Eruptive Syringoma: Two Cases with Dermoscopic Features

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Established Facts

- Syringoma is typically detected in the periorbital region.
- Eruptive syringoma is a rare variant generally biopsied by a provisional diagnosis of mastocytosis; and the typical histopathological features confirm the diagnosis.

Novel Insights

- Similar to the clinical presentation, dermatoscopy of syringoma also commonly mimicks mastocytosis.
- Only vulvar lesions represent typical features such as glittering white yellow clods.

Keywords

Syringoma · Eruptive · Dermoscopy

Abstract

Syringoma is an adnexal tumor typically observed on the periorbital region and readily diagnosed by clinical examination. Eruptive syringoma is a rare variant that is commonly confused with mastocytosis and lichen planus clinically. The diagnosis is generally confirmed by typical histopathological features. Herein, we report two eruptive syringoma cases along with the dermoscopic features. Through our dermoscopic evaluation before skin biopsy, we detected features also reminding that of maculopapular mastocytosis as reticular light brown lines, structureless light-brown areas, and reticular vessels. Additionally, as an additional pattern, shiny white dots were observed in the vulvar variant.

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Introduction

Syringoma is a common, benign adnexal tumor of the eccrine sweat duct, typically defined on the periorbital region of middle-aged women. Eruptive syringoma is a rare variant characterized by multiple, small, skin-colored to reddish-brown papules localized on the neck, chest, anterior trunk, axilla, and extremities. These cases are generally biopsied by a provisional diagnosis of mastocytosis or lichen planus, and the typical, distinctive histopathological findings confirm syringoma. We herein present two eruptive syringoma cases and describe the dermoscopic findings for this rare entity along with clinical and histopathological features.

Case Report/Case Presentation

Case 1

A 35-year-old man with a 20-year history of some red-brown spots located on his body demonstrated erythematous, infiltrated papules on the neck and brownish macular lesions on the abdomen and inguinal areas (Fig. 1a, b). The lesions were asymptomatic except for occasional mild pruritus. Dermoscopy showed a reticular vascular network of thin telangiectatic vessels admixed with multifocal hypopigmented areas for the bright red lesions located on the neck and thin reticular lines for the brownish maculopapular lesions located on the lower abdomen (Fig. 2a, b). Skin biopsies were obtained from two different lesions demonstrating distinct clinical and dermoscopic features. Both samples revealed

typical histopathological characteristics of syringoma as cystic-dilated ductal proliferations with rows of epithelial cells located in upper dermis with a typical “tad-pole” appearance. Some of them included keratinous material in their lumina (Fig. 3).

Case 2

A 31-year-old woman presented to our department with a long-standing history of asymptomatic skin lesions located scarcely on her body. Physical examination revealed multiple, brownish erythematous flat-topped, 1–5 mm papules on the neck, trunk, bilateral axillary regions, and labium majus (Fig. 4a). Grouped papules were evident on the flexor surface of the right forearm. Darier’s sign was negative. Dermoscopy showed a delicate pigment network with an erythematous background for the lesions located

Fig. 1. Eruptive syringoma. Clinical images of Case 1. **a** Brownish macular lesions located on the inguinal region. **b** Erythematous papules on the neck.

Fig. 2. Dermoscopy of eruptive syringoma. **a** Thin reticular network. **b** A reticular vascular network on a faint background. Note multifocal hypopigmented areas.

on the arm and trunk along with glittering white structures for multiple vulvar lesions (Fig. 4b). A skin biopsy from the neck demonstrated normal epidermal findings and cystic-dilated ductal proliferations in the upper dermis.

Discussion/Conclusion

In two eruptive syringoma cases, we defined three different dermoscopic patterns including reticular brown lines on a faint erythematous background, reticular vascular network, and glittering white dots. The first two pat-

terns were observed commonly, whereas the third was exclusive for vulvar localization.

The dermoscopic features of syringoma patients are poorly defined (Table 1). Hayashi et al. [1] reported the dermoscopic features of unilateral linear as a delicate and very faint brown pigment network and multifocal hypopigmented areas. Sakiyama et al. [2] also defined an incomplete pigment network with faint erythema in two eruptive syringoma cases. In our cases, the most common pattern was also reticular brown lines, and it became very prominent in some lesions reminding of a solar lentigo, whereas a delicate pigment network was also defined. Despite reticular vascular network is not regarded as a specific finding evident in many skin lesions, co-existing multifocal hypopigmentation might be useful to predict syringoma. Glittering yellow-whitish round-shaped structures over a fading pink background was defined for the vulvar variant in addition to dotted and short linear vessels [3].

The pigment network of syringoma was conferred to basal melanosis. The histopathologically apparent fibrotic stroma in syringoma was hypothesized to be the cause of epidermal thickening and basal melanosis, as often shown in dermatofibroma [1]. The glittering white dots of vulvar variant are similar to rosette structures despite their different spatial pattern. In a recent study, white shiny structures, including rosettes are shown to correspond to the optical effect of crossed polarization either by perifollicular fibrosis or horny material in adnexal openings [4]. The evident glittering structures in the vulvar variant might be secondary to the combination of cystic adnexal proliferations embedded in fibrous stroma. The most important mimicker of vulvar

Fig. 3. Cystic-dilated ductal proliferations with rows of epithelial cells located in upper dermis with a typical “tad-pole” appearance, some of them including keratinous material in their lumina $\times 40$, HE.

Fig. 4. **a** Clinical image demonstrating vulvar syringoma lesions. **b** Dermoscopy of vulvar syringoma with glittering structures.

Table 1. Previously defined dermoscopic features of syringoma in the literature

Author	Year	Syringoma type	Dermoscopic findings
Hayashi et al.	2011	Linear variant	Delicate brown pigment network
Sakiyama et al.	2014	Eruptive variant	Pigment network with a reddish tinge
Corazza et al.	2017	Isolated vulvar	Glittering yellow-whitish round structures Dotted-short linear vessels, patchy and clustered

syringoma is Fox-Fordyce disease, characterized by hyperkeratotic plugs in follicular infundibulum, perifollicular fibrosis, and lymphohistiocytic infiltrate. Despite the dermoscopy of vulvar Fox-Fordyce disease being not defined in the literature, depending on the similarity of histopathological features, it might also represent glittering structures.

Our preferential diagnosis was telangiectasia macularis eruptiva perstans, especially for the first case. The dermoscopic features of papular/plaque variant of mastocytosis such as urticaria pigmentosa and telangiectasia macularis eruptiva perstans are defined separately as thin telangiectatic vessels arranged in a reticular pattern for telangiectasia macularis eruptiva perstans cases and brown reticular lines for urticaria pigmentosa cases. Both of these features were noted on our dermoscopic examination [5].

Brown reticular lines are suggested to occur due to admixed melanocyte proliferation along with mast cells resulting from the local concentrations of soluble mast cell growth factor in lesions of cutaneous mastocytosis. Dermoscopically, a pigment network is not unique to melanocytic lesions and embraces an increasing list composed of different entities, including dermatofibroma, solar lentigo, seborrheic keratosis, accessory nipple, and mastocytoma.

In addition to previous descriptions, our cases indicate that eruptive syringoma can also demonstrate a

prominent pigment network and reticular telangiectatic vessels, including multifocal hypopigmented areas. The dermoscopy of the vulvar variant differ from other localizations.

Statement of Ethics

The authors obtained patients' consent to publish photos and details of the case.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

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Author Contributions

A.B. wrote the manuscript, performed the clinical and dermoscopic examination, did the literature research. E.C. revised the manuscript and commented on the clinical and dermatoscopic photos of the patient. A.C. did the pathological evaluation and revised the manuscript. M.T. revised the manuscript and did the literature research.

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