Isotretinoin Intoxication in Attempted Suicide

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Lindemayr H. Isotretinoin intoxication in attempted suicide. Acta Derm Venereol (Stockh) 1986; 66: 452–453.

Only mild symptoms of retinoid intoxication—headache, hallucinations and vertebral pain—were observed after ingestion of 800 mg isotretinoin among other drugs. Transaminases and serum lipids were found within normal range five days later. Mucocutaneous effects due to overdosage were absent. (Received March 8, 1986.)

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CASE REPORT

An 18-year-old, 80 kg, male patient, suffering from severe nodulocystic acne, had been treated with 3×20 mg isotretinoin (Roaccutane®) for 8 weeks until intoxication in suicidal intention was tried by swallowing 800 mg isotretinoin, 500 mg oxazepam, 450 mg doxepinhydrochloride, 60 mg 6-methylprednisolone and 5 g erythromycin. (Intake of alcohol was denied.)

The somnolent patient was found by his mother 8 hours later. He complained of headache, tingling, paraphasia and pain in the vertebral region, but was not overly worried. Emergency care was not required. The patient fell asleep again and awoke 24 hours later without any complaints.

After admission to the clinic 5 days later laboratory data were all within normal range, as they were before intoxication (e.g. transaminases, alkaline phosphatase, γ-GT, triglycerides, cholesterol, serum calcium, albumin; urea, blood cell count, coagulation parameters).

The clinical pattern of acne was unchanged at this time, but improved somewhat during the following weeks.

Only insignificant dryness, itching and scaling were noted. Isotretinoin therapy was reintroduced (2×20 mg) and tolerated well.

DISCUSSION

Isotretinoin has been found a most efficient drug in severe nodulocystic and conglobate acne not responding to other modalities. For optimal dosimetry most European multicenter groups recommend an initial dose of 1.0 mg/kg/day during the first three months of treatment. This dose should then be reduced to 0.5–0.2 mg/kg/day, in contrast to American studies, suggesting maintenance dosages of 1–2 mg/kg/day. Applications of higher dosages seem to be limited by severe side effects such as palmoplantar desquamation, dryness of mouth and lips, hair loss, pruritus, retinoid dermatitis, hemorrhages, paronychia, and also headache, nausea, loss of equilibrium, general malaise and arthralgia.

Elevation of serum lipids and, more rarely, of cholesterol, as well as liver enzyme disturbances may be encountered.

It is obvious that most side effects are dose dependent, some of them occurring after long term treatment with isotretinoin: musculo-skeletal pain and tenderness, hyperostosis, premature epiphyseal closure, secondary renal amyloidosis, pseudotumor cerebri syndrome and/or papilledema, hyperuricaemia, hypercalciaemia, creatine phosphokinase elevation and pyogenic granuloma-like lesions. For obvious reasons little is known about acute intoxication in man.

This case report presents a young male patient polyintoxicated with 800 mg isotretinoin and other drugs. Except for severe headache, hallucinations and vertebral (?) pain—all symptoms cannot exclusively be attributed to the retinoid—no other subjective or objec-

tive sign of overdosage could be observed. However, it has to be kept in mind that some of the other drugs simultaneously consumed might have influenced the course of intoxication.

REFERENCE

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Gonorrhoea in Heterosexual Men

Correlation between Gonococcal W Serogroup, Chlamydia trachomatis *Infection and Objective Symptoms*

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Rudén A-K, Bäckman M, Bygdeman S, Jonsson A, Ringertz O, Sandström E. Gonorrhoea in heterosexual men. Correlation between gonococcal W serogroup, *Chlamydia trachomatis* infection and objective symptoms. Acta Derm Venereol (Stockh) 1986; 66: 453–456.

Among 292 heterosexual men with gonorrhoea seen during one year, 59 (20%), had a co-existing chlamydial infection. Of the men infected with a serogroup W I strain 30% had a chlamydial infection compared with 16% of those infected with a serogroup W II/III strain ($p<0.01$). Heterosexual men infected with W I strains had less objective symptoms as judged by the number of leucocytes per high power field and by discharge, than men infected with W II/III strains ($p<0.05$ and $p<0.01$, respectively). *Key word: Monoclonal antibodies.* (Received March 17, 1986.)

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Serological classification of *Neisseria gonorrhoeae* by co-agglutination has recently been developed (1). With monoclonal antibodies the gonococci can be divided into two serogroups, W I and W II/III and further subdivided into serovars (2, 3). The serogroup W antigen, the major outer membrane protein, protein I, exists in two forms with different molecular weights (4). Serogroup W I and W II/III correspond to the two different proteins, protein I A and I B respectively.

A high frequency of co-existing chlamydial infection in patients with gonorrhoea is well-known (5, 6, 7). Approximately 20% of heterosexual men with gonorrhoea also have a chlamydial infection.

The purpose of this study was to investigate, if the serogroup of gonococcal isolates from heterosexual men with uro-genital gonorrhoea was correlated to a co-existing chlamydial infection and urethral symptoms.

MATERIAL AND METHODS

The venereal disease outpatient clinic at the Department of Dermatology-Venereology, Södersjukhuset, Stockholm, was attended during one year up to April 1983, by 312 consecutive heterosexual men