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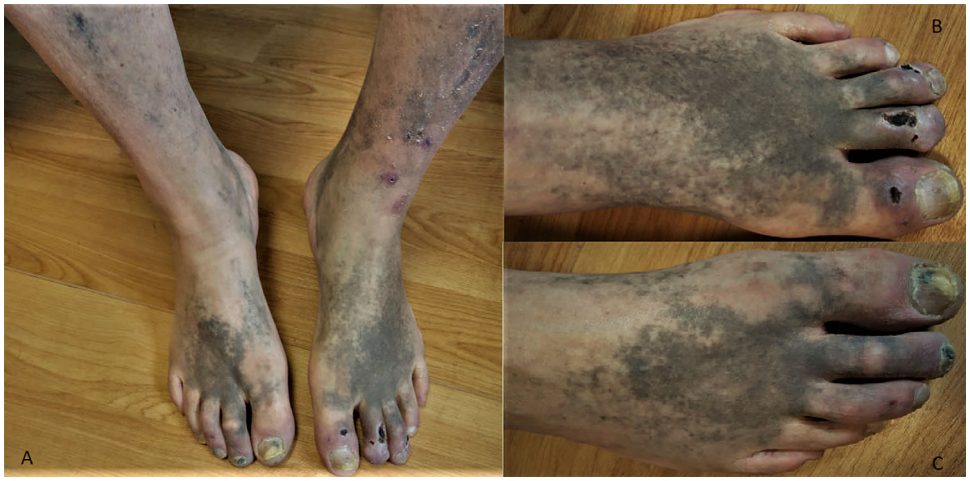
Clinical Images: Minocycline-induced vasculitis



The patient, a 60-year-old male with facial rosacea who was prescribed minocycline for more than 20 years, presented to outpatient rheumatology and dermatology practices with progressive gray hyperpigmentation and necrotic ulcerative lesions on his bilateral lower extremities (**A**) and toes (**B** and **C**). He also noted black hyperpigmentation in his oral gingiva and buccal mucosa. Additionally, he developed progressive numbness and neuropathic pain in the lower extremities. Serologically, he was negative for antinuclear antibody, antineutrophil cytoplasmic antibodies (including myeloperoxidase and proteinase-3 antibodies), rheumatoid factor, anti–cyclic citrullinated peptide antibodies, cryoglobulin, and anti-SSA (Ro) and anti-SSB (La) antibodies. His serum creatine kinase level and urinalysis result were normal. Serum protein electrophoresis did not detect a paraprotein. Serologic findings for hepatitis B and C and HIV were not detected. Minocycline-induced vasculitis was diagnosed (1,2). Lesions healed with cessation of minocycline, a course of oral glucocorticoids, and local wound care. Hyperpigmentation decreased. Neuropathic pain symptoms also improved. Recognition of drug-induced vasculitis is essential in patients with pigmentation changes, cutaneous ulcerations, and neuropathy (3,4). Case series of minocycline-induced vasculitis reactions, including polyarteritis nodosa–like vasculitis, have been reported (5).

Author disclosures are available at https://onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1002%2Facr2.11496&file=acr211496-sup-0001-Disclosureform.pdf.

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