EA with muscular continuity is a rare entity, and may be associated with upper pouch TEF. Therefore, great care must be taken to exclude a proximal TEF in these cases.

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Levent DUMAN[1], Çağrı SAVAŞ[1], İlker BÜYÜKYAVUZ[1], Nermin KARAHAN[2], Mustafa AKÇAM[3], Mustafa MELİKOĞLU[4]

Departments of [1]Pediatric Surgery, [2]Pathology and [3]Pediatrics, Süleyman Demirel University School of Medicine, Isparta

Department of [4]Pediatric Surgery, Akdeniz University School of Medicine, Ankara

Esophageal ulcers: A possible adverse effect of isotretinoin

İsotretinoin tedavisine bağlı özofageal ülser

To the Editor,

Drug-induced esophageal injury is a common cause of esophageal diseases. Many drugs have been reported to cause esophagitis and esophageal ulcers; among these are antibiotics such as doxycycline and tetracycline, nonsteroid anti-inflammatory drugs, aspirin, and potassium chloride (1).

Isotretioin is a synthetic analogue of vitamin A and is widely used in the management of acne vulgaris. However, several adverse effects of this drug have been reported, including mucositis and chelitis (2). Among these, a possible association of inflammatory bowel disease with isotretioin deserves further attention (3). Although the exact mechanism is not clear, the possible role of isotretinoin in the inhibition of epithelial cell growth, induction of apoptosis, lymphocyte migration, and immunomodulation have been proposed. We report a patient with multiple esophageal ulcers in which the only possible cause was the oral ingestion of isotretioin.

A 29-year-old woman who had no previous gastrointestinal complaints (including no reflux symptoms) and no serious medical or surgical history presented to our gastroenterology department with severe odynophagia. She had started to use isotretioin for acne vulgaris one month before and had not used any other medication recently. Her odynophagia began suddenly two days before presentation and was similar in intensity while swallowing solids and liquids. Her physical examination, routine laboratory tests, chest x-ray and upper abdominal ultrasonography were all within normal limits. An emergency endoscopy was performed and showed discrete esophageal ulcers (3-8 mm in size) starting 30 cm from the incisors and disappearing gradually towards the 38th cm (Figu-

Address for correspondence: Tolga Enver YÜCETÜRK
Kent Hospital, Department of Pathology, İzmir, Turkey
E-mail: tolga.yuceturk@kenthospital.com

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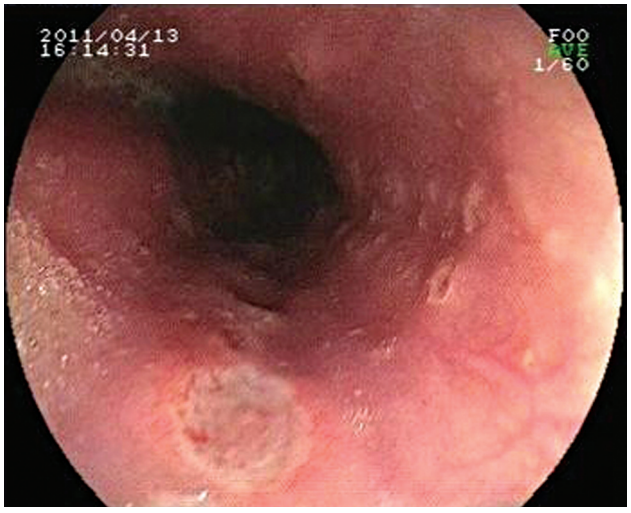

Figure 1. Esophageal ulcers at 30th cm.

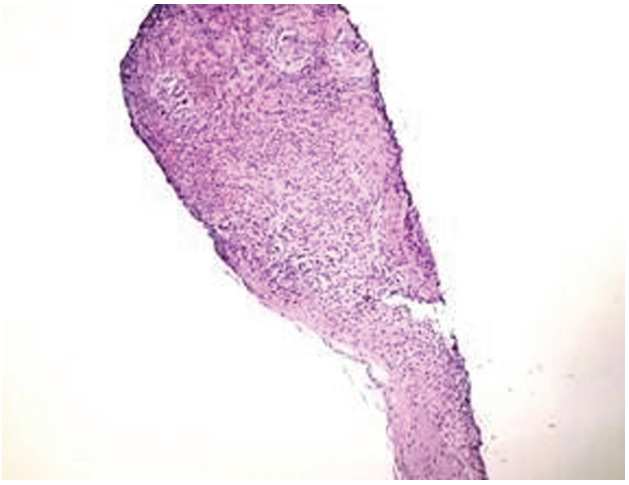

Figure 2. Ulceration, inflammatory infiltrate and obliterated vessels in the submucosa (hematoxylin-eosin, x100).

re 1). At the gastroesophageal junction (40 cm), no signs of reflux esophagitis were seen. Histopathology of biopsy samples from the ulcers revealed evidence of ulcerative esophagitis, i.e. small obliterated vessels in the ulcerated area, reminiscent of vasculitis (Figure 2). No fungus was identified with PAS stain.

Isotretinoin was stopped; paracetamol and sucralfate liquid (6 times daily once before and after each meal) were started. Investigations for other vasculitic or rheumatologic conditions (serum CRP, ANA, C-ANCA, P-ANCA and ACE) were all within normal values. In a few days, the patient's pain waned and finally disappeared after one week following the cessation of isotretinoin.

Isotretioin was the probable etiologic agent of esophageal ulcers in this patient. Pill-induced esophagitis may occur due to several mechanisms (direct injury by caustic coatings, dissolution after prolonged contact and direct injury to the esophagus by the drug, etc.); the ulcer-causing mechanism of isotretinoin may be similar to that involved in the pathogenesis of inflammatory bowel disease.

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Ethem TANKURT[1], Latife DOĞANAY[2],
Tolga Enver YÜCETÜRK[3]

Departments of [1]Gastroenterology, [2]Pathology and [3]Internal Medicine, Kent Hospital, İzmir