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## References

1. Doolan BJ, Rayinda T, Chiu FP, McGrath JA, Onoufriadis A. A review of genotrichoses and hair pathology associated with inherited skin diseases. *Br J Dermatol* 2023;189:154-60.
2. Rayinda T, McSweeney SM, Lalagianni N, Liu L, Guy A, Fenton D, *et al.* Familial hypotrichosis simplex of the scalp associated with a novel heterozygous nonsense variant in CDSN. *Clin Exp Dermatol* 2023;48:579-83.
3. Hamada K, Kubo R, Nishio D, Nakamura M. A homozygous mutation, c.736T>A (p.C246S), in LIPH gene in a patient manifesting woolly hair, hypotrichosis, hearing difficulty, cleft palate and amblyopia. *Eur J Dermatol* 2014;24:272-3.
4. Kinoshita-Ise M, Kubo A, Sasaki T, Umegaki-Arao N, Amagai M, Ohyama M. Identification of factors contributing to phenotypic divergence via quantitative image analyses of autosomal recessive woolly hair/hypotrichosis with homozygous c.736T>A LIPH mutation. *Br J Dermatol* 2017;176:138-44.
5. Vastarella M, Martora F, Ocampo-Garza S, Patri A, Battista T, Nappa P, *et al.* Treatment of hereditary hypotrichosis simplex of the scalp with oral minoxidil and growth factors. *Dermatol Ther* 2022;35:e15671.
6. Peled A, Samuelov L, Sarig O, Bochner R, Malki L, Pavlovsky M, *et al.* Treatment of hereditary hypotrichosis simplex of the scalp with topical gentamicin. *Br J Dermatol* 2020;183:114-20.
7. Chanasumon N, Sriphojanart T, Suchonwanit P. Therapeutic potential of bimatoprost for the treatment of eyebrow hypotrichosis. *Drug Des Devel Ther* 2018;12:365-72.

# Acute painless loss of vision due to bilateral hemiretinal vein occlusion in a case of bullous pemphigoid on tofacitinib: A potentially red flag symptom

Dear Editor,

Janus kinase (JAK) inhibitors have the potential to replace immunosuppressants for varied autoimmune and inflammatory conditions. Although safer than traditional steroids, these molecules have a labelled concern for thromboembolic events like deep vein thrombosis and pulmonary embolism. We report a refractory case of bullous pemphigoid who developed bilateral hemiretinal vein occlusion (HRVO) on tofacitinib therapy. We discuss the possible association and elaborate the concerning ocular side effect of tofacitinib.

A 72-year-old male, a known case of bullous pemphigoid, in remission for four years, presented with acute flare of disease activity for two months, associated with intense itching (Bullous pemphigoid disease area index [BPDAI]. Subjective –24/30, Objective 30/360). The patient reported a past history of treatment with steroids and azathioprine for a year. He also complained of gradual painless progressive diminution of vision in both eyes for the last six months. Ophthalmological examination showed advanced glaucomatous changes in both eyes. In view of these ocular changes, the patient was started on doxycycline 100 mg twice a day, niacinamide 1 gm twice a

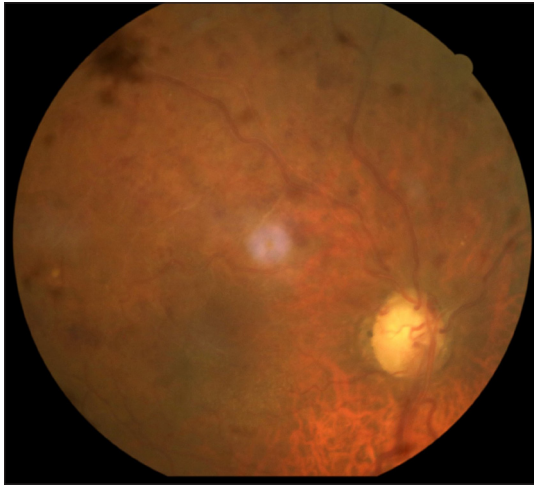
day, antihistamines and high-potency topical steroids for the management of bullous pemphigoid. The daily lesional count was reduced, but the intractable pruritus persisted worsening his sleep quality. For this we administered Tofacitinib 5 mg BD, which reduced his itching markedly within six days, but he complained of acute painless worsening of vision. Repeat ophthalmological examination revealed attenuated arteriole with dilated tortuous venules and extensive superficial retinal haemorrhage in the superior half of the retina in both eyes, suggestive of HRVO [Figures 1 and 2]. Fundus fluorescein angiography confirmed the diagnosis showing a prolonged arteriovenous phase, delayed filling of venules, its staining and non-perfused areas. Intraocular pressure was 12 mmHg (right eye) and 14 mmHg (left eye), respectively, with no sudden spike on diurnal charting. There was no personal or family history of any neurological disorder, stroke, diabetes and hypertension. He was a non-alcoholic and non-smoker. An extensive haematological investigation ruled out any evidence of hyperviscosity or thromboembolism. A two-dimensional echocardiography and computed tomography angiography of the brain was normal, ruling out atherosclerotic thrombi as a cause.

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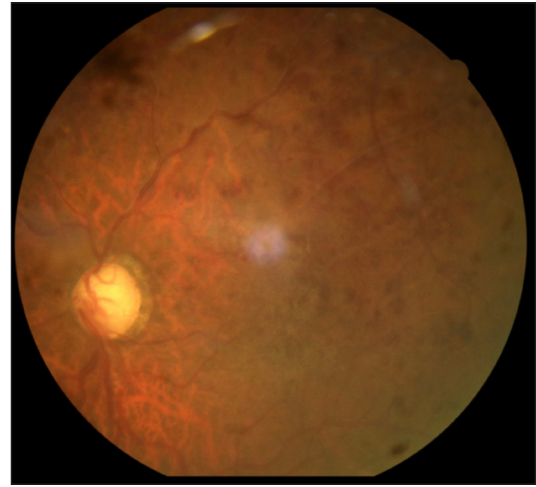
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**Figure 1:** Fundus right eye showing a dilated tortuous vessel with extensive superficial retinal haemorrhage in the superior half of the retina.



**Figure 2:** Fundus left eye showing a dilated tortuous vessel with extensive superficial retinal haemorrhage in the superior half of the retina.

For the management, tofacitinib was withdrawn, based on the temporal association between the drug and symptoms and the patient remained under close follow-up. His intraretinal haemorrhage resolved with few collaterals in the ischemic area without neovascularisation. Retinal photocoagulation of non-perfused areas was done. The intraocular pressure was normalised. His inferior altitudinal field loss persists with visual acuity stable at 6/18 in either eye.

Bullous pemphigoid is a chronic, relapsing autoimmune disease frequently affecting elderly patients and the treatment is aimed at arresting the development of new lesions along with cutaneous healing and control of pruritus. Topical/systemic steroids remain the first-line treatment, but in view of glaucomatous changes in the eye, this was not an option. The patient had persistent pruritus despite the reduction in BPDAI with second-line medications and hence tofacitinib was administered based on a previous report.<sup>1</sup> The isolated event of bilateral HRVO without any evidence of a systemic venous thromboembolic event and normal intraocular pressure, with no sudden spike on diurnal charting and no prior veno-occlusive changes ruled out glaucoma, suggesting that tofacitinib could be a cause of HRVO. Non-specific jakinibs like tofacitinib that target IL-10R associated JAKs and IFN $\beta$  and IFN  $\lambda$  associated JAK may result in the imbalance of prothrombotic and antithrombotic mechanisms resulting in thrombus formation.<sup>2</sup> We hypothesise that endothelial dysfunction and damage secondary to glaucoma, coupled with advanced age, bullous pemphigoid as a comorbid disease, may have led to acute HRVO, developing within a week of tofacitinib initiation. There have been similar reports of retinal vein occlusion reported with tofacitinib and with other JAK inhibitors.<sup>3-5</sup> The previous case of RVO was reported after a period of two months in a 47-year-old female with hypertension and rheumatoid arthritis treated with tofacitinib 5 mg BD for scleritis, resulting in drug withdrawal.<sup>3</sup> Another report of tofacitinib induced RVO was seen in a 45-year-old,

**Table 1: Ocular reactions reported with tofacitinib as per FDA adverse events reporting system (FAERS) database (2013–2023)\*.**

Reaction	Number of cases	Percentage of total cases (%)
Number of cases	5033	
Visual impairment	1064	21.14047
Cataract	834	16.57063
Dry eye	640	12.71607
Vision blurred	478	9.497318
Eye disorder	448	8.901252
Blindness	365	7.252136
Glaucoma	277	5.503676
Eye pain	218	4.331413
Ocular hyperaemia	160	3.179018
Eye swelling	140	2.781641
Eye irritation	138	2.741903
Uveitis	129	2.563084
Lacrimation increased	115	2.28492
Macular degeneration	103	2.04649
Retinal vein occlusion	17	0.338

\*The reported side effects are self-registered by patients, the pharmaceutical industry, healthcare providers and consumers, but they do not establish causation and reflect only the reporters' observations and opinions and have not been consistently verified by a medical specialist.

non-smoking woman with no risk of thromboembolic disease necessitating drug withdrawal.<sup>5</sup> We further searched the US Food and Drug Administration (FDA) adverse events reporting system (FAERS) public dashboard, which revealed 17 similar events, even though these adverse events reported do not implicate a drug causation [Table 1].<sup>6</sup>

While a pre-existing ocular pathology existed in our patient, ocular complaint is uncommon. This report highlights the importance of ocular evaluation before starting tofacitinib, especially in elderly patients with comorbidities.

**Declaration of patient consent:** The authors certify that they have obtained all appropriate patient consent forms. In the form, the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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## References

1. Youssef S, Gallitano S, Bordone LA. Two cases of bullous pemphigoid effectively treated with oral tofacitinib. *JAAD Case Rep* 2022;32:77–80.
2. Kotyla PJ, Engelmann M, Gienza-Stokłosa J, Wnuk B, Islam MA. Thromboembolic adverse drug reactions in janus kinase (JAK) inhibitors: Does the inhibitor specificity play a role? *Int J Mol Sci* 2021;22:2449.
3. Manoharan A, Atmakur H, Dutta Majumder P, Biswas J. Branch retinal vein occlusion in a case of recalcitrant diffuse anterior scleritis treated with tofacitinib. *J Ophthalmic Inflamm Infect* 2023;13:45.
4. Genovese MC, Kalunian K, Gottenberg JE, Mozaffarian N, Bartok B, Matzkies F, *et al.* Effect of filgotinib vs placebo on clinical response in patients with moderate to severe rheumatoid arthritis refractory to disease-modifying antirheumatic drug therapy: The FINCH 2 randomized clinical trial. *JAMA* 2019;322:315–25.
5. Allocca M, Catalano G, Savarino EV, Chaparro M, Levartovsky A, Michalopoulos G, *et al.* Comparison between tofacitinib and ustekinumab as a third-line therapy in refractory ulcerative colitis: A multicenter international study. *United European Gastroenterol J* 2024;12:543–51.
6. US FDA. FDA adverse event reporting system (FAERS) public dashboard. Available from: <https://fis.fda.gov/sense/app/95239e26-e0be-42d9-a960-9a5f7f1c25ee/sheet/8eef7d83-7945-4091-b349-e5c41ed49f99/state/analysis> [Last accessed on February 20, 2024].

# Primary carcinoma of accessory breast presenting as axillary ulcer

Dear Editor,

A 50-year-old man presented to the dermatology clinic with a one-year history of recurrent discharging ulcer in the left axilla. The lesion initially appeared as asymptomatic erythematous plaques for which he received antibiotics and infrared therapy at a community health center. The skin lesions improved temporarily but recurred 2 weeks later. Due to financial constraints, the patient did not seek further treatment. Over the next 6 months, the lesions progressively enlarged and subsequently developed ulceration. The lesion edges were sharp and irregular, with visible proliferative granulation tissue on the surface [Figure 1]. Patient denied a history of trauma, exposure to chemical substances or radiation. An incisional biopsy from the ulcer revealed a moderately differentiated adenocarcinoma. The tumour cells were arranged in solid nests or cord-like pattern, with focal areas showing glandular arrangement and infiltrative growth.



**Figure 1:** Discharging ulcer of the left axilla with sharp and irregular edges.

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