SKIN

SKINmages

Syringofibroadenomas of the Bilateral Lower Extremities

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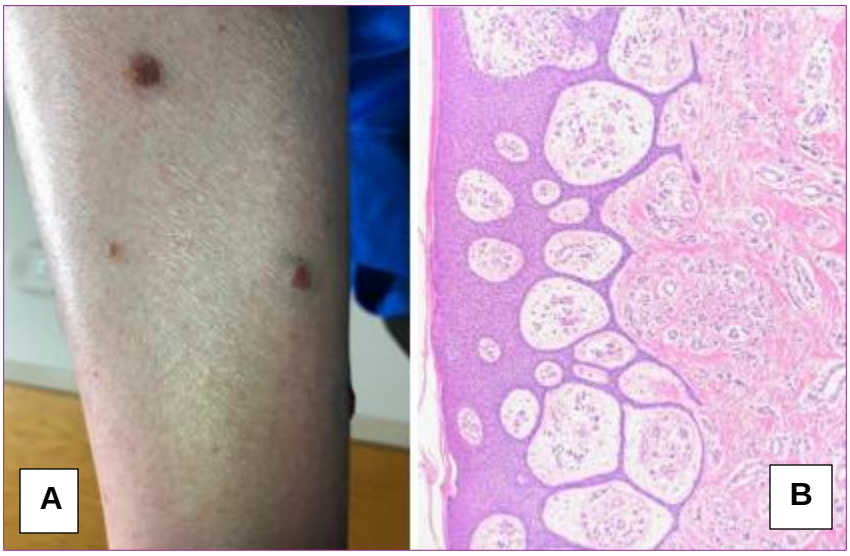

A 52-year-old man presented to clinic with a one-year history of asymptomatic lesions located on his bilateral lower legs (**Figure A**). He reported that occasionally these lesions “pop open”, bleed, and become painful. He denied scratching the lesions. No prior or current treatments have been used. The patient has cerebral palsy and is wheelchair bound. A shave biopsy was performed (**Figure B**).

The biopsy showed thin anastomosing epithelial cords and strands extending from the epidermis and forming a lattice. Rare ductal structures were noted within the thin cords. There was underlying dermal fibrosis with thickened and increased fibrocytes, and a proliferation of thin-walled blood vessels. The anastomoses of the thin epithelial cords with underlying fibrovascular stroma supported the diagnosis of syringofibroadenoma.

Syringofibroadenoma is a rare adnexal tumor that arises from the acrosyringial cells of the eccrine ducts. The tumor was first described in 1963 by Mascaro, with only 75 cases reported to date.[1] While the clinical presentation is variable and nonspecific, definitive diagnosis can be made using histopathology.

Syringofibroademoma is more commonly seen in elderly individuals in their seventh

and eighth decade of life with the majority of the lesions located on the extremities, most commonly acral sites.[2] Although it does not have a clear racial or age predilection, it has been associated with Schopf-Schulz-Passarge Syndrome, Clouston Syndrome, and leprosy.[1,3,4] This neoplasm has also been reported to present in conjunction with other dermatological disorders most commonly chronic stasis dermatitis.[5]

Syringofibroadenoma can present as a plaque, papule, or nodule. It is typically a solitary lesion but can also be multiple. The lesions tend to be slow-growing and have the potential to spread over large areas of the body.[1,3] Eccrine syringofibroadenoma is classified into five subtypes: (1) solitary, (2) multiple with hidrotic ectodermal dysplasia, (3) multiple without associated cutaneous findings, (4) nevoid, and (5) reactive.[2] The histopathology described above is shared among all subtypes.

Due to the variable nature of this tumor, it can be easily misdiagnosed or mismanaged. Histopathology allows for confirmation of the disorder due to the distinct histopathological presentation.[5] Differential diagnoses includes poroma which, while sharing the histogenesis, does not contain the corded epithelium found in syringofibroadenoma. Fibroepithelioma of Pinkus has a similar pathologic appearance, but lacks the ductile formation within the cords, and has basaloid differentiation. Early Kaposi Sarcoma shows staghorn, ectatic, lymphatic-like vessels, and plasma cells, while late KS has a busy dermis surrounding adnexal structures and pre-existing vessels with positive promontory sign.

In this case, the patient most likely developed reactive syringofibroadenomas from his chronic stasis. He was treated with compression and close follow-up. Reported treatment options included excision for solitary lesions, cryotherapy, curettage, electrodessication, radiotherapy and etretinate topical therapy.[2] It is considered to be a benign condition, though there have been cases reported of malignant transformation into syringofibrocarcinoma and eccrine porocarcinoma.[5] For this reason, it is appropriate to excise or follow the lesions to monitor progression.

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