Chondroid Syringoma on Face

INTRODUCTION

Chondroid syringoma is a rare mixed tumor of the skin which is composed of both mesenchymal and epithelial cells. Its incidence at less than 0.1% and is frequently located on the head and neck. Chondroid syringoma is easily confused with epidermal cysts. Since malignant forms of chondroid syringoma have been reported, accurate and timely diagnosis is important for proper management. We report clinical and histological features of chondroid syringoma in 5 patients treated at our institution. In most of the cases, chondroid syringoma presented as a round, firm, nodular or cystic lesion that had well marginated heterogeneity in sonography. Clinically, all of the lesions were removed by simple excision. Microscopically, all five tumors were well circumscribed and consisted of epithelial, myoepithelial, and stromal components. The epithelial component formed tubules lined by one or more rows of eosinophilic epithelial cells. The outer layer of tubules appeared to be flattened myoepithelial cells. The stroma is myxoid and contained spindle shaped myoepithelial cells. We expect that the clinical, sonographic, and histological data from our report may help clinicians who are confronted with various kinds of analogous facial lesions to decide the most proper management for their patients.

Keywords: Facial neoplasm / Pleomorphic adenoma / Skin neoplasm

CASE REPORT

In the past 7 years, our department has managed 5 cases of chondroid syringoma, which were reevaluated clinically and histologically for this report. We reviewed the medical records for demographic information, location and size of tumor, sonographic findings, and histopathologic results (Table 1).

In Case 1, a 44-year-old man was referred for treatment of a palpable lesion that had been recurrent on the upper lip for a year. There was a history of trauma to the upper lip by an electric shaver a year prior to presentation. Physical examination showed a non-tender, round, elevated, and palpable nodule, measuring 1.2 cm in diameter. Upon excision, the lesion was a round, firm, nodular mass with a well-circumscribed margin. Microscopically, the tumor was composed of epithelial, myoepithelial, and stromal components. The epithelial component formed tubules lined by one or more rows of eosinophilic epithelial cells. The outer layer of tubules appeared to be flattened myoepithelial cells. The stroma was myxoid and contained spindle shaped myoepithelial cells. The patient has been free of recurrence after 2 years of follow-up.

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cm in diameter. The mass was excised and closed primarily. Histopathologic report was a chondroid syringoma.

In Case 2, a 39-year-old man presented with an elevated lesion on the nasal dorsum that had been growing slowly for 3 years. There was no history of trauma to the nose. On examination, the lesion was soft, fixed, and round which was 0.7 cm in diameter. Face sonography revealed an oval hypoechoic nodule in the deep dermal layer. The mass was extirpated and closed primarily. Histopathologic report was a chondroid syringoma.

In Case 3, a 47-year-old man was referred for treatment of a recurrent palpable lesion that had been on the upper lip for 2 years. There was no history of trauma to the upper lip. However, the patient had undergone incision and drainage of the lesion at a dermatology clinic. Physical examination showed a firm, round, movable, and protruded mass which was 1 cm in diameter and with postoperative scar on the left upper lip beside a philtral ridge. Face sonography revealed a well demarcated lesion without increased vascularity in the orbicularis superficialis muscle to the skin layer. The mass was excised and closed primarily. Histopathologic sectioning revealed a chondroid syringoma.

In Case 4, a 64-year-old man developed an elevated lesion on the philtrum for 6 months. There was no history of trauma to the philtrum. On examination, the lesion was non-tender, firm, and oval shaped, measuring 0.8 cm in diameter. The mass was excised and closed primarily. Histopathologic report was a chondroid syringoma.

In Case 5, a 65-year-old woman presented with an elevated lesion on the left nasolabial fold, which had grown slowly over 20 years. There was no history of trauma to the left nasolabial fold. Physical examination revealed a hard, movable, and round nodule, which was 2.2 cm in diameter (Fig. 1). Face sonography showed a well margined heterogeneous solid nodule with multiple internal calcification in the left nasolabial junction (Fig. 2). The mass was extirpated and closed primarily. Histopathologic report was a chondroid syringoma (Figs. 3, 4).

![Fig. 1. Surgical specimen from Case 5. The mass was firm and measured 2.2 cm in diameter.](image1)

![Fig. 2. Face sonography in Case 5. The ultrasound exam revealed a well demarcated lesion without increased vascularity in the orbicularis superficialis muscle to the skin layer.](image2)
DISCUSSION

In our review, most patients with chondroid syringoma presented with a round, firm, nodular or cystic lesion with well-marginated heterogeneity on sonography. All instances of chondroid syringoma were surgically excised. Microscopically, all five tumors were well circumscribed and consisted of epithelial, myoepithelial, and stromal components. The epithelial component formed tubules lined by one or more rows of eosinophilic epithelial cells. The outer layer of tubules appeared to be flattened myoepithelial cells. The stroma was myxoid. It contained spindle-shaped myoepithelial cells. Three out of five cases had keratinous cysts and foci of squamous differentiation. In one case, patchy calcification was observed.

Complete excision with a cuff of normal tissue remains the standard treatment for chondroid syringoma [5]. However, all five cases in our report were removed by simple excision of the mass without any recurrence during the follow-up period.

The clinical, sonographic, and histological data of our report may help clinicians who are confronted by various kinds of analogous facial lesions to decide the proper management for their patients.

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