included gastric antral vascular ectasia (GAVE) (6), GAVE and AD (6), tumor (9), polyps (2), Crohn's disease (3), NSAID ulceration (3), peptic ulcer disease (3), varices (2), small bowel ulcers (4), Dieulafoy (1), and miscellaneous (11).

Carey described advanced age as the only predictive factor in overt OGB. However, in our data set (using multivariate analysis), both transfusion dependence ($P = 0.005$) and co-morbidity ($P < 0.0001$) were significant predictive factors. The management was altered in 42% and 23% in the overt bleeders and occult bleeders, respectively ($P < 0.025$). This was in the form of endoscopic treatment of angioectasia: heater probe (16), variceal glueing (1), polypectomy (1), surgery (12), drug therapy (11: *Helicobacter* eradication/proton pump inhibitors [2], thalidomide [3], beta blockers [1], azathioprine [1]/withdrawal of nonsteroidal anti-inflammatory drugs [4]), and initiation of a gluten-free diet (1).

In conclusion, transfusion dependence and comorbidity may also be significant predictors of a positive diagnostic yield. Further CE studies are required to validate these criteria, ensuring efficient use of the CE service.

Reena Sidhu, M.R.C.P.
David S. Sanders, M.D., F.R.C.P., F.A.C.G.
Viv P. Sakellariou, M.R.C.P.
Mark E. McAlindon, B.Med.Sci., D.M., F.R.C.P.

Royal Hallamshire Hospital, Sheffield S10 2JF, United Kingdom

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Isotretinoin and Inflammatory Bowel Disease

TO THE EDITOR: We read with great interest the recent review published in your *Journal* by Reddy *et al.*, which suggests a possible association between isotretinoin use and inflammatory bowel disease (IBD) (1). Although IBD is described as a possible adverse drug reaction in the product information, little attention has been given in the literature to this association.

In fact, we could not ignore the fact that the most common occurrence of isotretinoin prescription is in young adulthood, which also corresponds to the peak age for IBD onset. Knowing that abnormalities may not appear until months to years after its discontinuation, the association with prior isotretinoin use can easily go unnoticed (2). So, besides a thorough history of IBD risk factors before isotretinoin prescription, gastroenterologists must be aware of this fact and ask for newly diagnosed patients with IBD about previous isotretinoin use.

It is conceivable that isotretinoin can act as a trigger for IBD in already predisposed individuals, or unmask symptoms in patients with preexisting subclinical disease (1, 2). While no well-documented relationship between acne and IBD exists, we might remember that other dermatologic lesions commonly included in the acne differential diagnosis may be associated with IBD, being described as extraintestinal manifestations, such as hidradenitis suppurativa (or acne inversa) (3). Thus, we might consider these dermatologic lesions as the first manifestation of IBD. In these circumstances, isotretinoin could be considered as neither acting as a trigger nor unmasking subclinical disease.

This discussion is supported by our own personal experience, in a case concerning a 19-yr-old female who had been on isotretinoin for genitofemoral acne inversa 20 mg/day for a year. There were no other gastrointestinal disorders on her previous medical and family history. One month before the end of treatment, she developed persistent aqueous diarrhea and progressive weight loss. Five months later, colonoscopy revealed an aftoid ileocolitis and pathological examination was compatible with Crohn's disease. There was a significant clinical improvement after starting oral mesalazine 3 g/day.

The relationship between isotretinoin and the emergence of Crohn's disease in this particular case, with no other risk factors for IBD, is clear. However, could we assume that acne inversa was not the first manifestation or a predisposing sign for Crohn's disease?

Carla Rolanda, M.D.
Guilherme Macedo, M.D., Ph.D., F.A.C.G.

Department of Gastroenterology, S. Marcos Hospital, Braga, Portugal
Life and Health Sciences Research Institute (ICVS), School of Health Sciences, University of Minho, Braga, Portugal

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