

Vulvar Syringoma: A Rare Cause of Vulvar Pruritus

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To the Editor:

Although vulvar syringomas are rare, they are probably underdiagnosed because most are asymptomatic lesions. However, they can give rise to vulvar pruritus that is unresponsive to conventional treatments and, if severe, may considerably affect quality of life. Consequently, such lesions should be considered in the differential diagnosis of pruritus and papular lesions of the vulva.^{1,2}

We describe a 78-year-old woman with a 9-year history of urinary incontinence who consulted for intermittent, nonseasonal vulvar pruritus that had started 4 years earlier. She was treated with oral antihistamines and topical corticoids, but did not improve. The physical examination showed multiple papules of 3 to 5 mm that were flesh-colored and of lichenoid appearance. Some of these papules were eroded on the surface and coalesced to form plaques on both of the labia majora (Figure). No such lesions were observed at other sites.

Contact allergy testing based on the standard Spanish panels was positive at 96 hours for the perfume blend and the black rubber blend. Biopsy of a papule showed a proliferation composed of nests and ducts of epithelial cells

embedded in a stroma of collagen bundles. The ducts were lined with 2 layers of cuboid cells and some showed tadpole-like extensions. These findings were consistent with eccrine syringoma.

The lesions were treated by carbon dioxide laser, with clear improvement in both the symptoms and the lesions. After 11 months of follow-up, the patient has presented few episodes of pruritus, all less severe than before and controlled with topical corticoids.

Syringoma is a benign tumor of eccrine origin usually located in the periorcular region; however, there are other, more unusual sites, such as the vulva. Simultaneous involvement of the vulvar region and extragenital areas has been described.¹ It mainly affects women during puberty and middle age,¹⁻³ and rarely manifests in the later years as in our case.^{1,4}

Syringomas are usually asymptomatic, but can cause pruritus in the vulva. On occasions, pruritus may become more severe during menstruation, pregnancy, and summertime.^{1,5} A review of the published cases of vulvar syringomas indicates that pruritus develops over a number of years before the definitive diagnosis,^{2,4-8} severely impacting on quality of life. Persistence of the lesions may occasionally cause venereophobia and carcinophobia.^{5,8}

Three clinical forms of presentation of vulvar syringomas have been described. Most commonly, they appear symmetrically on the labia majora as multiple flesh-colored or brownish papules. The other presentations are cystic lesions or lichenoid plaques,¹ as was the case in our patient. The clinical differential diagnosis mainly considers epidermal cysts, steatocystoma multiplex, condyloma, lichen planus, and lichen simplex chronicus.^{1,3,5,9}

Because the appearance of vulvar syringoma is nonspecific, clinical

diagnosis of this condition may be difficult. Histology is key to establishing the diagnosis and ruling out malignancy.^{5,8} In the case of vulvar syringoma, histology will reveal dermal proliferation composed of cells arranged in nests and ducts within a fibrous stroma. Some ducts present characteristic small, comma-shaped epithelial cell tails that resemble a tadpole. Normally, the ducts are lined with 2 rows of epithelial cells and may be filled with eosinophilic material.^{1,4,7}

In our case, the clinical symptoms, physical examination, and additional tests excluded other common causes of vulvar pruritus such as candidiasis, scabies, pediculosis, allergic contact dermatitis, psoriasis, lichen sclerosis, and atrophic lichen. Because the patient had a history of urinary incontinence, she was initially diagnosed with irritant dermatitis and associated lichen simplex chronicus, but later definitively diagnosed with syringomas after the biopsy. The presence of lichenification due to chronic scratching may mean that vulvar syringomas are hard to see and, therefore, patients may be incorrectly diagnosed with lichen simplex chronicus.⁷ Therefore, vulvar syringoma should be considered in all patients with lichen simplex chronicus who respond poorly to oral antihistamines and topical corticoids.¹

The treatment for vulvar syringomas is not standardized. Only a minority of patients achieve adequate control of pruritus with topical corticoids, with or without oral antihistamines.^{1,3} Oral tranilast,⁶ topical atropine,⁷ curettage, cryotherapy,⁴ electrosurgery,^{2,5,7} and resection⁷ are some of the treatments that have been used with variable results. One of the best therapeutic options is carbon dioxide laser treatment, which has proven to be highly effective for the relief of pruritus and for resolving the lesions safely and easily.^{1,2,10}



Figure 1. Multiple lichenoid papules in labia majora.

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Oncocytoma of the Lacrimal Caruncle

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To the Editor:

Oncocytomas are neoplasms that originate in the glandular and secretory epithelia.¹ Histologically, the masses are composed of polyhedral cells of granular eosinophilic cytoplasm, which presents abundant mitochondria when examined ultrastructurally.¹ In cutaneous presentations, the most common sites are the ocular caruncle and medial eyelid canthus.²

The incidence of neoplasm in the caruncle is around 3% of all tumor biopsies from ocular adnexa. Ostergaard³ published a Danish series spanning 25 years that included 574 biopsies of caruncular lesions, reporting an incidence of 2.8%. In another series of 466 biopsies of the caruncle reported by Pecorella,⁴ the incidence of oncocytoma was 2.7%. This tumor is more common among older adults and women: the average age at presentation is 73 years and 5 times more women

than men are affected.⁴ Biologically, the tumor is benign, although malignant oncocytomas have been described.⁵

We describe an 82-year-old man who attended an ophthalmology clinic in Colombia for a cystic lesion that had been growing on the inner area of the left eye for 1 year and presented occasional bleeding. The physical examination revealed a rounded polypoid lesion measuring 7 mm across in the caruncle of the left eye. The lesion was highly vascularized, but there was no involvement of the skin of the palpebral fold. The mass was surgically removed.

The anatomical pathology department received a fragment of tissue partially lined with epidermis that measured 1.2 × 1.1 cm at the largest diameter. The fragment contained a strongly vascularized reddish-brown polypoid lesion of 0.7 × 0.6 cm at the cross diameter. Tissue sections with

hematoxylin eosin stain showed an area of palpebral and bulbar conjunctiva corresponding to the area of the caruncle. The lamina propria contained a benign tumor of epithelial origin composed of polyhedral cells with a slightly hyperchromatic central nucleus and eosinophilic granular cytoplasm, with well-circumscribed cell borders. The cells were arranged in solid nests associated with vascular congestion and foci of microhemorrhaging (Figure 1). Periodic acid-Schiff staining revealed an intense granular acidophilic content in the cytoplasm, corresponding to the high number of mitochondria (Figure 2).

The lesion was diagnosed as an oncocytoma of the lacrimal caruncle.

Oncocytoma, also known as an oncocytic tumor or oxyphilic cell adenoma, is a tumor that originates in the cells of glandular and secretory epithelia. Oncocytomas have been