

PhotoDermDiagnosis

Multiple asymptomatic papules over neck and upper extremities

Ashim Kumar Mondal, Piyush Kumar, Satyendra Nath Chowdhury, Subrata Pal, Joyashree Nath Barbhuiya

Department of Dermatology, Medical College, Kolkata, India

A 35-year-old female presented with numerous discrete brown to skin coloured asymptomatic papules for 2 years. Lesions first appeared on neck and are now present over forearms and neck. All the lesions were persisting in nature and new lesions kept appearing. However, lesions did not grow in size beyond 5 mm. She had mentioned history of summer aggravation- more lesions appeared during summer months. There were no systemic features and there was no history of intake of drugs prior to onset of lesions. None of the family members was having similar lesions. On examination, skin coloured to brownish 2-4 mm angulated papules of size 2-5 mm were found on neck and forearms. Both flexure and extensor aspects were involved (**Figures 1 and 2**). Rest of the mucocutaneous and systemic examination was non-contributory.

Routine blood investigations and lipid profile were within normal limit. A skin biopsy was performed from the lesion on forearm, which is shown in **Figures 3 and 4**.



Figure 1 Asymptomatic yellow brown papules over neck.



Figure 2 Asymptomatic yellow brown papules over extensor aspect of left forearm (close up view).

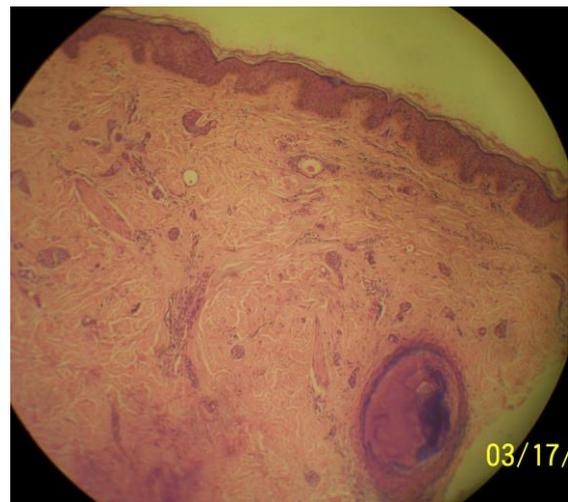
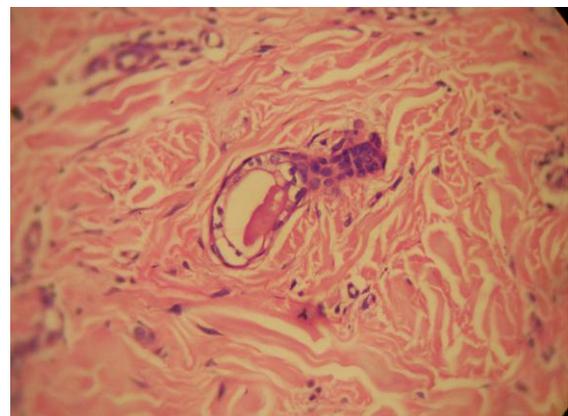


Figure 3 Hematoxylin and eosin stain X 100.



Hematoxylin and eosin stain X 400.

What is your diagnosis?

Diagnosis

Eruptive syringoma

Discussion

Syringoma, first described by Biesiadecki and Kaposi, is a benign appendageal tumour of intraepidermal eccrine sweat duct.¹ The disease manifests as multiple, flesh-coloured 1-5 mm papules around the eyelids and upper cheeks of adolescent females. Syringoma appears to be an exception to the general rule that solitary appendageal tumours are sporadic; while multiple tumours are often inherited.² There is female preponderance in both sporadic and familial forms. In most reported families, syringoma has been observed to occur in an autosomal dominant pattern.³ Summer aggravation is frequently noted.

Based on Friedman and Butler's classification scheme, four variants of syringoma are recognized: (1) a localized form, (2) a form associated with Down syndrome, (3) a generalized form that encompasses multiple and eruptive syringomas, and (4) a familial form.⁴

Eruptive syringoma, also called eruptive hidradenoma of Darier and Jaquet, is a rare variant of syringoma where the lesions often arise in large numbers and in successive crops on the anterior neck, chest and abdomen and either remain stationary throughout life or disappear.⁵ They may develop at any age with a peak incidence between the third and fourth decades of life.⁶ Eyelids may or may not be involved in this type as they are involved in the common type.⁵

Address for correspondence

Dr. Ashim Kumar Mondal
Department of Dermatology
Medical College & Hospital
88, College Street, Kolkata- 700073
Email: dr.ashim10@gmail.com

Syringoma has been found in association with Down syndrome. Rarely, syringoma may be associated with the Brooke-Spiegler syndrome, an autosomal dominant disease characterized by the development of multiple cylindromas, trichoepitheliomas, and occasional spiradenomas.⁴

Syringoma on face should be differentiated from verruca plana, trichoepithelioma, sarcoidosis and milia. Eruptive syringoma may clinically resemble lichen planus, verruca plana, xanthoma disseminatum, granuloma annulare, papular mucinosis and mastocytosis.⁷

The diagnosis is suspected clinically and is confirmed by histopathology. Histopathologically, there are numerous small ducts, embedded in a fibrous stroma, the walls of which are lined usually by two rows of epithelial cells.⁸ The lumina of the ducts contain amorphous debris. Some of the duct possess small comma like tails of epithelial cells giving the appearance of "tadpoles or the pattern of paisley tie".⁷

Treatment is very difficult, topical, surgical, and treatment is often unsatisfactory. In eruptive syringoma, electrocoagulation, cryotherapy or electrodesiccation may be too laborious and often yield poor cosmetic results. Topical tretinoin may give some benefit in such cases.¹

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Dr. Ijaz Hussain
drijazhussain@gmail.com