Chondroid syringoma: Histopathology a cornerstone tool in diagnosis

Sir,

Chondroid syringoma is a benign, skin appendageal tumor. It is also known as mixed tumor of the skin as it contains epithelial and mesenchymal stromal components. It usually involves head and neck region and presents as asymptomatic slow growing, firm subcutaneous or intra dermal nodule. Histopathology reveals differentiation towards the adnexal ductal epithelium with chondromyxoid differentiation in the stroma. Here we report a case of chondroid syringoma where histopathology was a cornerstone tool in the diagnosis.

A 48-year-old man presented with an asymptomatic, slowly growing nodule on the right side of the upper lip since a year. There was no history of trauma, pain, discharge, or previous surgery for the same. Examination revealed a skin colored, firm and non tender nodule on the upper lip [Figure 1]. Overlying skin was adherent to the nodule and the surface irregular, but the nodule was not fixed to the underlying structures. There was no regional lymphadenopathy. The lesion was excised and closed by primary intention [Figure 2a and b].

Histopathological examination showed tubular cystic structures lined by two layers of cells, inner cuboidal cells and peripheral layer of flattened cells [Figures 3 and 4]. The cells of the peripheral layer showed proliferation into the stroma which had a mucoid, faintly basophilic appearance suggestive of chondroid syringoma (CS). No cellular atypia was seen. Margins were free of tumor cells ensuring complete removal.

CS is a rare, mixed tumor of the sweat-gland, first described by Billroth in 1859.\(^1\) It can have a benign and malignant form. The term CS was first introduced by Hirsch and Helwig in 1961.\(^2\) The incidence of CS has been reported as <0.01% of primary tumors of the skin.\(^3\)

Benign CS commonly affects males of middle age. It presents as a slow growing, asymptomatic, skin colored intradermal or subcutaneous nodule, usually affecting the head and neck region. Size varies from 0.5 cm to 3 cm, although bigger lesions have been reported.\(^4\) CS may be confused clinically with epidermal cyst, pilar cyst, calcifying epithelioma, or solitary trichoepithelioma.\(^5\) The diagnosis is typically made histopathologically. Hirsch and Helwig have proposed five histopathological criteria for its diagnosis, which include nests of cuboidal or polygonal...
cells, ductal structures composed of one or two rows of cuboidal cells, intercommunicating tubulo-alveolar structures lined by two or more rows of cuboidal cells, a matrix of varying composition and occasional keratinous cysts. Headington described two histological variants of this tumor, the eccrine type with uniform small round tubules, lined by a single row of epithelial cells and the apocrine variant with tubular and cystic branching lumina, lined by two rows of epithelial cells. The stroma of CS is mucoid, myxoid, chondroid, adipose, and rarely osteoid. Stromal mixtures are common in these lesions. The tumor in our case was of apocrine type.

Excision is the treatment of choice. This should be followed by regular follow-up to look for local recurrence and features of malignancy. The recurrent lesions can be treated by surgical excision.

Although CS is a benign tumor, malignant CS has also been reported in the literature. These malignant forms commonly affect women, involve the trunk and extremities, grow larger than 3 cm and locally invade. Cellular atypia, tumor necrosis, satellite tumor nodules, infiltrative margins and involvement of the deep structures indicate malignant transformation. For malignant lesions, the initial treatment modality is aggressive surgery. Adjuvant radiotherapy with or without chemotherapy may be recommended.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Kanathur Shilpa, Budamakunta Leelavathy, Gorur Divya, D. V. Lakshmi
Department of Dermatology, Bangalore Medical College and Research Institute, Bengaluru, Karnataka, India
E-mail: shilpakvinod@gmail.com

REFERENCES

1. Askari K, Ghorbani G, Yousefi N, Saadat SM, Saadat SN, Zargari O. Chondroid syringoma of the forearm: A case report of a rare localization. Indian J Dermatol 2014;59:507-9.
2. Hirsch P, Helwig EB. Chondroid syringoma. Mixed tumor of skin, salivary gland type. Arch Dermatol 1961;84:835-47.
3. Yavuzer R, Basterzi Y, Sari A, Bir F, Sezer C. Chondroid syringoma: A diagnosis more frequent than expected. Dermatol Surg 2003;29:179-81.
4. Bekerecioglu M, Tercan M, Karakok M, Atik B. Benign chondroid syringoma: A confusing clinical diagnosis. Eur J Plast Surg 2002;25:316-8.
5. Shashikala P, Chandrashekar HR, Sharma S, Suresh KK. Malignant chondroid syringoma. Indian J Dermatol Venereol Leprol 2004;70:175-6.
6. Headington JT. Mixed tumors of skin: Eccrine and apocrine types. Arch Dermatol 1961;84:989-96.
7. Padma M, Rao BN. Giant chondroid syringoma: Case report of rare entity at unusual site – Cytohistological features. IOSR J Dent Med Sci 2015;14:01-3.
8. Mebazaa A, Trabelsi S, Denguezli M, Sriha B, Belajouza C, Nouira R. Chondroid syringoma of the arm: An unusual localization. Dermatol Online J 2006;12:14.
9. Bellquh H, El Mostarchid B, Ouakalli M, Akhaddar A, Boucetta M. Benign chondroid syringoma of the orbit: A rare cause of exophthalmos. Head Face Med 2012;8:8.

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

Access this article online

Quick Response Code: 
Website: www.ijdpdd.com
DOI: 10.4103/2349-6029.184005

Cite this article as: Shilpa K, Leelavathy B, Divya G, Lakshmi DV. Chondroid syringoma: Histopathology a cornerstone tool in diagnosis. Indian J Dermatopathol Diagn Dermatol 2016;3:20-1.