Eruptive Syringoma

Erüptif Siringoma

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Geliş Tarihi/*Received:* 26.02.2009
Kabul Tarihi/*Accepted:* 25.05.2009

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Key Words:
Syringoma, eccrine glands

Anahtar Kelimeler:
Siringoma, ekrin bezleri

Syringoma, characterized by skin-colored or yellowish, small, 1-3 mm dermal papules, is a benign adnexal tumor that derives from the intraepidermal portion of eccrine sweat ducts. Syringomas appear during puberty or in the third or fourth decade. Most commonly, the lesions are limited to the upper parts of the cheeks and lower eyelids.[1-5] Syringomas can be classified into four principal clinical variants: localized form, familial form, form associated with Down syndrome, and generalized form that encompasses multiple and eruptive syringoma.[1] Patients with diabetes mellitus may present with a histological variant known as clear-cell syringoma.[2]

Eruptive syringoma is a rare variant first described by Jacquet and Darier in 1887.[1,3] The lesions occur in large numbers and in successive crops on the anterior chest, neck, upper abdomen, axillae, and periumbilical region at puberty or during childhood.[1-5] Other anatomic sites occasionally may be involved include the scalp, where they may be associated with nonscarring alopecia, the dorsal aspects of the hands, and the buttocks.[1,3,4] More rarely cases with wider involvement of the body have also been reported. The lesions consist of generally asymptomatic, occasionally pruritic, multiple, small, firm, yellow-brown colored papules that typically present in a bilateral, symmetrical distribution. It occurs more frequently among females. The lesions are benign and may spontaneously resolve or more commonly, remain stable.[1-5] The clinical, histological, and histochemical characteristics of this variant do not differ from those of classic syringoma. The cause of eruptive forms is uncertain. Timpanidis et al reported a case in which eruptive syringoma with clear cell morphology was found to express progesterone receptors, suggesting the possibility of hormonal control of the tumor.[1,2,4] Some other studies proposed that some of the so-called eruptive syringomas may represent a hyperplastic response of the eccrine ducts to an initial inflammatory reaction.[1,4] The disorder is generally described as sporadic, either in the localized or generalized forms. Some cases of eruptive syringoma were also reported associated with a genodermatose such as Nicolau-Balus (syringomas, milia and atrophodermia vermiculata), Marfan, Ehler-Danlos, and Down syndromes, although there is no single genoder-

matosis with a phenotype significant only for syringoma.[1,5] In our patient, there was no associated genodermatosis.

Clinically, it may be mistaken for many skin disorders like acne vulgaris, sebaceous hyperplasia, trichoepitheliomas, milia, lichen planus, eruptive xanthoma, flat warts, sarcoidosis, granuloma annulare, Darier's disease, Fox-Fordyce disease, urticaria pigmentosa, or hidrocystoma. Definitive diagnosis can be made on histological examination, because syringomas demonstrate distinctive histopathological features. Examination of the dermis demonstrates numerous, small ducts lined with a double row of flattened epithelial cells. Often the outer layer extends into the surrounding stroma, forming a comma-like projection. Ductal lumina are filled with an amorphous, periodic acid-Schiff-positive material.[1-5]

Because they are persistent, usually numerous, and often on exposed sites, the lesions may be disfiguring and often pose significant cosmetic concerns for patients. Many treatment modalities such as dermabrasion, electrodesiccation with curettage, and scissors excision have been tried with some success, but more recently, lasers have provided good to excellent results.[1-5] The combination of trichloroacetic acid and CO_2 laser resurfacing provided acceptable cosmetic results without significant side effects.[3] A recent report suggests the use of topical atropine to alleviate the pruritus in symptomatic eruptive syringoma.[1]

Eruptive syringoma, although a very rare variant of syringoma, should be considered in the differential diagnosis of widespread eruptive papular dermatosis appearing before or during puberty.

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