sed in specific types of cancer, KAI1 is over expressed in MM. Interestingly, KAI1 was not expressed in cutaneous BCCs, SCCs and normal tissues. More work is needed to characterize the pathway through which KAI1 is over-expressed in MM skin tumor.

ACKNOWLEDGMENT

This work was supported by the Soonchunhyang University Research Fund.

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http://dx.doi.org/10.5021/ad.2013.25.4.500

Lichenoid Drug Eruption after Low-Dose Imatinib Mesylate Treatment

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Dear Editor:

Imatinib mesylate, a selective antitumor tyrosine kinase inhibitor, has been approved as the first-line therapy for gastrointestinal stromal cell tumor and chronic myeloid leukemia. Lichenoid drug eruption (LDE) is known to cause uncommon adverse cutaneous reactions of imatinib mesylate, usually appearing with 400 mg or more of imatinib mesylate per day[1,2]. Here, we present a case of severe LDE after low-dose imatinib mesylate treatment for gastrointestinal stromal cell tumor.

Received October 19, 2012, Revised December 1, 2012, Accepted for publication December 5, 2012

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A 77-year-old Korean male patient came to our dermatology clinic in March 2011 for skin rash over the entire body. He was diagnosed with gastrointestinal stromal cell tumor with multiple liver metastasis, and began imatinib with 400 mg per day on September 2007. Two months later, violaceous pruritic papules developed symmetrically on both legs. The skin lesion progressed to the whole body despite a dose reduction to 300 mg per day. His skin lesion was markedly improved after a medication change to sunitinib. However, his kidney function gradually worsened and consequently, sunitinib was changed to imatinib again with a reduced dose to 300 mg per day from December 2010. Extensive skin lesion reappeared soon and a dose reduction to 200 mg per day had no effect on improving skin lesion. On physical examination, violaceous, slightly elevated papules symmetrically covered the extensive body surface (Fig. 1A). The distribution was mainly on both extremities (Fig. 1B). Skin biopsy was performed on his left lower leg. Specimen showed lichenoid lymphocytic infiltration on the upper dermis and deep dermal perivascular lymphocytic infiltration (Fig. 2A). In the high-magnification, 'saw-toothed' rete-ridges were similar to those of lichen planus; however, the finding of cytoid bodies in the granular layer was favorable to LDE (Fig. 2B). Based on the clinical and histologic findings, a diagnosis of LDE due to imatinib was made.

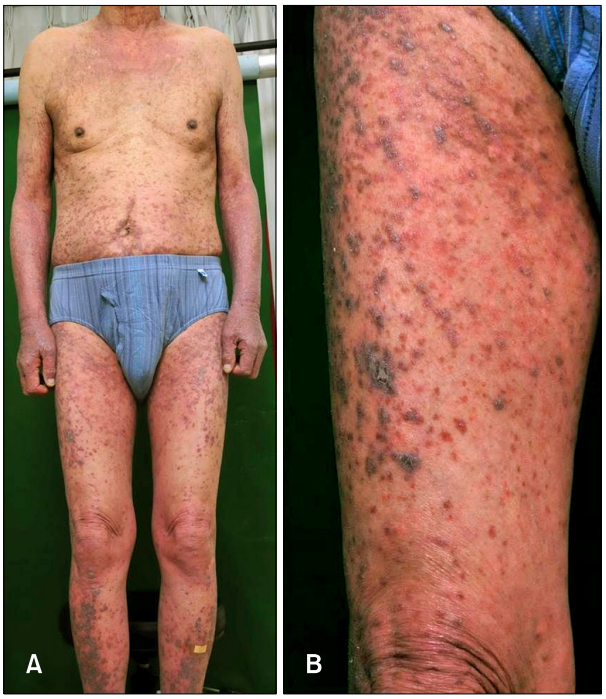

Fig. 1. (A) Symmetrically involved erythematous to violaceous papules and plaques, covered extensive body surface area. (B) Slightly elevated violaceous papules and plaque on the right thigh.

Adverse cutaneous reactions after imatinib are quite common and various[2]. Among them, imatinib-induced LDE is a relatively uncommon adverse skin reaction and has been reported in 15 cases to date[2]. In the PubMed online research, all 15 affected patients took more than 400 mg per day of imatinib, except 1 case which showed a lasting LDE despite the dose reduction from 400 mg per day to 200 mg per day[3]. One case of a Korean patient with LDE

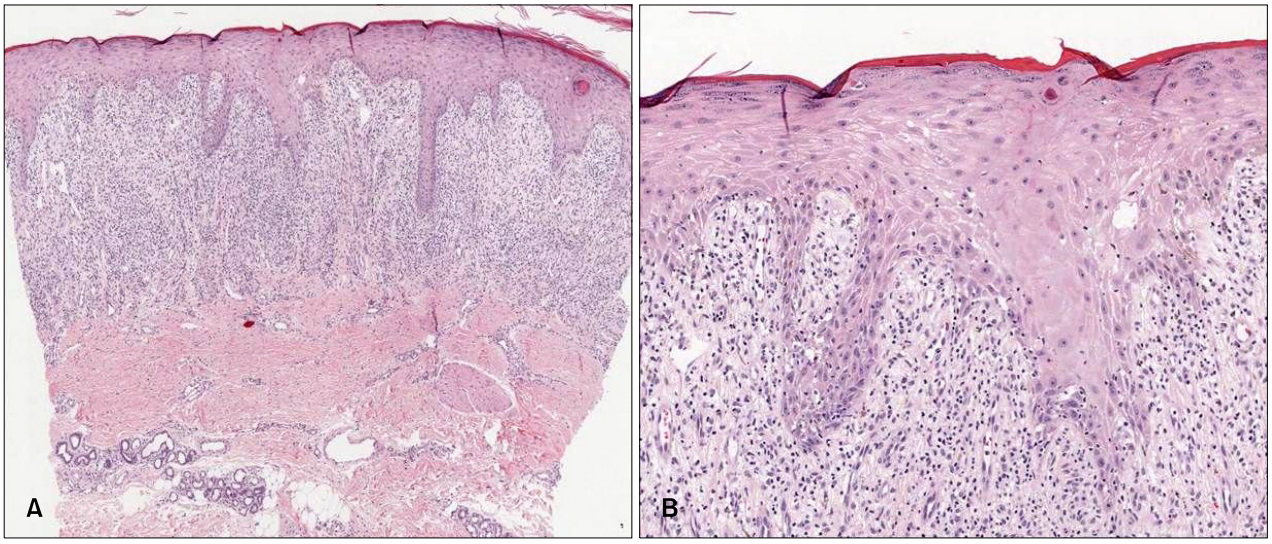

Fig. 2. Histopathological findings. (A) Dense band like lymphocytic infiltration in the upper dermis and deep dermal lymphocytic infiltration (H&E, ×40). (B) Lichenoid lymphocytic infiltration with 'saw-toothed' rete ridges and vacuolar degeneration of the cells in the basal layer. Cytoid bodies in the granular layer (H&E, ×100).

after imatinib was reported to date; yet, the case differs with our case in that the eruption was well-controlled with a dose reduction to 300 mg per day[4]. Ugurel et al.[5] reported that imatinib acts as a dose dependent inducer of the development of LDE and may show mild reactivity to low or intermediate dose (200 to 600 mg/day). However, in this case, the patient suffered from extensive drug eruption in spite of the low dose of 200 mg per day. We present here LDE after imatinib treatment of 400 mg per day to a low dose of 200 mg per day. This case presented that a low dose of imatinib does not always prevent LDE and can induce severe eruption in some patients. We suggest clinicians to keep in mind that all patients taking imatinib mesylate have the possibility of extensive LDE even in a low dose and therefore should carry a close observation.

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http://dx.doi.org/10.5021/ad.2013.25.4.502

Minor Salivary Gland Sialolithiasis of the Upper Lip

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Dear Editor:

Sialolithiasis is a common disease of the salivary glands. Most calculi occur in the major salivary glands such as the submandibular glands (80% to 92%) and parotid glands (16% to 19%), while minor salivary glands are rarely affected (2%)[1]. Minor salivary gland sialolithiasis is characterized by a small, solitary submucosal nodule, which is hard and in some cases can be movable in the surrounding tissue[2]. Since it is rare and its clinical features are not always typical, clinical misdiagnosis is possible[3]. Most otolaryngologists and dentists are relatively familiar with sialolithiasis, but many dermatologists are not. In order to heighten the awareness of this disease and to facilitate diagnosis, we report a case of minor salivary gland sialolithiasis that was initially misdiagnosed clinically.

A 56-year-old man presented with a six-year history of an asymptomatic solitary submucosal nodule on the upper lip. He reported no history of trauma to the lip. Physical

Received November 22, 2012, Accepted for publication December 5, 2012

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