SAS Journal of Surgery
Abbreviated Key Title: SAS J Surg
ISSN 2454-5104
Journal homepage: https://www.saspublishers.com

OPEN ACCESS

Surgery

Chondroid Syringoma of the Cheek: A Case Report and Literature Review

Zakaria Toubi[1]*, Anas Hanine[1], Dounia Kamal[1]

[1]Department of Reconstructive and Maxillofacial Surgery, Hassan II University Hospital of Fez, Sidi Mohamed Ben Abdellah University, Faculty of Medicine, Pharmacy, and Dentistry, Fez, Morocco

DOI: https://doi.org/10.36347/sasjs.2026.v12i05.009 | **Received:** 11.03.2026 | **Accepted:** 28.04.2026 | **Published:** 06.05.2026

***Corresponding author:** Zakaria Toubi
Department of Reconstructive and Maxillofacial Surgery, Hassan II University Hospital of Fez, Sidi Mohamed Ben Abdellah University, Faculty of Medicine, Pharmacy, and Dentistry, Fez, Morocco

Abstract | **Case Report**

Introduction: Chondroid syringoma is a rare benign cutaneous adnexal tumor of sweat-gland origin, occurring in less than 0.1% of primary skin tumors. It has a predilection for the head and neck, and its clinical appearance is non-specific enough that diagnosis is rarely made before tissue examination. ***Case Presentation:*** A 68-year-old woman with no relevant medical history presented with a two-year history of progressive left cheek swelling. Examination revealed a firm, painless, polylobulated nasolabial mass of approximately 2 cm with overlying telangiectasias. CT imaging demonstrated a well-defined 27 × 23 mm soft-tissue lesion containing internal calcifications, abutting the buccinator muscle and facial vessels. Complete excision was performed via an intraoral approach. Histopathology confirmed chondroid syringoma: epithelial ducts, tubules, and nests in a bilayered pattern within a chondromyxoid stroma, with no atypia or infiltrative growth. At one year, the patient remains recurrence-free. ***Conclusion:*** Chondroid syringoma should be included in the differential diagnosis of any slow-growing, painless facial mass. Diagnosis requires histopathological confirmation. Complete surgical excision through an approach that minimizes facial scarring provides definitive treatment and an excellent long-term outcome.

Keywords: chondroid syringoma; mixed tumor; cheek; cutaneous adnexal tumor; sweat gland neoplasm.

INTRODUCTION

Chondroid syringoma—also called mixed tumor of the skin—is a rare benign neoplasm that arises from eccrine or apocrine sweat glands. It represents less than 0.1% of primary cutaneous tumors (1,2). The head and neck region is involved in the vast majority of reported cases, with the cheek being the single most common location (1,3).

Clinically, the tumor grows slowly and painlessly as a firm subcutaneous nodule, often remaining unchanged for years. This quiet course overlaps with several benign entities—epidermoid cysts, dermoid cysts, pilomatricomas, and occasionally pleomorphic adenoma—and explains why clinical diagnosis is unreliable without tissue sampling(3–6). Most published series report that the diagnosis is established only after excision or incisional biopsy (1–6) .

We present a 68-year-old woman with a chondroid syringoma of the left cheek excised through an intraoral approach, with complete resolution at one year, and we review the relevant literature.

CASE PRESENTATION

A 68-year-old woman with no significant medical history presented to the maxillofacial surgery department with a two-year history of slowly progressive left cheek swelling. The lesion had been present throughout that period without pain, fever, or any change in her general condition.

Clinical examination revealed a firm, indolent, polylobulated mass in the left nasolabial region, measuring approximately 2 cm. The mass was poorly defined from the superficial plane but mobile relative to deeper structures. Telangiectatic vessels were visible over the skin surface; there was no ulceration and no palpable cervical lymphadenopathy (Figure 1).

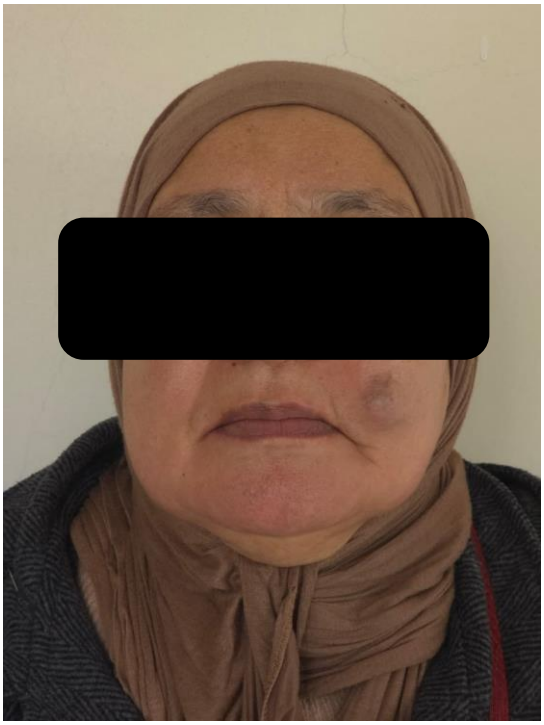

Figure 1: Frontal view of the left cheek showing the nasolabial mass with telangiectatic skin surface.

Facial CT with contrast showed a well-defined oval soft-tissue lesion measuring 27 × 23 mm in the left cheek, containing internal calcifications and closely abutting the buccinator muscle and facial vessels without bony erosion or intrabuccal extension (Figure 2).

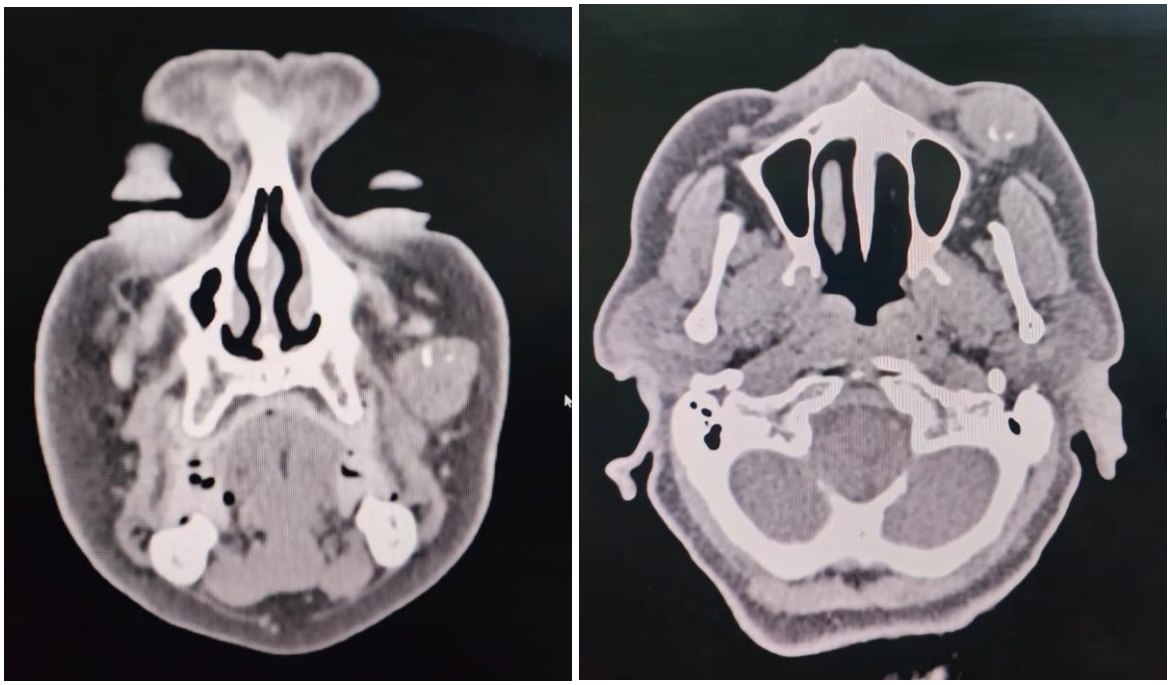

Figure 2: Axial and coronal CT at the level of the lesion showing its boundaries, relationship to the buccinator, and internal calcifications

Given the clinical and imaging findings, surgical excision was planned. The procedure was performed under general anesthesia via an intraoral buccal approach, which provided adequate exposure of the nasolabial plane while avoiding any visible facial incision. The mass was dissected en bloc from the surrounding soft tissue and excised in continuity with a cuff of normal tissue (Figure 3). Hemostasis was achieved and the mucosa was closed with resorbable sutures.

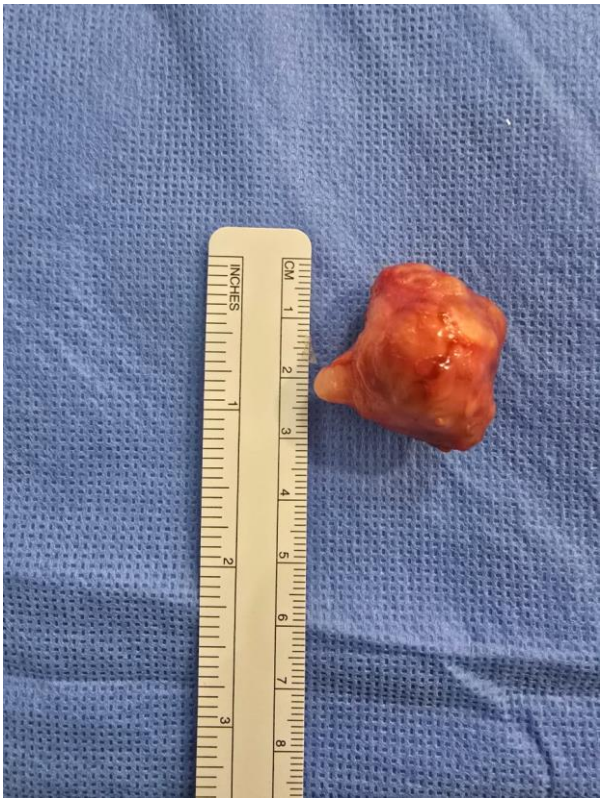

Figure 3: View of the excised specimen.

Histopathological analysis of the specimen showed a well-circumscribed tumor composed of epithelial ducts, tubules, and nests of cuboidal cells arranged in a bilayered pattern, embedded within a chondromyxoid stroma. No cytological atypia, necrosis, mitotic activity, or infiltrative growth was present. The findings were diagnostic of chondroid syringoma (Figure 4).

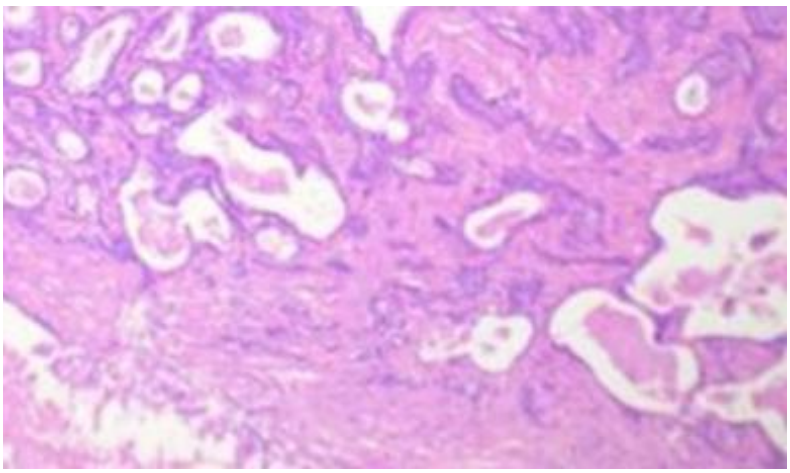

Figure 4. 40x H&E Staining of the specimen showing chondromyxoid stroma

The postoperative course was uneventful. At one-year follow-up, the patient reported no facial swelling, no functional complaint, and clinical examination showed no evidence of recurrence.

DISCUSSION

Chondroid syringoma is genuinely rare. The largest systematic review of the benign form identified only 347 cases across the entire published literature [1]. It is more common in men, typically between the ages of 20 and 60 [1,3], although our patient—a 68-year-old woman—is a reasonable outlier. Female and older cases are well documented, and neither age nor sex should dissuade clinicians from including chondroid syringoma in the differential [1,6].

The clinical presentation is the main diagnostic problem. A slow-growing, painless, firm cheek nodule with telangiectatic skin could be an epidermoid cyst, a dermoid cyst, a pilomatricoma, a neurofibroma, or a

pleomorphic adenoma. Most published case reports describe patients who waited one to several years before seeking care, and most were given an initial clinical diagnosis of a benign cyst [2–6]. Our patient had a two-year history, which is entirely typical. The practical lesson is straightforward: any persistent facial soft-tissue nodule that does not resolve over weeks, regardless of how benign it appears, warrants tissue sampling.

CT is helpful when the lesion is bigger or when you need to figure out how it relates to nearby structures before surgery. In our instance, CT validated the distinct characteristics of the mass, detected internal calcifications—a result noted in a limited number of cases [4,7]—and excluded bony erosion or deep extension. CT cannot make a histological diagnosis, and the calcifications can also be seen in other non-cancerous conditions [4,8]. Imaging is not a replacement for biopsy; it is an addition to it.

Histologically, chondroid syringoma exhibits a biphasic architecture characterized by epithelial structures, including ducts, tubules, and nests of cuboidal cells arranged in a bilayered pattern, embedded within a chondromyxoid or fibromyxoid stroma [1,2,9]. It is different from its cancerous counterpart because it doesn't have any cytological atypia, necrosis, mitotic activity, or infiltrative growth. Malignant chondroid syringoma is extremely rare, with only approximately 51 documented cases. It typically occurs in the extremities rather than the face, frequently exhibiting rapid growth, dimensions exceeding 3 cm, and histological characteristics indicative of malignancy [9]. Our patient did not have any of these features.

The treatment is surgical excision. Recurrence is rare after resection is finished [1,3,5]. The method can be changed depending on where the tumor is. For lesions in the nasolabial area, an intraoral buccal incision avoids visible scarring and still gives good access to the subcutaneous [5,6]. This is not a small thing to think about: the cheek is an area that is very sensitive to aesthetics, and a well-placed intraoral incision makes a big difference for the patient. Larger lesions or those with suspected deep extension may necessitate an external approach; however, our case demonstrates that smaller nasolabial tumors can be managed intraorally with favorable oncological and cosmetic outcomes.

Conclusions

Chondroid syringoma of the cheek is an uncommon but well-characterized condition that is frequently misidentified as more prevalent benign lesions. It is not possible to make a diagnosis based only on clinical evidence. Imaging shows how bad the lesion is and helps plan surgery, but histopathology is still the only way to confirm the diagnosis and rule out cancer. Complete surgical excision, utilizing an intraoral approach when feasible, provides a conclusive cure with minimal morbidity and no discernible scarring. It is a good idea to follow up for a long time, although recurrence after complete excision is uncommon.

References

1. Di Guardo A, Balampanos CG, Gargano L, Giordano D, Capalbo A, Persechino F, *et al.,* Clinical and Dermoscopic Characteristics of Cutaneous Chondroid Syringoma: A Systematic Review. Dermatol Pract Concept. 2024 Oct 30;14(4):e2024237. doi:10.5826/dpc.1404a237
2. Ferragina F, Barca I, Sorrentino A, Kallaverja E, Cristofaro MG. Cutaneous chondroid syringoma: A case series. Oral Maxillofac Surg Cases. 2023 Mar;9(1):100291. doi: 10.1016/j.omsc.2022.100291
3. Anandani G, Singh Pathania Y, Patel T, Parmar R, Dhruva G, Katoch C. Benign Chondroid Syringoma on Chin: A Case Report and Literature Review. Cureus. 2023 Feb;15(2):e34571. doi:10.7759/cureus.34571 PubMed PMID: 36883086; PubMed Central PMCID: PMC9985670.
4. Amin D, Al-Gorashi A, Al-Habbab RY. Case report: chondroid syringoma of the cheek. 2015.
5. Liaquat A, Baig MA, Mehmood A, Alamgir W. Chondroid Syringoma of Cheek – A Case Report.
6. Schulhof Z, Anastassov GE, Lumerman H, Mashadian D. Giant Benign Chondroid Syringoma of the Cheek: Case Report and Review of the Literature. J Oral Maxillofac Surg. 2007 Sep;65(9):1836–9. doi: 10.1016/j.joms.2006.11.051
7. Min KH, Byun JH, Lim JS, Lee HK, Lee WM, Joo JE. Chondroid Syringoma on Face. Arch Craniofacial Surg. 2016 Sep;17(3):173–5. doi:10.7181/acfs.2016.17.3.173 PubMed PMID: 28913278; PubMed Central PMCID: PMC5556809.
8. Zufall AG, Mark EJ, Gru AA. Malignant Chondroid Syringoma: A Systematic Review. Skin Health Dis. 2023 Apr 1;3(2):ski2.144. doi:10.1002/ski2.144
9. Wan H, Xu M, Xia T. Clinical and pathological study on mixed tumors of the skin. Medicine (Baltimore). 2018 Sep;97(36):e12216. doi:10.1097/MD.0000000000012216 PubMed PMID: 30200138; PubMed Central PMCID: PMC6133443.