

Case Report

Chondroid Syringoma of the Back: A Rare Clinical Entity

Vijay P Agrawal^{1*}, Nikhil Shetty², Ashwin Narasimhaprasad³

¹Assistant Professor, Department of General surgery, NKPSIMS, Nagpur, Maharashtra, India

²Assistant Professor, Department of General surgery, A.J Shetty Institute of Medical Sciences, Mangalore, Karnataka, India

³Orthopaedic surgeon, Ashwini hospital, Hoskote, Bangalore, Karnataka, India

*Corresponding author

Dr. Nikhil S Shetty

Email: vijugunnu@gmail.com

Abstract: Chondroid syringomas or a mixed tumor of skin is a rare subcutaneous tumor that may be confused with various skin lesions. The incidence of chondroid syringoma has been reported to be as low as 0.01-0.098 %. The lesions are commonly located on the head and neck region and are non-ulcerating, slow growing, subcutaneous or dermal nodules. A close follow-up of these tumors is recommended because of the risk of malignancy. We present such one rare case of chondroid syringoma in a 60 year old male in an unusual site [lower back] which was completely excised with no recurrence following 12 months after surgery.

Keywords: Chondroid syringomas, Skin tumor.

INTRODUCTION

Chondroid syringoma, also known as mixed tumor of the skin, is a rare, benign adnexal tumor with an unknown etiopathogenesis [1, 2]. Some authors suggest the hypothesis of both epithelial and mesenchymatous origin [3]. It is similar to pleomorphic adenoma of salivary gland and hence it is called a mixed tumor. CS is also thought to originate from both secretory and ductal segments of the sweat gland, and both eccrine and apocrine variants have been described. [4]. The reported incidence of CS among primary skin tumors is less than 0.01 percent [5]. A greater incidence of 0.098 percent was reported by Yavuzer *et al.* [2]. Chondroid syringoma usually affects middle-aged or older male patients. In our observation, CS occurred in a 60-year-old male.

CASE REPORT

A 60 year old male presented with a painless swelling measuring 15X10 cms on the left lower back since one and half year. The swelling had irregular surface, margins were well defined, firm in consistency, fixed to the overlying skin and non tender. FNAC revealed chondroid syringoma, biopsy for confirmation. The tumor was completely excised under spinal anesthesia. HPE showed chondroid syringoma. No recurrence of the tumor has been observed 12 months after surgery (Fig. 1 & 2).



Fig. 1: Swelling on left lower back



Fig. 2: Wide excision of the swelling

Histopathological examination revealed cords, nests and tubuloglandular structures that are composed of well differentiated tumor cells embedded in a hyalinized stroma with abundant chondroid matrix. Thus, the diagnosis of chondroid syringoma was established [22]. No features suggested a malignancy was observed.

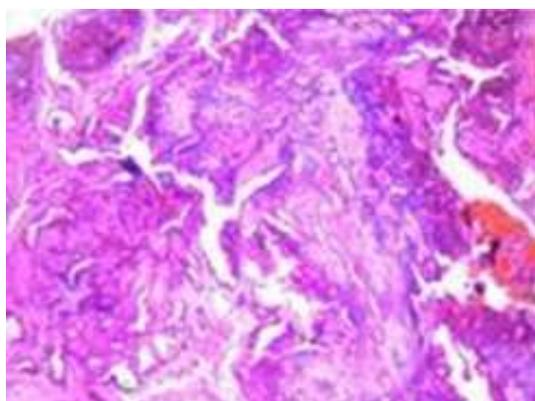


Fig. 3: Low power showing tubular glands embedded in chondroid matrix

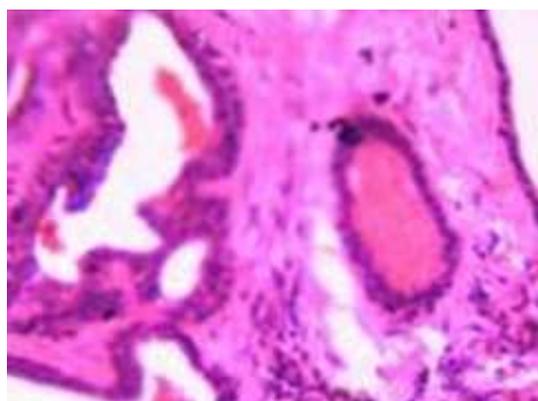


Fig. 4: High power view showing Tubular glands in hyalinized stroma

DISCUSSION

Clinically, chondroid syringoma (CS) presents typically as a slow growing, painless, firm, non-ulcerated subcutaneous or intracutaneous nodule. The lesion measures 0.5-3 cm in diameter in commn [1, 2, 6]. However, larger forms of CS have also been reported [6-9].

The sites that are commonly involved include head and neck region, particularly cheek, nose, or skin above the lip [1-3, 6]. Tumor occurring on the scalp, eyelid, orbit, hand, foot, forehead, axillary region, abdomen, back, penis, vulva and scrotum are less common [2, 6, 7, 9-13]. In our patient, CS developed on the right side lower back.

CS is often overlooked because of rarity of this tumor and unremarkable clinical presentation [2].

The differential diagnosis of CS is carried out with other benign tumors of epidermal or mesenchymatous appendages including dermoid or sebaceous cyst, dermatofibroma, neurofibroma, pilomatricoma, basal cell carcinoma, histiocytoma, and seborrheic keratosis. Usually, CS lesions are not clinically distinctive; diagnosis is made on microscopic examination [1, 2].

Histologically, this tumour consists of mixed epithelial and mesenchymal elements. Epithelial cells are arranged in cords and form tubules with a myoepithelial layer, set in a myxoid or chondroid stroma. In rare cases, osteoid stroma or mature adipocytes can be observed. Histologically two variants of CS are described; the eccrine variant with smaller lumens lined by a single row of cuboidal epithelial cells and the apocrine variant with tubular and cystic branching lumina that are lined by two rows of epithelial cells. Immunohistochemical study exhibits focal positivity for keratin, desmin, vimentin, and S-100 protein in the stroma [2, 15].

Multiple treatment options have been proposed that include electro-desiccation, dermabrasion, and vaporization with argon or CO₂ laser. The usual first-line treatment is total excision of tumor without destroying aesthetic and functional structures.

Chondroid syringoma is a benign tumor and recurrence does not occur if excised completely. However, rare cases of malignant CS have been reported. These malignant forms are more common in younger female patient commonly involving the trunk or extremities [1, 16]. These tumors often are larger than 3 cm and are locally invasive. Metastasis to bones and viscera are rare [5, 17-19]. Histological findings reporting cytologic atypia, infiltrative margins, satellite tumor nodules, tumor necrosis, and involvement of deep structures indicate malignant transformation. However, the histopathological features of malignant and benign may be very similar. There are reported cases of CS with a benign histology that turned out to be malignant [20]. Immunohistology is of no help in distinguishing between benign and malignant forms.

Because of malignant potential, complete excision of CS must be done. The patient should be followed carefully for both local recurrence and metastasis. Regarding the previous literature reports, our patient's presentation is of interest because of the atypical location of CS [21].

CONCLUSION

In conclusion, CS should be included in the differential diagnosis of cutaneous or subcutaneous slow-growing solid nodules and a close follow-up of these tumors is recommended because of risk of malignancy.

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