hydronephrosis and hydroureter, obstructed at the pelvic brim by uterine fibroids with non-obstructing renal stones. She also had an echocardiogram which showed "left ventricular enlargement with decreased left ventricular function to 46%".

She was treated and improved and eventually discharged but was later found to be having worsening azotemia. It was decided that she needed relief of the obstructive uropathy and had a failed attempt at stenting the ureter. It was then decided to do a hysterectomy to relieve the obstruction and an interim nephrostomy was inserted with some improvement of her renal function.

She was readmitted three months later for hysterectomy and sent for dialysis. This was uneventful; however, later that day she had a cardiac arrest and died. This patient had end-stage renal failure which could have resulted from low-output cardiac failure, renal disease from diabetes and hypertension, and post renal obstructive uropathy from uterine fibroids and renal calculi (1).

We have previously described cases of renal obstructive uropathy secondary to uterine fibroids (2). We found that in most cases, the renal obstruction, as occurred here, was unilateral and therefore unlikely to cause end-stage renal failure by itself. However, in the patient who has other causes for renal disease, the obstructive uropathy can tip the scale and result in end-stage renal failure with demise of the patient.

The renal calculi can occur if there is distal obstruction. They can also cause obstruction, but in the index case, they were non-obstructing (3). Relief of the obstruction by surgery could have helped her renal function. We therefore recommend that if obstructive uropathy is found from uterine fibroids, the fibroids need to be removed, especially in women with other co-morbidities which can lead to renal failure, as this may ultimately be life saving.

AUTHORS' NOTE

The authors report no conflicts of interest. Consent was received to publish this case report from the husband of the deceased. The authors alone are responsible for the content and writing of the paper. HF and JD managed the patient; MA-V did the imaging and reported on the findings. All three authors were responsible for the writing of the manuscript.

Keywords: Fatal end-stage renal failure, fibroids

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DOI: 10.7727/wimj.2014.043

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Isotretinoin and Psychotic Mania

The Editor,

Sir,

Isotretinoin is a synthetic oral retinoid, which is effective against severe, recalcitrant, nodulocystic acne. Since it entered the market, it has been associated with a variety of adverse psychiatric effects, including depression, psychosis, mood swings, violent behaviour, suicide and suicide attempts (1). In a retrospective review of 1743 patients, many side effects were reported. However, only 22 patients had mood swings (2).

Three cases with bipolar disorder, who experienced an untoward psychiatric side effect while receiving isotretinoin treatment, were reported. In that study, psychiatric side effects of isotretinoin were examined in a larger group of patients with bipolar disorder than in previous research (3).

In another review, isotretinoin (Roaccutane) ranks in the top 10 of the US Food and Drug Administration's database of drugs associated with reports of depression and suicidal attempts (4). However, this association is still controversial for the following reasons: (a) up to 5.6% of patients with moderate acne may have pre-existing suicidal ideations, (b) improvement of acne often reduces associated depression and (c) isotretinoin users are not more likely to have depression or commit suicide than those taking antibiotics for acne (4). There are many case reports and reviews about the relationship between depression, suicide and isotretinoin.

We suggest that there is a relationship between isotretinoin and manic psychosis. Further studies are required to strengthen our findings.

TA is a 19-year old female student in law school. She was brought in by her family with complaints of insomnia, nervousness, fear and extreme religious pursuits.

Two weeks previously, she was restless and irritable and had bizarre behaviour. She claimed that she was a special kind of human. Her symptoms increased in the last two days and her family reported that she had totally changed and became religious.

In her mental examination, she was irritable. There were spontaneous increases in her attention. She had paranoid and grandiose delusions and her insight was poor.

When her medical history was examined, it was noted that she had visited a dermatologist two months ago with severe acne complaints. Roaccutane was prescribed to her. During her treatment, her skin complaints had disappeared. Triiodothyronine (T3), thyroxine (T4), thyroid-stimulating hormone, liver function tests and blood count results were normal.

She was diagnosed with manic episode, and haloperidol (20 mg/day), biperidin (4 mg/day) and olanzapine (20 mg/day) were prescribed to her. Her Roaccutane medication was stopped. No pathologic findings were observed in her magnetic resonance imaging (MRI) and electroencephalography (EEG) results.

She recovered from the acute episode in about 15 days. Haloperidol was reduced and later discontinued. Valproate (1000 mg/day) mercury treatment was maintained with olanzapine (10 mg/day).

According to her Rorschach test results, she had a neurotic structuring, feelings of inadequacy and she was depressive, anxious and narcissistic. She used to cope with difficulties with hypomanic defence mechanisms. No family history of psychiatric illness was determined. Approximately one month later, she asked us to restart Roaccutane medication. Because it might lead to depression, we explained that restarting Roaccutane medication was not a good idea. The patient was closely monitored and controlled while reducing and discontinuing olanzapine. She was able to continue her education. Neither manic nor depressive episodes recurred during two years follow-up, although her grandmother died during the treatment process. After two years, valproate was reduced and later discontinued. During this period, she finished her study and began to work in a corporation. We visited her every three months. Finally, she went to live in another country after not using any drug, and psychiatric control for 1.5 years.

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DOI: 10.7727/wimj.2012.256

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Dangerous Ulcerative Lesion in the Inguinal Area?

The Editor,

Sir,

Squamous cell carcinoma (SCC) is among the most frequent skin cancers, with sunlight being one of its most recognized aetiopathogenic factors, although it is well recognized that it can also occur in non-sun exposed sites, most certainly having other causative factors. Some authors believe that the large diversity of histological variants and locations account for the different behaviour and prognosis within this heterogeneous group of neoplasms (1). One important fact is that they may vary from lesions with a low metastatic potential to others that possess a high potential for invasion and metastases (2–4).

The authors present the case of a 68-year old patient who attended the outpatient clinic for a lesion on the left inguinal fold that had been present for two years. He had no significant previous medical history or chronic medication. He reported no excessive alcohol intake or smoking habits and denied risky sexual behaviour. On observation, a large ulcerated lesion of 2.6 × 1.9 cm was seen, with a slightly raised edge, and an area of perilesional erythema and brownish pigmentation. There was no palpable inguinal lymphadenopathy (Fig. 1).

Histological examination of the excision specimen revealed features consistent with a non-keratinizing poorly differentiated SCC (Fig. 2). The tumour infiltrated the dermis to a thickness between 2 and 6 mm (stage pT2c). Ultrasound revealed a solitary enlarged lymph node measuring 20 × 6 × 6 mm above the right inguinal ligament. The patient was submitted to excision of the lesion with 1 cm margin and adjuvant radiotherapy with a dose of 25 × 2 Gy directed to the inguinal nodes.

Four months later, he presented with enlarged lymph nodes in the left inguinal area, with involvement of intrapelvic nodes on computed tomography (CT), and was subsequently treated with lymph node dissection (three lymph nodes positive for SCC with extracapsular spread, upgrading patient's stage to pT₂N₂M₀), further radiotherapy and adjuvant chemotherapy with methotrexate. About one