Acral Syringomas

Siringomas acrales

To the Editor:

Syringomas, which are common benign adnexal tumors, arise in the intraepidermal ductal part of the eccrine sweat gland. They are more common in women and often develop on the eyelids. An exclusively acral site of the lesions, as we describe here, is very rare.

A 44-year-old Ecuadorian woman with no past medical or surgical history of interest described the progressive appearance of slightly pruritic lesions on both forearms over the previous 4 years. The lesions had not improved with tacrolimus or topical or oral corticosteroids. She reported no history of similar lesions in her family.

On physical examination we observed the presence of multiple monomorphic erythematous papules with a shiny surface and lichenoid appearance. They were 1 to 2 mm in diameter and were distributed symmetrically on the extensor surfaces of both forearms (Figure 1). There were no other lesions on the mucosas or on other areas of the skin.

Histopathology revealed an epithelial proliferation in the superficial dermis formed of small cords and ducts and the presence of comma-like structures within a sclerotic stroma, confirming the diagnosis of syringoma (Figure 2). There was no cellular atypia. Immunohistochemical analysis was positive for the carcinoembryonic antigen receptor and negative for estrogen and progesterone receptors.

Further tests were performed. Blood tests including tumor markers only detected eosinophilia (12%). A chest radiograph and an abdominopelvic ultrasound were within normal limits. A gynecologic examination was also normal.

In view of the benign nature of the disorder, the patient decided to continue follow-up with observation of the lesions; after 16 months none had developed at other sites.

Syringomas are adnexal tumors with a clear predominance in women. They often start to develop during puberty, and there are cases in which the lesions have developed during pregnancy, leading to the suggestion of a possible hormonal influence. In the case described here, both estrogen and progesterone receptors were negative.

From a clinical point of view, syringomas are characterized by the presence of multiple pink or yellowish papules that most commonly appear in the periocular region in women. They have been described more rarely on other areas of the body, such as the neck, thorax, axillas, abdomen, or genital region.

As they are benign, no treatment is necessary, although this is often requested for cosmetic reasons. A number of treatments have been tried—surgical excision, cryotherapy, electrocoagulation, trichloroacetic acid, tretinoin, topical atropine, and erbium-yttrium-aluminum-garnet, carbon dioxide, argon, and pulsed dye lasers—with variable results.

In 1987, Friedman and Butler[1] proposed a classification of syringomas based on their clinical features and associations, naming 4 variants: a localized form (solitary or multiple), a familial form, a type associated with Down syndrome, and a generalized form subclassified into multiple and eruptive types.

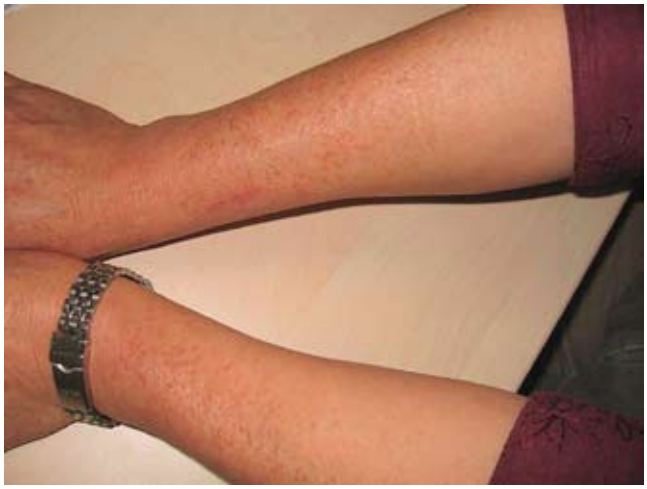

Figure 1 Symmetric acral distribution of multiple erythematous lesions with a shiny surface. The lesions were of 1 to 2 mm in diameter and were located on the extensor surfaces of the forearms.

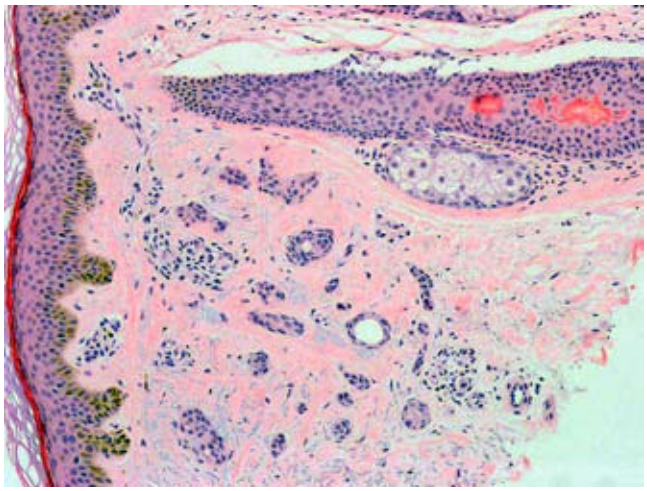

Figure 2 Benign tumor of the papillary dermis, formed of cords and ducts of epithelioid cells in a sclerotic stroma (Hematoxylin-eosin, original magnification ×100).

Localized syringomas are the most common, and the case we present is compatible with this form. Attention should be drawn to the difficulty of clinical diagnosis of these lesions in acral sites. It is important to include syringomas in the clinical differential diagnosis of papular lesions on the limbs.

The appearance of syringomas exclusively on acral areas of the upper limbs (forearms, wrists, and dorsum of the fingers), as described in this report, is very rare, with only 10 articles published in the English-language literature (Table 1).

Among all the cases reviewed, a symmetric distribution limited to the upper limbs has been described in only in 7 patients.[2-8] In a further 2 reports, this distribution was associated with the typical periocular involvement[9,10] and in another case with symmetric lesions on the distal parts

Table 1 Syringomas With an Acral Distribution Reported in the Literature

	Sex	Age, y	Time Since Onset	Site	Other Sites	Family History	Follow-up	Otherfindings
Hughes, 1977[2]	Male	31	Many years	Dorsum of the fingers of both hands	No	–	–	Postpartum cerebral damage
Asai, 1982[9]	Female	35	Many years	Dorsum of the proximal phalanges of both hands	Periocular	–	–	–
Hans van den Broek, 1982[10]	Male	52	6 mo	Dorsum of the wrists, distal forearms	Periocular	–	1 year	Clear-cell acanthoma
Berbis, 1989[7]	Male	70	1 y	Forearms, flexures	No	–	4 years	Pulmonary carcinoid tumor. *Inhibition of growth of the syringomas after surgery
Metze, 1990[3]	Male	69	3 y	Dorsum of the hands	No	No	–	Basal cell carcinomas, Melanoma Clark stage IV, Breslow depth 0.8
García, 1997[11]	Female	43	6 mo	Dorsum of the hands and feet	No	–	–	Race: black. Stage IV breast cancer, tamoxifen and chemotherapy
Patrizi, 1998[6]	Male	43	–	Wrist and forearm	No	–	–	–
Patrizi, 1998[6]	Female	60	–	Extensor surface of the forearms and scar	No	–	–	Tubular adenoma of the breast –
of breast surgery								
Martín-García, 2006[4]	Female	43	2 y	Forearms, distal upper arms	No	–	3 y	Similar to photosensitive eruption. Periods of complete disappearance
Balci, 2009[5]	Female	41	–	Forearms	No	–	–	Trichoepitheliomas on the face
Muniesa, 2008[8]	Female	28	16 y	Dorsum of the phalanges of both hands	No	Sister	–	–
Valdivielso-Ramos, 2009 (Present case)	Female	44	4 y	Forearms	No	No	20 mo	–

*Review performed up to January, 2010.

Table 2 Distinctive Characteristics of Acral Syringomas

In men and women in equal proportions
Older (28-70 y)
Exclusively acral sites mentioned (with/without periocular involvement)
Association with tumors

of both lower limbs[11]; and 1 report described concomitant involvement of the surgical scar of an adenoma of the breast.[6]

Analysis of all published cases of acral syringomas highlights a number of specific features (Table 2). First, the numbers of women and men were very similar (7 women versus 5 men) and the patients were older (between 28 and 70 years) than has usually reported for these tumors. We note that there have been reports of syringomas exclusively in acral areas. Secondly, it is interesting that the lesions were associated with a tumor in 4 of the patients. In 1 patient, they presented concomitantly with a pulmonary carcinoid tumor, the excision of which halted the advance of the syringomas[7]; another patient also had a superficial melanoma and basal cell carcinomas,[3] another breast cancer treated with tamoxifen and chemotherapy,[11] and finally 1 patient had a tubular adenoma of the breast.[6]

As suggested by other authors, we propose that acral syringomas should be classified as an independent entity in the initial classification of syringomas proposed by Friedman (in fifth place), as they present specific characteristics that differentiate them from other syringomas included in that classification.[1,4,6] Further series with larger numbers of patients may be able to confirm this hypothesis.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Sudden Onset of Viral Warts During Treatment With Etanercept

Aparición brusca de verrugas virales durante el tratamiento con etanercept

To the Editor:

Etanercept is a tumor necrosis factor (TNF) antagonist that has been shown to be effective and safe in the treatment of psoriasis.[1-3] However, there is some discussion of a possible link with new infections.[4]

We present the case of a 70-year-old woman diagnosed with chronic plaque-type psoriasis resistant to conventional systemic therapy. When the patient first came to the outpatient clinic, she presented numerous plaques on the trunk and limbs (baseline Psoriasis Area and Severity Index [PASI] score of 17.9) and treatment was prescribed with subcutaneous etanercept 50 mg twice weekly. A good response to treatment was seen 3 months later and there was a fall in the PASI score to 1.8; the dosage of etanercept was reduced to 50 mg per week as maintenance therapy. However, the patient reported that, 1 month after starting treatment with etanercept, she developed multiple asymptomatic lesions of sudden onset; this was