brass musicians and therefore, lanoline oil should be considered as an alternative brass lubricant in patients with negative patch testing for this allergen. In addition, we should be aware about the possibility that certain factors[1-3] in conjunction with irritant oils might help in developing irritant contact dermatitis.

We believe that this case report can alert of the possibility of irritant contact dermatitis due to lubricant oils, so manufacturers could develop oils with a more suitable composition. This, along with adopting proper preventive measures in relation to the practice of the instrument, could reduce this skin conditions, and potential work impairment and incapacity.

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Double Primary Acral Lentiginous Melanoma of both Soles

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Dear Editor:

Multiple primary cutaneous melanoma (MPM) is defined as two or more independent melanoma lesion without attribution of metastasis or recurrence to each other's presence. Histopathological differences, chronological orders, or negativity for metastasis work-ups indicate a possibility of MPM[1]. The presence of multiple primary acral melanoma is extremely rare. There are one case series of four MPM patients in African-American ethnicity, and one case has been reported in Korean patient[1-3].

A 78-year-old Korean man referred to the dermatology clinic for the black and hyperkeratotic patch on his right heel (Fig. 1B). The lesion was first noticed 10-years ago. A punch biopsy of lesional skin was done at the center and it turned out to be an acral lentiginous melanoma *in situ*. He had another lesion on the left sole, which was 12 years old, diagnosed as melanoma 2 years ago and it was surgically excised (Fig. 1A; T4bN0M0, wide excision with

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full thickness skin graft). There was no radiological evidence of lymph node or visceral organ metastasis at that time, but now liver, lung, and chest wall metastasis was found on the radiological studies. He was referred to the hemato-oncology department for the palliative care, but refused all treatment options.

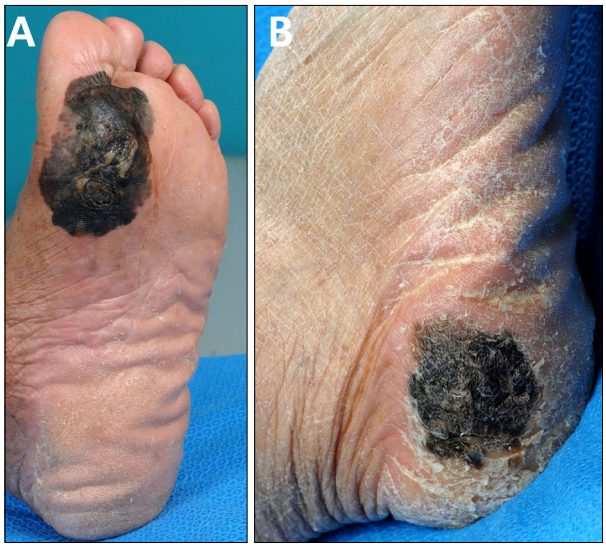

Fig. 1. The excised melanoma (A) and a black, hyperkeratotic macule on the right heel (B).

The right sole lesion occurred at the distant location from the left sole lesion, and there are pathological differences between the 2 melanomas: the excised right heel lesion shows only lentiginous spreading of atypical cells with no dermal invasion (Fig. 2C, D), but the left sole melanoma showed deeply invasive vertical growth with heavily pigmented melanoma cells (Fig. 2A, B). Therefore, it is plausible to conclude that the right side lesion is not the metastasis or recurrence of the left sole melanoma but another primary melanoma. One limitation is that we did not analyzed the excision specimen of the right sole lesion, because excision was not performed due to the extensive metastasis.

Acral lentiginous melanoma frequently occurs in oriental ethnicity[2,4]. However, MPM of acral site is exceedingly rare when comparing to the superficial spreading melanomas. Therefore, we performed cancer-specific high-throughput annotation of somatic mutations (CHASM) study for the both melanomas. The genetic mutation profile was

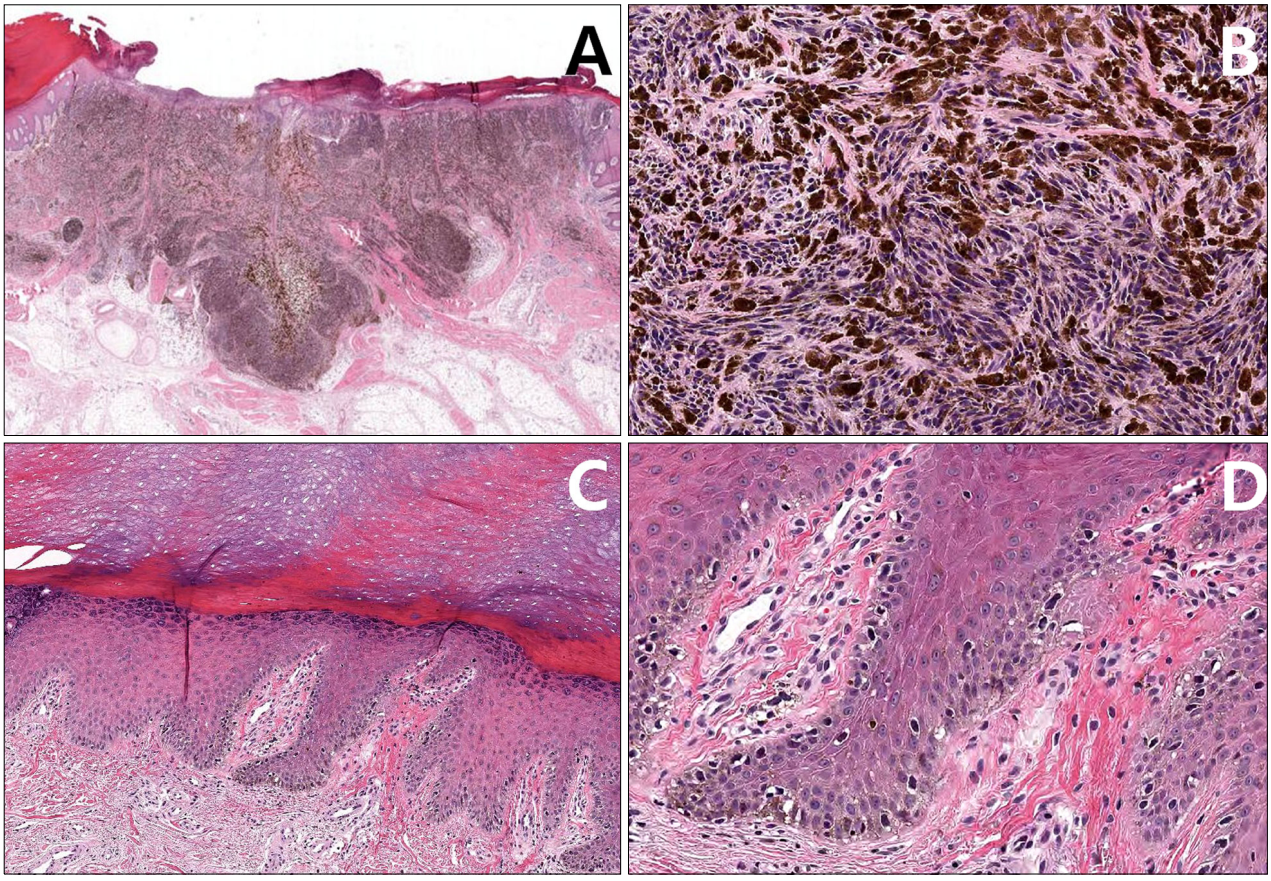

Fig. 2. Histopathology of the excised melanoma of left sole (H&E; A: ×40, B: ×200), and the right heel lesion (H&E; C: ×40, D: ×200).

negative for known KIT, BRAF, MEK, or NRAS gene mutations in melanomas. In recent study on multiple primary superficial spreading melanomas, CDKN2A gene mutation was statistically significant in these cases other than non-multiple melanoma cases[5]. Therefore, we suggest comparing genetic mutations in acral MPMs with solitary cases for the further studies.

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Infliximab for Treatment of Synovitis, Acne, Pustulosis, Hyperostosis, and Osteitis Syndrome: A Case Report

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Dear Editor:

A 26-year-old Japanese man presented with high fever (>38.0°C). He had a history of intractable acne of the face, chest, and back beginning from his early teens. The facial acne had worsened during the previous 2 weeks, and was accompanied by diffuse arthralgia followed by high fever. On admission, the patient had multiple erythematous follicular papules and pustules on his forehead, lower jaw, and posterior neck (Fig. 1A). The white blood cell count was $11.8\times10^3/\mu l$ (normal 4.0 to $8.5\times10^3/\mu l$) with 66% neutrophils (normal 38% to 58%), 25% lymphocytes (normal 27% to 46%), and 9% monocytes (normal 3% to 7%). The C-reactive protein level was 4.86 mg/dL (normal <0.3 mg/dl), the tartrate-resistant acid phosphatase-5b level was 638 mU/dl (normal 170 to 590 mU/dl), and the serum type I collagen cross-linked N-telopeptides (s-CTx) level was 66.9 nmol bone collagen equivalent (BCE)/mmol・Cr (normal <35.3 nmol BCE/mmol・Cr). All other laboratory values were normal. Culture of a facial pustule was negative; histological examination of the pustule folliculitis. Bone scintigraphy and enhanced magnetic resonance imaging showed sacroiliac arthritis (Fig. 2). We diagnosed synovitis, acne, pustulosis, hyperostosis, and osteitis (SAPHO) syndrome, because he ex-

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