Case Letter

Multiple Progressive Papules on the Abdomen

To the Editor:

Syringoma is a benign adnexal tumor derived from the intradermal portion of the eccrine sweat ducts that occurs predominantly in women at puberty or in early adulthood. Eruptive syringoma (ES) is a rare variant that has been described to occur in successive crops on the anterior body surface. It usually presents as soft, flesh-colored to yellowish dermal papules on the lower eyelids of healthy individuals. Other sites of predilection are the cheeks, axillae, neck, and abdomen.[1-3] According to clinical features and associations, syringomas may be classified into 4 principal clinical variants: localized, familial, in association with Down syndrome, and generalized encompassing multiple and eruptive syringomas.[4] We report a case of ES in a 35-year-old woman.

A 35-year-old otherwise-healthy woman presented with eruptions that began as a few papules on the anterior aspect of the abdominal wall and spread to a larger area on her upper body in successive crops over the last 4 years. Her face and eyelids were relatively spared. The papules were nonpruritic and the lesions were asymptomatic. Since the initial onset of the papules, the patient's skin had never completely cleared at any point. She was not taking any medications and had no family history of similar skin conditions; a review of systems was noncontributory. Physical examination revealed multiple, flesh-colored to tan, flat-topped papules that measured 1 to 3 mm in diameter on the neck, shoulders, anterior chest, abdomen (Figure 1), legs, and axillae. The lesions were bilateral, symmetric, and had follicular and nonfollicular distribution. No puncta or remarkable surface changes were noted. The palms and soles, dorsal aspects of the feet, groin, scalp, face, oral mucous membrane, hair, and nails were spared. The remainder of the physical examination was unremarkable. Biopsy of the lesion showed a normal epidermis overlying a fibrous nodule in the reticular dermis that was composed of small ductules lined by a double layer of cuboidal cells. Near the epidermis, small cysts were found lined by inner clear cells containing amorphous material in the lumen. Tail-like projections of the ductule were seen (Figure 2). Ducts were surrounded by dense fibrous tissue that contained fragmented elastic fibers. Perivascular lymphoid infiltration was seen. A diagnosis of ES was made. The condition was explained to the patient and she decided against treatment because of its benign nature.

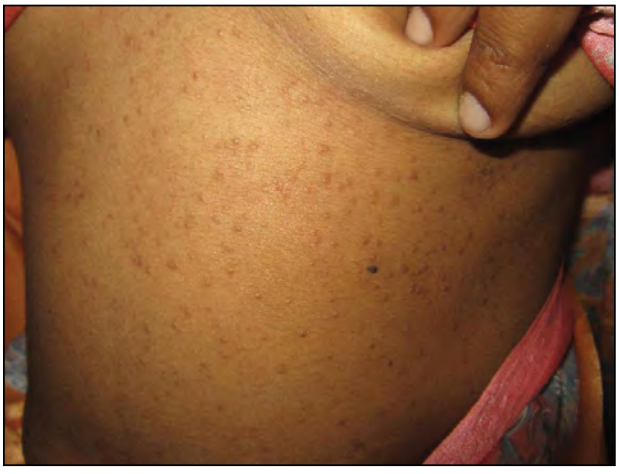

Figure 1. Multiple flesh-colored papules on the abdomen.

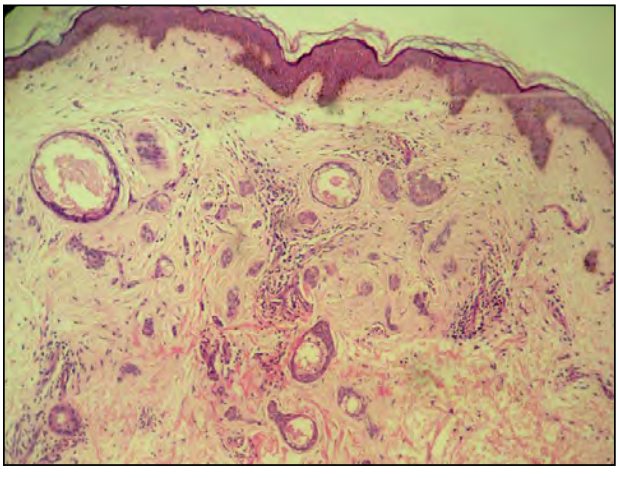

Figure 2. Histopathologic examination revealed a normal epidermis with numerous ductules in the reticular dermis lined by a double layer of cells. Few ductule having tail-like projections were seen (H&E, original magnification ×10).

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The authors report no conflict of interest.

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First described by Kaposi,[5] syringomas are benign tumors derived from the intraepidermal portion of the eccrine sweat ducts.[1,5] They are most common on the eyelids. Other clinical variants, such as eruptive, linear, familial, vulvar, penile, scalp, acral, and plaque-type syringomas, have been described.[6] In ES, a rare variant first described by Jacquet and Darier[7] in 1887, the lesions occur in large numbers and in successive crops on the anterior aspect of the chest, neck, upper abdomen, axillae, and the periumbilical region at puberty or during childhood. Although rare, cases with wider involvement of the body also have been reported.[8] Eruptive syringomas are described more frequently in patients with Down syndrome or Ehlers-Danlos syndrome.[7] In our case, no association was detected.

The lesions consist of asymptomatic, multiple, small, firm, yellow to brown papules that typically present in a bilateral symmetric distribution. There have been reports of unilateral, unilateral nevoid, bathing trunk, and generalized distributions.[2,3] The lesions are benign and may spontaneously resolve or more commonly remain stable.[8] However, in our patient, lesions progressively increased in number.

Syringoma is currently believed to be a neoplastic process. However, data that point to the reactive hyperplastic nature of ES have been put forward and referred to by Guitart et al[9] and Garrido-Ruiz et al.[10] Our patient did not give any history suggestive of preceding inflammatory condition.

Clinically, ES may be mistaken for acne vulgaris, sebaceous hyperplasia, milia, lichen planus, eruptive xanthoma, urticaria pigmentosa, hidrocystoma, trichoepithelioma, or xanthelasma on the face and granuloma annulare on the trunk. Definitive diagnosis can be made on histologic examination because syringomas demonstrate distinctive histopathologic features. Examination of the dermis demonstrates numerous small ducts lined with a double row of flattened epithelial cells. Often the outer layer extends into the surrounding stroma, forming a commalike projection. The ductal lumina are filled with an amorphous material that is positive using periodic acid–Schiff stain. Histochemistry and electron microscopy findings have confirmed that syringomas represent adenomas of the eccrine sweat ducts.[11]

Treatment of syringoma is cosmetic, and options are abundant and generally unsatisfactory. Treatment modalities have included dermabrasion, various methods of excision, cryosurgery, electrodesiccation, chemical peeling, and oral and topical retinoids. Successful treatment of facial syringomas with the CO_2 laser also has been reported.[12] One report suggests the use of topical atropine to alleviate pruritus in symptomatic ES.[13] Because they are located in the dermis and often are numerous, there is no standard treatment for widespread syringomas. Any method of surgical or chemical destruction carries the risk for scarring. Furthermore, no method eliminates the risk for recurrence. Rarely, tumors may regress spontaneously in adulthood.[8] Oral isotretinoin, topical tretinoin, and topical adapalene, as well as ablative techniques such as the CO_2 laser, have been reported with variable success; however, no treatment eliminates the risk for recurrence.[14]

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