A Case of Eruptive Syringoma Mimicking Plane Warts

Sir,

Syringoma is a benign tumour arising from the intraepidermal portion of sweat ducts, affecting approximately 0.6% of the general population, of which the generalized eruptive form is a rare clinical variant.1

A 26-year-old female presented with multiple asymptomatic, skin-colored lesions of 10 years duration which were progressive in nature. Lesions started from the neck and spread to the chest up to the suprasternal area. Patient was not on any medication. Family history was unremarkable. Cutaneous examination revealed multiple skin-colored papules over the chest, neck [Figure 1], and infraorbital region [Figure 2], varying from 1 to 4 mm in size. Few discrete papules were also present over both the arms and abdomen. No mucous membrane, nails, scalp, or palmoplantar involvement was seen. Systemic examination was unremarkable. Biopsy was taken from one of the papules over the chest, with plane warts, acrokeratosis verruciformis, and syringoma as clinical differentials. The section showed histology of a benign adnexal tumour composed of small island and duct-like structure embedded in collagen in the upper dermis. The overlying epidermis was unremarkable. The tumour cells were monomorphic, having round-to-vesicular nuclei and eosinophilic cytoplasm.
Letters to the Editor

Small ducts lined with a double row of flattened epithelial cells, with outer layer extending into the surrounding stroma, forming a comma-like projection (tails), and giving them the appearance of tadpole [Figure 4] were seen. Findings were consistent with the clinical diagnosis of syringoma. Patient was advised for cryotherapy with liquid nitrogen. After 6 to 8 sittings, only minor improvement was seen. Patient is still under follow up. As the patient was in child bearing age group, wedid notadminister isotretinoin.

The word syringoma is derived from the Greek word syrinx meaning pipe or tube. It refers to a group of benign adnexal neoplasms with a tendency to ductal (acrosyringeal) differentiation. Based on Friedman and Butler’s classification scheme, four variants of syringoma are recognized, namely, localized, associated with Down syndrome, generalized form having multiple and eruptive syringomas, and a familial form. Estrogen and progesterone receptors have been detected in histochemical studies, explaining its occurrence more commonly in females and during puberty.

There are reports in literature where syringoma is seen to be associated with Down’s syndrome, diabetes mellitus, milium, sarcoidosis, elevated serum carcinoembryonic antigen (CEA), psychiatric disorders, and with heat stimuli.

Classically, syringoma presents with multiple skin-colored flat papules which are dome-shaped to flat with characteristic angulated borders. The papules are 1–5 mm in size over the periorbital area, particularly around the lower eyelid. In the variant of eruptive syringoma, successive crops of disseminated multiple lesions develops involving anterior chest, neck, upper arm, penis, vulva, upper abdomen, axillae, and periumbilical region. The eruptions are generally asymptomatic, although pruritus has been reported in some cases.

Recent studies suggest that eruptive syringoma is not a true neoplasm but a reactive process in hyperplastic eccrine duct, resulting from a previous cutaneous inflammation, although its pathophysiology is not yet completely understood.

Histochemical studies have shown that all eccrine type of enzymes and glycogen are present in the tumor cells of syringoma. Eccrine-specific monoclonal antibody positively stains syringoma lesions. Hence, formerly thought to be of mixed origin, now it is considered to be a benign appendageal tumor of intraepidermal eccrine sweat duct.

Clinically, syringoma may be mistaken with lichen planus, plane warts, papular mucinosis, xanthoma disseminatum, mastocytosis, acne vulgaris, sebaceous hyperplasia, milia, urticaria pigmentosa, hidrocystoma, and trichoepithelioma.

Morphology of lesions in our patient was mimicking plane warts in the form of multiple skin-coloured flat papules.

Syringomas demonstrate distinctive histopathological features. Dermis shows 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 (tails) of epithelial cells giving them the appearance of tadpole, as was seen in our case. Ductal lumina are filled with an amorphous, periodic, acid-Schiff-positive material.

Therapy for syringomas is usually unsatisfactory as they are embedded within the dermis; complete removal is often unsuccessful and recurrences are common. Various treatment modalities include dermabrasion, excision, cryosurgery, electrocautery, electrodesiccation, and chemical peeling. Successful treatment of facial syringomas with carbon dioxide laser has been reported. Oral isotretinoin and topical tretinoin and adapalene have also been used. Spontaneous involution of the lesions has also been reported.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The
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