

Multiple Acral Syringomas[☆]



Siringomas acrales múltiples

To the Editor:

A 40-year-old woman with no personal or family history of interest was seen for a mildly pruritic rash of progressive onset on both forearms that had appeared 2 years earlier. The lesions were not exacerbated by sun exposure and had not improved following treatment with either antihistamines or topical corticosteroids. Physical examination revealed multiple, slightly raised papules of 1 to 2 mm in diameter on the ventral forearms. The papules were monomorphic with an erythematous-brownish coloration (Fig. 1A and B). The patient had no lesions in any other areas of the integument or mucous membranes. Hematoxylin-eosin staining showed an epithelial proliferation in the middle and upper reticular dermis consisting of ductal structures covered with a cuboidal epithelium. Some of the ductal structures had comma-shaped epithelial prolongations (Fig. 2). Mitosis and cellular atypia were absent. Culture for human papilloma virus was negative. Based on these clinical and histological findings the patient was diagnosed with multiple acral syringomas.

Photoprotection and topical treatment with 0.05% tretinoin twice daily were prescribed. After 4 months of treatment the patient reported flattening of the lesions and a reduction in pruritus, and showed good tolerance to the treatment.

Syringoma is a common benign adnexal tumor derived from the intraepidermal portion of the eccrine excretory (acrosyringal) duct. The most common presentation is small, yellowish or skin-colored papules on the lower eyelids of middle-aged women. Less frequent locations include the neck, thorax, armpits, and genital region.¹

In 1987 Friedman and Butler² proposed a classification system that distinguishes 4 clinical variants of syringoma: localized (solitary or multiple), familial, Down's syndrome-associated, and generalized (multiple or eruptive) forms. Eruptive syringoma can be associated with Nicolau-Balus syndrome, which is characterized by the presence of eruptive syringomas, milium cysts, and vermiculate atrophoderma.³

Histologically, syringoma is characterized by the proliferation of cells arranged in nests, cords, or tubular structures and located in the upper dermis. Depending on the plane of section, syringomas can have a comma- or tadpole-like morphology. The tubular structures exhibit ductal differentiation and an eosinophilic cuticle lining the lumen. Bundles of thick, sclerotic collagen are evident in the surrounding stroma. The histological differential diagnosis should include microcystic adnexal carcinoma, desmoplastic trichoepithelioma, sclerodermiform basal cell carcinoma, and sclerosing adenosis of the sweat glands. Syringoma is distinguished from microcystic adnexal carcinoma by its smaller size, greater symmetry, more superficial location in the dermis, and the absence of prominent horn cysts. While solid strands of basophilic epithelial cells and corneal cysts may be observed in desmoplastic trichoepithelioma, ductal

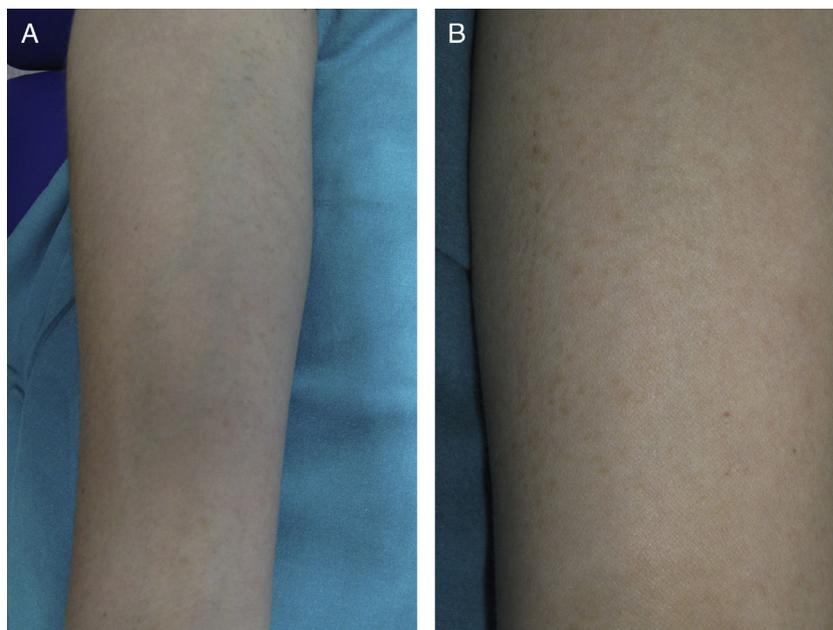


Figure 1 A, Multiple papules of several millimeters in diameter located on the ventral forearm. B, More detailed image showing the erythematous-brownish coloration and monomorphic appearance of the lesions.

[☆] Please cite this article as: Gómez-de Castro C, Vivanco Allende B, García-García B. Siringomas acrales múltiples. *Actas Dermosifiliogr*. 2018;109:834–836.

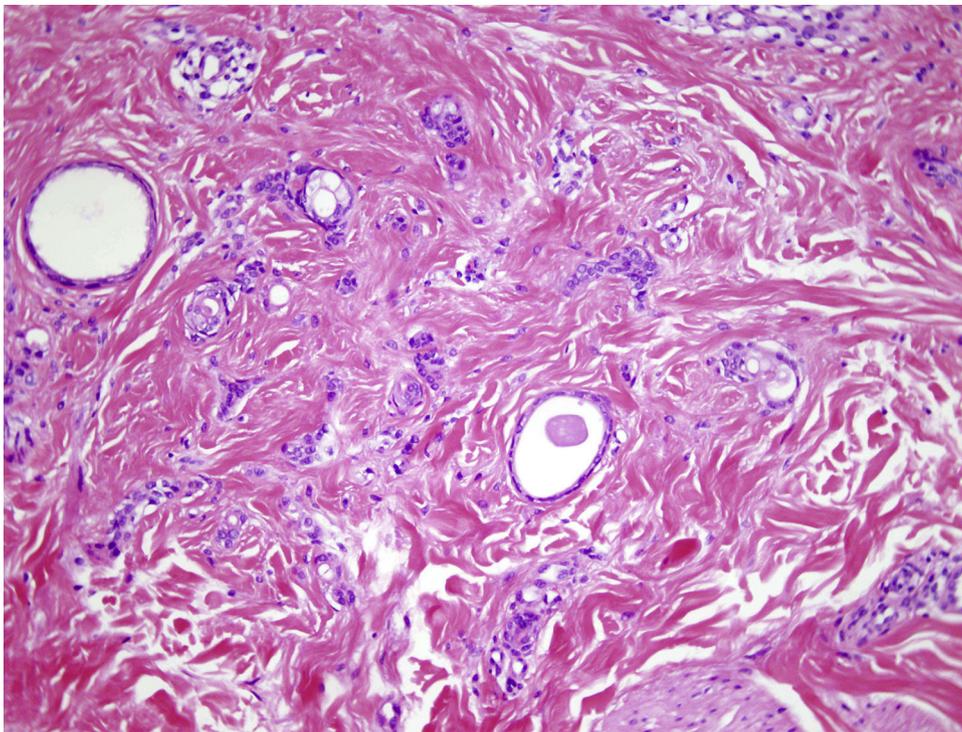


Figure 2 Biopsy reveals the presence in the dermis of ductal structures covered with a cuboid epithelium with comma-shaped prolongations (hematoxylin-eosin, original magnification $\times 200$).

Table 1 Published Cases of Acral Syringoma.

Author(s), Y	Sex	Age, Y	Site	Associated Tumors
Hughes and Apisarnthanarax, ¹ 1977	Male	31	Dorsal aspect of the fingers of both hands	No
Asai, 1982	Female	35	Periocular area and dorsal aspect of the fingers	No
van den Broek, 1982	Male	52	Periocular area, forearms, and dorsal aspect of the wrists	Clear cell acanthoma
Berbis, 1989	Male	70	Flexures of the forearm	Pulmonary carcinoid tumor
Metze, 1990	Male	69	Dorsal aspect of the hands and forearms	Basal cell carcinomas and melanoma (Breslow thickness, 0.8 mm)
García, 1997	Female	43	Dorsal aspect of the hands and feet	Stage IV breast cancer
Patrizi, 1998	Male	43	Wrist and forearm	No
Patrizi, 1998	Female	60	Breast surgery scar and dorsal aspect of the forearms	Tubular breast adenoma
Iglesias-Sancho et al, 1999	Female	76	Flexor surface of the forearm and intermammary cleft	No
Martín-García, 2006	Female	43	Forearms and distal portions of the arms	No
Muniesa, 2008	Female	28	Dorsal aspect of the phalanges of both hands	No
Koh, 2009	Female	27	Dorsal aspect of the fingers of both hands	No
Balci, 2009	Female	41	Forearms	Facial trichoepitheliomas
Valdivielso-Ramos, 2009	Female	44	Forearms	No
Varas-Meis and Prada, 2015	Female	62	Forearms and periorbital area	Promyelocytic leukemia
Gómez et al, 2016	Female	40	Forearms	No

Adapted from Valdivielso-Ramos et al.⁶

structures are absent. Sclerodermiform basal cell carcinoma lacks ductal structures containing amorphous material. Finally, stellate sclerosis, which is absent in syringoma, is very common in the benign condition known as sclerosing adenosis of the sweat glands.^{4,5}

Acral syringoma is limited to the distal areas of the upper and/or lower extremities. This form is very rare, and only a few cases are described in the literature (Table 1).^{6,7} Distinctive characteristics of this form include onset at more advanced ages and a similar prevalence in men and women.^{6,8} Concomitant periorbital involvement is absent in most reported cases. It is important to highlight the occasional association of acral syringoma with malignant tumors, including pulmonary carcinoid tumor, cutaneous melanoma, basal cell carcinoma, breast carcinoma, and promyelocytic leukemia.⁶⁻⁸ Our patient was a healthy woman with no symptoms and no known tumors.

The differential diagnosis of papular acral lesions should include syringoma, as well as lichen planus, milium cysts, urticaria pigmentosa, flat warts, and certain photodermatoses.^{8,9}

Given the benign nature of the process treatment is not required, although aesthetic or symptomatic treatment is often instituted. Available therapeutic options include surgical excision, electrocoagulation, cryotherapy, laser ablation, topical retinoids, and trichloroacetic acid.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References

- Hughes PS, Apisarnthanarax P. Acral syringoma. *Arch Dermatol*. 1977;113:1435-6.
 - Friedman SJ, Butler DF. Syringoma presenting as milia. *J Am Acad Dermatol*. 1987;16:310-4.
 - Dupré A, Carrère S, Bonafé JL, Christol B, Lassère J, Tournon P. Syringomes éruptifs généralisés, grains de milium et atrophodermie vermiculée. Syndrome de Nicolau et Balus. *Dermatologica*. 1981;162:281-6.
 - Klein W, Chan E, Seykora JT. Tumors of the epidermal appendages. In: Elder DE, Elenitsas R, Johnson BL Jr, Murphy GF, editors. *Lever's Histopathology of the skin*. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2005. p. 900.
 - Henner MS, Shapiro PE, Ritter JH, Leffell DJ, Wick MR. Solitary syringoma: Report of five cases and clinicopathologic comparison with microcystic adnexal carcinoma of the skin. *Am J Dermatopathol*. 1995;5:465-70.
 - Valdivielso-Ramos M, de la Cueva P, Gimeno M, Hernanz JM. Acral syringomas. *Actas Dermosifiliogr*. 2010;101:458-60.
 - Varas-Meis E, Prada-García C, Samaniego-González E, Rodríguez Prieto MA. Acral syringomas associated with hematological neoplasm. *Indian J Dermatol Venereol Leprol*. 2017;83:136.
 - Iglesias Sancho M, Serra Llobet J, Salleras Redonnet M, Sola Casas MA, Creus Vila L, Sánchez Regaña M, et al. Siringomas diseminados de inicio acral, aparecidos en la octava década. *Actas Dermosifiliogr*. 1999;90:253-7.
 - Martín-García RF, Muñoz CM. Acral syringomas presenting as a photosensitive papular eruption. *Cutis*. 2006;77:33-6.
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1578-2190/
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Ultrasound Assessment of a Subcutaneous Eumycetoma of the Eyebrow in an Immunocompromised Patient[☆]



Evaluación ecográfica de un eumicetoma subcutáneo ciliar en una paciente inmunodeprimida

To the Editor:

A 74-year-old Spanish woman who had a history of type 2 diabetes mellitus and high blood pressure, had undergone

a kidney transplant in 2013 due to chronic renal failure secondary to diabetes, and was receiving immunosuppressant treatment with tacrolimus (1 mg/12 h), everolimus (1 mg/12 h), and prednisone (5 mg/24 h) was seen in the Dermatology Department for asymptomatic lesions on the right eyebrow that had appeared 2 months earlier and had grown progressively. The patient reported no history of trauma in the affected area. Physical examination revealed 2 painless nodules on the right eyebrow of 1 cm in diameter that were the same color as the neighboring skin and showed no signs of associated phlogosis (Fig. 1A and B).

Skin ultrasound (MyLab 25 Gold; Esaote SpA, Genoa, Italy) in B mode using an 18-MHz probe revealed the presence in the subdermis of 2 well-delimited, rounded, hypochoic/anechoic structures with posterior reinforcement and lateral acoustic shadowing (Fig. 1C). Color Doppler mode revealed an increase in perilesional flow (Fig. 1D). There was no evidence of involvement of adjacent muscle or bone. Suspecting simple cysts, the lesions were excised and samples sent for pathologic examination and culture.

[☆] Please cite this article as: Combalia A, Giavedoni P, Pigem R, Mascaró Jr JM. Evaluación ecográfica de un eumicetoma subcutáneo ciliar en una paciente inmunodeprimida. *Actas Dermosifiliogr*. 2018;109:836-838.