Case Reports

Eccrine Acrospiroma – A Rare Sweat Gland Tumour- A Case Report

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ABSTRACT

A 50-year-old patient presented with a history of a longstanding, non-healing skin lesion with 15 years duration, which was clinically diagnosed as a case of skin cancer which had high probability as squamous cell carcinoma and later with histopathological evaluation it was confirmed to be a rare sweat gland tumor "eccrine acrospiroma". Eccrine acrospiroma is a relatively rare sweat gland tumor that affects people of all age groups and can involve any area of the body and is usually 1 to 2 cm in size and rarely may attain sizeable proportions. In1969, Johnson and Helwig introduced the term "eccrine acrospiroma". The majority of the tumors are benign. Clinically these lack diagnostic specificity and should be differentiated from other nodular and cystic lesions.

Key Words: Eccrine acrospiroma, Clear cell hidradenoma, Sweat duct tumour, Malignant transformation

INTRODUCTION

Eccrine acrospiroma is a unique cutaneous tumour of sweat gland origin which presents as solitary plaques, or exophytic papules and nodules. In 1969, Johnson and Helwig introduced the term eccrine acrospiroma which was previously termed as "eccrine poroma" by Pinkus H in 1956 (1,2). This tumor presents with large cells and ductal structure and has various other reported names such as nodular hidradenoma, clear cell carcinoma, clear cell adenoma, clear cell myoepithelioma, clear cell hidradenoma, superficial hidradenoma, carcinoma of the sweat gland, basal cell carcinoma of sweat gland origin, dermal sweat duct tumor and porosyringoma (3). These tumors affect people of all age groups and can involve any area of the body. These tumors on longstanding cases, may rarely become malignant (4) . Here we report a case of eccrine acrospiroma in a 50-year-old woman in the right leg.

Case Report

A 50-year-old woman came to the dermatology outpatient department of Saveetha Medical College and Hospital with an asymptomatic raised solid lesion on the right leg, which started as a small lesion and gradually increased in size in a span of 15 years with no prior history of trauma before the onset of the lesion. On local examination single, skin-colored to slightly hyperpigmented, polypoidal nodule with granulomatous edges of size 3x5 cm with varying consistency noted over the anterior aspect of the lower one-third of the right leg (Fig.1). Complete blood count, liver function tests, renal function tests, serum electrolytes, chest x-ray, and urine examination were normal. Incisional biopsy was done from the lesion and evaluated histopathologically. Microscopically it showed tumor cells arranged in lobules and sheets with cystic spaces in between and the cells were polygonal with abundant clear to pale eosinophilic cytoplasm and regular small round nuclei (Fig 2 and Fig 3). So the final diagnosis was consistent with benign eccrine acrospiroma.

DISCUSSION

The term eccrine acrospiroma was termed by Johnson and Helwig in 1969 to define a cutaneous tumor which was previously reported under various names and was

considered to be a tumor of sweat gland origin (1,3). This tumor typically presents as an asymptomatic, single, nodular, solid, cystic, elevated cutaneous mass and the covering skin may be smooth, thickened or verrucous and the color of the lesion varies from red to reddish blue (1,3).

The size of the lesion varies from 0.5 to 10 cm (1). Eccrine acrospiroma is a non-encapsulated multilobar tumor in the dermis, mostly involving the epidermis and rarely extending below the dermis (1). Tumors that are connected exclusively to the dermis are known as dermal acrospiroma or hidradenoma (8).

Tumours

Figure 1: Clinical picture of eccrine acrospiroma on the right leg – lower one third

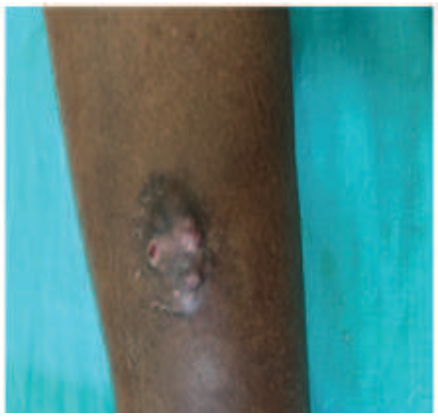


Figure 2:

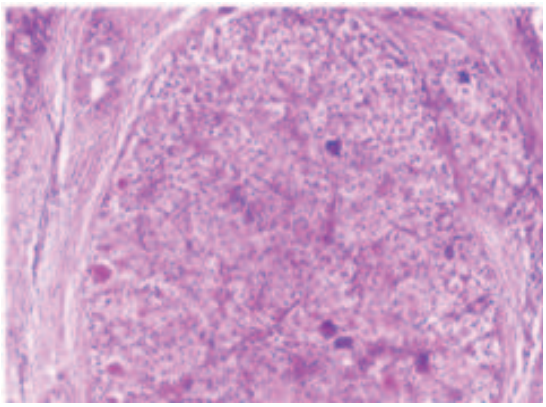
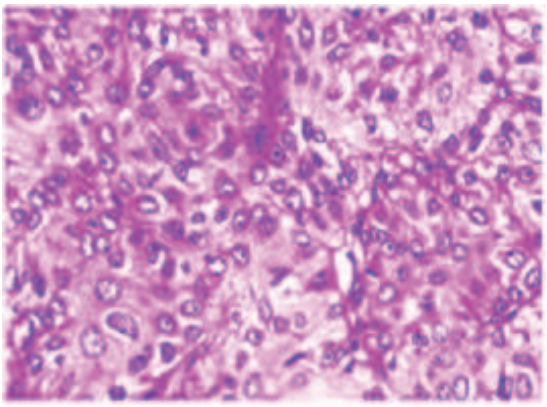


Figure 3:



The tumor can occur in any site of the body and can affect people of any age group. The most common site of involvement is found to be the trunk (40%), followed by head (30%) and extremities (30%) (1,6,7). This tumor is commonly seen in females, and the higher number of cases are seen in middle-aged and older adults (1,4). Painful lesions and discharge from the lesions are very rare (1). Eccrine acrospiromas have a very lower rate for it to undergo malignancy (1). Malignant tumors are not only rare but are usually of only moderate size, and the largest size of the malignant tumor was reported to be 4 cm (1,10). Malignant tumors are invasive with lymphatic involvement and distant metastasis. The presence of mitotic figures, cellular atypia, infiltrative local growth, and necrosis are the characteristics of malignancy (5,9). The clinical differential diagnosis of eccrine acrospiroma consists of haemangioma, melanoma, squamous cell carcinoma, metastatic, and other adnexal tumors (3).

The treatment of benign eccrine acrospiromas is surgical excision (1). Regional lymph node dissection along with wide local excision, is recommended in case of malignant eccrine acrospiroma (9). In our present case scenario, it was confirmed that it was a benign eccrine acrospiroma and the prognosis is good and not associated with recurrence when adequately excised.

CONCLUSION

Herein we would like to report this case because of its diagnostic difficulties as most of the longstanding skin lesions were likely diagnosed as either cutaneous malignancies or eczematous conditions with limited treatment options. Hence a good history taking and histopathological evaluation are important in alleviating the longstanding sufferings of the patient and providing a complete cure.

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