, (b) sternoclavicular hyperostosis, (c) palmoplantar pustulosis concomitant with bone involvement and (d) aseptic osteomyelitis (3). As for diagnostic imaging, radiographs are the initial tools to detect bone pathologies. Further, computed tomography and particularly MRI are more sensitive to show inflammatory changes (sacroiliitis, discitis, bone marrow oedema). The characteristic scintigraphy sign of 'bull's head' is typical for SAPHO (4). Concerning the laboratory investigations, SAPHO syndrome is usually accompanied by a moderate increase in erythrocyte sedimentation rate/C-reactive protein. Although nonspecific, there may be a mild increase in leukocyte and alkaline phosphatase levels (3, 4). Treatment for SAPHO is symptomatic *ie* non-steroidal anti-inflammatory drugs, corticosteroid, methotrexate, anti-tumour necrosis factor-alpha (TNF-α), pamidronate, or a combined drug approach (4, 5).

In conclusion, we suggest that patients who are receiving isotretinoin treatment need to be followed for likely musculoskeletal complications and SAPHO syndrome must be kept in mind for the differential diagnosis.

Keywords: Acne vulgaris, back pain, bull's head sign, retinoic acid, SAPHO syndrome

A Karatas Togral[1], MT Yildizgoren[2], OM Koryurek[3], T Ekiz[4]
From: [1]Department of Dermatology, and [2]Physical Medicine and Rehabilitation, Occupational Diseases Hospital, [3]Department of Dermatology, Ankara Training and Research Hospital, [4]Department of Physical Medicine and Rehabilitation, Ankara Physical Medicine and Rehabilitation Training and Research Hospital, Ankara, Turkey.

Correspondence: Dr T Ekiz, Ankara Fizik Tedavi ve Rehabilitasyon Egitim ve Arastirma Hastanesi, Ankara, Turkey. Fax: +90 312 311 80 54; e-mail: timurekiz@gmail.com

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Toxoplasma Chorioretinitis Subsequent to Anti-tumour Necrosis Factor Alpha Treatment in a Patient with Ankylosing Spondylitis

The Editor,

Sir,

A 25-year old female patient who was under treatment for ankylosing spondylitis (AS) for two years presented to our clinic with blurred vision that had started in the right eye two weeks previously. The visual acuity (VA) in the right eye was 2/10, while it was 10/10 in the left eye. The biomicroscopic examination revealed +2 cells in the anterior chamber and the vitreous, and chorioretinitis superiorly to the optic disc in the right eye (Fig. 1).

The left eye was observed to be normal. The patient's history revealed that she was under treatment with etanercept for the last three months. Her blood count and biochemistry results were normal. ToxoIgG was positive while the ToxoIgM was negative.

Among the other serological markers, syphilis, brucella and tuberculosis were negative. Based on these findings, the patient was diagnosed with ocular toxoplasmosis and treatment with the biological agent was stopped. The patient was started