Case 24

Patient : A 68-year-old Thai man from Chaiyaphum

Chief Compliant : Hyperpigmented verrucous plaques on both feet.

Present illness : He presented with 10 years history of the eruption of dry hyperkeratotic verrucous plaques on both feet with occasionally pruritus. He was treated with oral and topical medications without any improvement.

Past history : He has Hepatitis B virus infection. Otherwise is normal.

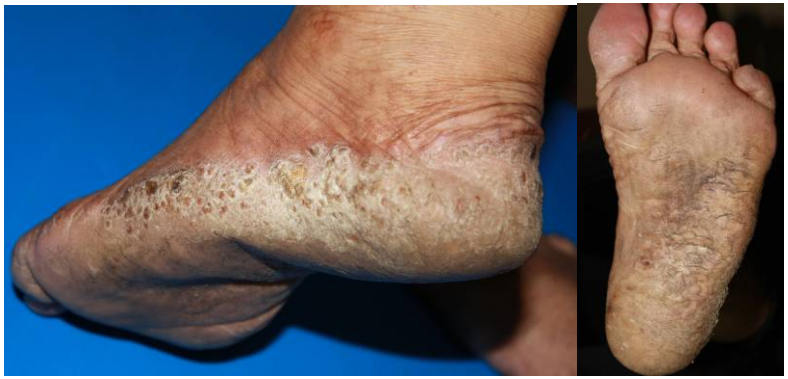
Family history : No family member has similar skin lesion.

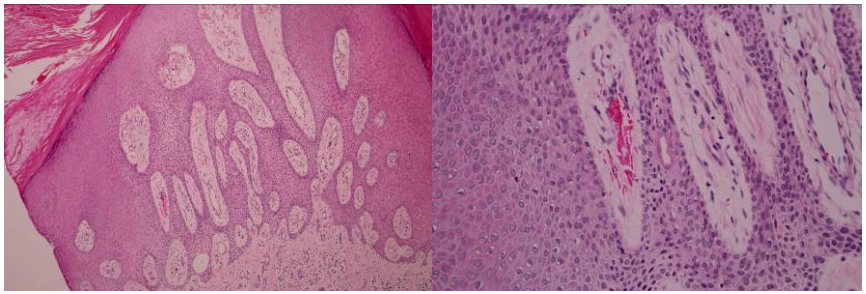
Dermatological examination : There are multiple dry hyperkeratotic verrucous nodules and plaques markedly on lateral side of left foot and also occur less on lateral side of right foot.

Histopathology : (S10-019641A)

Thin elongated anastomosing cords of uniform small epithelial cells, emanating from the epidermis and extending into fibroangiomatous stroma

Compact hyperkeratosis, hypergranulosis epidermal hyperplasia in the overlying epidermis





Diagnosis: Eccrine syringofibroadenoma

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Discussion :

Eccrine syringofibroadenoma (ESFA) is an uncommon tumor of eccrine derivation that was first described by Mascaro in 1963[1] as a skin tumor with a histopathological picture mimic fibroadenoma of the breast and fibroepithelial type of basal cell carcinoma[2].

ESFA typically presents as a slow-growing, solitary or multiple, flesh- or reddish-colored nodule or plaque, with a predilection for the extremities especially palms and soles, however other sites such as faces, back of hands, nail and lumbar area have been reported[3]. It usually affects eldery patient with most presenting

in their seventh and eighth decades[4]. Recently, EFSA has been classified according to the clinical presentation into 5 subtypes [5]

1) Solitary ESFA: The most common type, non hereditary verrucous growth in elderly patients

2) Multiple ESFA in the SchÖpf syndrome: Multiple erythematous papules in mosaic pattern on the palms and soles, generally appeared between age 15-25 years

3) Multiple ESFA without associated cutaneous findings: Nonfamilial palmoplantar lesion only and no significant associated cutaneous finding

4) Non-familial unilateral linear ESFA: Rare form , probably represents a genetic mosaism caused by a postsomatic mutation in an early embryogenic stage.

5) Reactive ESFA: Associated with inflammatory dermatoses or blistering disorder, the suggested pathogenesis of reactive ESFA includes repeated eccrine duct trauma resulting in eccrine duct remodeling and repair.

EFSA are believed to arise from acrosyringium, dermal sweat duct or both. The histological appearance characterized by proliferation of anastomosing cords and strands of cuboidal epithelial cells in a reticular pattern extending from epidermis into dermis. The strands contain tubular structure with eccrine duct formation embedded in a fibrovascular stroma with lymphocytes and plasma cells[6]. The histologic differential diagnosis includes fibroepithelia tumor of Pinkus, tumor of the follicular infundibulum pseudoepitheliomatous hyperplasia, papillary eccrine adenoma, reticulated seborrheic keratosis, squamous cell carcinoma, and artifacts of histologic processing[1].

ESFA is typically benign clinical course. Unfortunately, recent reports demonstrate the possibility of malignant transformation to eccrine syringofibrocarcinoma and the co-existence with squamous cell carcinoma has been reported in cases of ESFA. However, whether the ESFA develop in response to a SCC or the SCC represents a malignant degeneration of the ESFA is still unclear[6]. The worrisome features including increase in size, pain, inflammation, new growth, ulceration and crusting, and persistent disease despite extensive treatment have been associated with malignancy changes[4].

The treatment of ESFA depends on the number, location, and resectability of lesions. Excision is the mainstay of treatment for solitary ESFA, however if tumor is unresectable, generous sampling to rule out malignant transformation is suggested.

Dual pulse width flashlamp pulsed dye laser, CO2 laser and radiation therapy may be alternative treatment options which have been reported to be an effective treatment especially for for large lesion or located at difficult anatomical site[3, 7, 8].

In case of ESFA associated with or exhibiting malignant feature, complete excision is the appropriate treatment.

Reference :

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