

CASES FOR DIAGNOSIS

[Translated article] Nodule on the Right Helix



Lesión nodular en el hélix derecho

Clinical history

This is the case of a 72-year-old man, with no significant past medical history who presented to the health center with a 5-year history progressively growing lesion on his ear right helix. He did not complain of associated pain, itching, spontaneous bleeding, or sustained any traumas to the region of interest.

Physical examination

The physical examination revealed the presence of a 1.5 cm nodular excreting lesion with skin-colored appearance, well-demarcated borders, firm consistency, mobile, non-infiltrated, and non-painful upon palpation in the upper third of the right helix (fig. 1). The dermatoscopy did not reveal any characteristic structures and was entirely non-specific.

Histopathology

The punch biopsy performed confirmed the presence of a well-demarcated tumor located in the dermis with a dual component, epithelial, and stromal. Cuboidal cells were seen arranged in cords, along with tubulo-alveolar structures surrounded by stroma exhibiting chondroid differentiation (fig. 2).



Figure 1

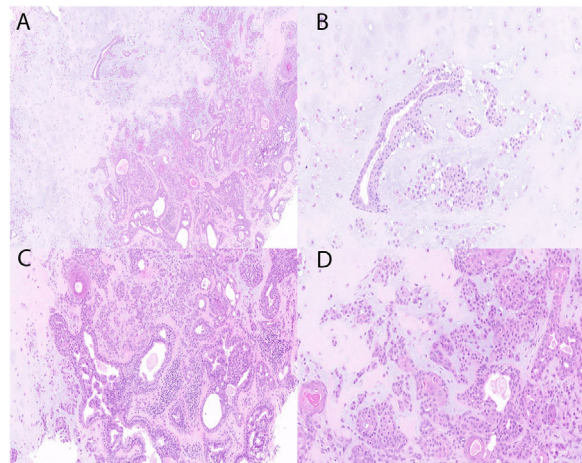


Figure 2 A: Hematoxylin-eosin (x5). B, C, D: Hematoxylin-eosin (x20).

What is your diagnosis?

DOI of original article:

<https://doi.org/10.1016/j.ad.2022.07.046>

<https://doi.org/10.1016/j.ad.2023.11.014>

0001-7310/© 2023 AEDV. Published by Elsevier España, S.L.U. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Diagnosis

Chondroid syringoma.

Disease progression and treatment

After achieving the final diagnosis of chondroid syringoma, surgical excision was performed with satisfactory cosmetic results.

Comment

Chondroid syringoma, also known as cutaneous mixed tumor, is a rare benign adnexal tumor originating from the sweat glands, with an estimated incidence ranging from 0.098% to 0.01%.¹ Back in 1859, Billroth described a salivary gland tumor with similar morphological characteristics for the first time. A century later, in 1961, Hirsch and Helwig first introduced the term chondroid syringoma.¹ The etiology and risk factors of chondroid syringoma are still unknown. Clinically, it presents as a slowly growing subcutaneous tumor nodule, covered by normal-looking or slightly erythematous skin that often presents as a solitary lesion. Chondroid syringoma is often asymptomatic, has a firm consistency, and is typically 0.5 cm to 3 cm in size. Lesions > 3 cm are considered giant and have a relatively high likelihood of being malignant. Chondroid syringomas often occur between the ages of 20 and 60 and are more common in men than women, with a ratio of 2:1.^{1,2} It is very rare in children and was first described in kids back in 2007.³ The most common locations are the nose, cheeks, upper lip, scalp, forehead, chin, eyelids, ears, and neck. It is less common in the trunk, limbs, and genitals. The clinical presentation is nonspecific, which is tremendously challenging for dermatologists.^{1,2} The differential diagnosis of chondroid syringomas includes epidermal cysts, neurofibromas, dermatofibromas, pilomatrixomas, trichoepitheliomas, histiocytomas, and basal cell carcinomas.^{1,2} The confirmatory diagnosis is histopathological reporting the presence of a dual component, one epithelial—with cells arranged in cords or tubulo-alveolar structures—and the other one stromal with fibrous, myxoid, and/or chondroid features.^{1,2,4} Islands of squamous cells, keratin cysts, calcification foci, ossification foci, and even adipose metaplasia can sometimes be found. Chondroid syringomas can be categorized into

eccrine or apocrine based on the epithelial component. The former consists of small luminal spaces coated by a single layer of cuboidal epithelial cells, while the latter consists of tubulo-alveolar structures coated by a double layer of cuboidal epithelial cells, with the outer layer being flatter and of myoepithelial origin.^{1,2} Typical findings of malignancy include cellular atypia, more mitoses, neural and vascular invasion, infiltration of underlying tissues, and the presence of necrosis.^{5,6} The treatment of choice is complete surgical excision, after which recurrence is exceptionally rare. Other therapeutic options include electrocoagulation, dermabrasion, or vaporization with argon laser or CO₂ laser.⁴ Malignant chondroid syringoma is extremely rare, more common in women, and tends to occur on the extremities and trunk. It has the potential for local and distant spread, being the lymph nodes, lungs, and bones common sites for metastasis.^{5,6}

References

1. Vázquez Hernández A, Pérez Campos AE, Gamboa Jiménez TI, Fenton Navarro BF. Giant chondroid syringoma on the upper lip: A case report. *Dermatol Online J* [Internet]. 2021;27 [citado 18 Mar 2022]. Available from: <https://escholarship.org/uc/item/9ws2483n>
2. Linares González L, Aguayo Carreras P, Rueda Villafranca B, Navarro-Triviño FJ. Siringoma condroide simulando un carcinoma basocelular. *Actas Dermosifiliogr*. Mayo de 2020;111:341–3.
3. Purkayastha P, Thomson R, Wilson Jones N, Ng S. Chondroid syringoma: An unusual presentation in a 7-year-old boy. *BMJ Case Rep*. 2021;14:e232943.
4. Vrotsos E, Alexis J. Chondroid syringoma. *Cutis*. 2014;93:68; 77–78;.
5. Requena C, Brotons S, Sanmartín O, Llombart B, Traves V, Guillén C, et al. Malignant chondroid syringoma of the face with bone invasion. *Am J Dermatopathol*. 2013;35:395–8.
6. Zia S, Shaw B, Chapman S, Friedman BJ. An atypical chondroid syringoma with malignant degeneration: Utility of comparative genomic hybridization in confirming the diagnosis. *J Cutan Pathol*. 2021;48:775–80.

J.F. Orts Paco*, M.D. Ruiz Martínez, J. Navarro Pascual

Servicio de Dermatología, Hospital General Universitario Reina Sofía, Murcia, Spain

* Corresponding author.

E-mail address: jose.orts.95@gmail.com (J.F. Orts Paco).