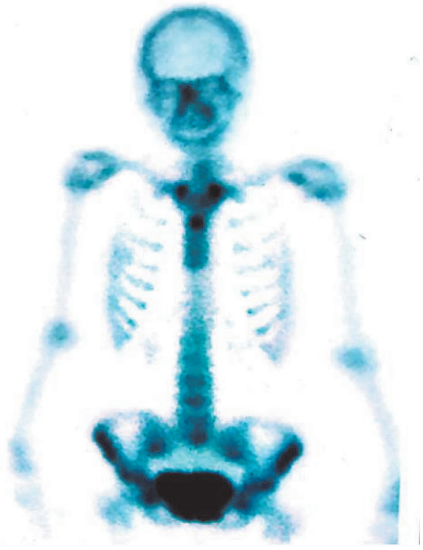

Fig. 2: Tc-99m bone scintigraphy showing increased uptake in manubrium sterni and bilateral costoclavicular joints (bull's head sign) and bilateral sacroiliac joints.

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

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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

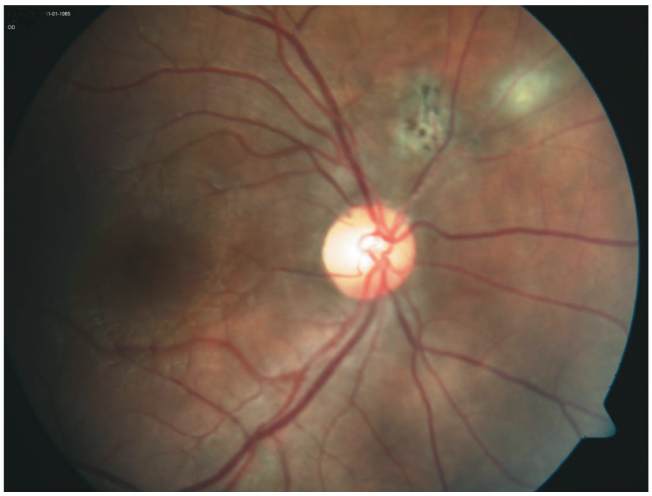

Fig. 1: Colour fundus photograph showing scar formation and active chorioretinitis in optic disc superiorly at first visit.

on a regimen of clindamycin, steroids and trimethoprim/sulfamethoxazole for six weeks. Following the treatment, the VA of the patient returned to 10/10 in both eyes with scarring superiorly to the optic disk (Fig. 2).

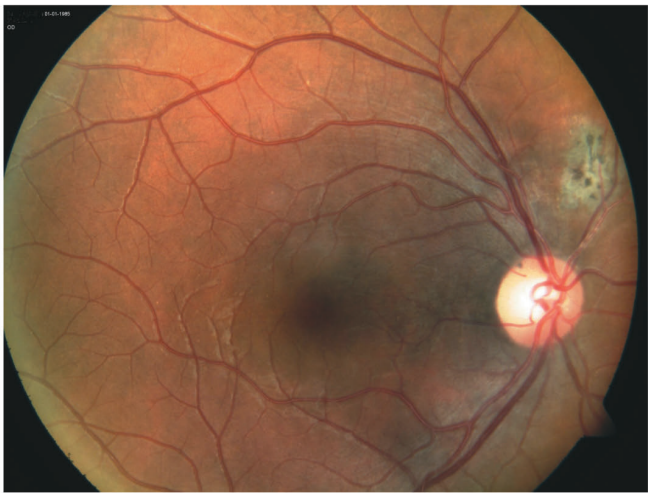

Fig. 2: Colour fundus photograph showing scar formation in right eye after treatment at last visit.

Ankylosing spondylitis is a chronic, progressive and inflammatory rheumatic disease characterized by axial and peripheral joint involvement, which may cause severe disability (1). Currently, if the disease activity continues in spite of the conventional treatments, anti-tumour necrosis factor-alpha (TNF-α) agents may be used. However, patients should be kept under close monitoring for the side effects of the treatment with biological agents (2). Biological agents may be associated with a higher incidence of granulomatous infections including tuberculosis (3). Still, there is only a limited number of reports regarding patients observed to develop toxoplasma infections during treatment with anti-TNF-α agents and these include rheumatoid arthritis patients with chorioretinitis treated with either etanercept or infliximab (4).

In conclusion, we reported a case of toxoplasmic chorioretinitis in a patient treated with anti-TNF-α agents. The possibility of severe toxoplasma infection during the anti-TNF-α therapy should be kept under consideration due to its serious ocular consequences, which may lead to major sequelae. We are of the opinion that patients should be advised to avoid exposure to infectious agents including toxoplasma before and during treatment with anti-TNF-α.

Keywords: Ankylosing spondylitis, anti-TNF-α, toxoplasma chorioretinitis

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Intracranial Subdural Haematoma after Thoracic Epidural without Signs of Dural Puncture

The Editor,

Sir,

We report the development of an intracranial subdural haematoma (ISH) in a 33-year old male patient who underwent an epidural procedure without evidence of dural puncture, after obtaining his written consent.

The patient presented for surgical excision of a gastrointestinal stromal tumour. He had no history of trauma, headaches or neurological disorders. His coagulation profile was normal. Preoperatively, a thoracic epidural catheter was placed uneventfully and the patient received general anaesthesia under intermittent positive pressure mechanical ventilation (IPPV). Postoperatively, the epidural catheter was used for 72-