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Asymptomatic flesh-colored lobular nodule on the nose

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Abstract

Chondroid syringoma is a rare benign tumor of the skin appendages. Chondroid syringoma is mostly manifested by a slow-growing, painless, well defined subcutaneous or intradermal nodule. A 43-year-old man presented to our clinic with the complaint of an asymptomatic nodule on the dorsum of the nose for 8 months. The lesion was totally excised. Histopathological examination was notable for epithelial islets embedded in the chondroid matrix in the dermis. The patient was diagnosed with chondroid syringoma in light of the clinical and histopathological findings.

Keywords: chondroid syringoma, nose, benign

Introduction

Chondroid syringoma (CS) is a rare benign tumor of the skin appendages. The reported incidence of CS is 0.01–0.098%. CS is considered to originate from eccrine or apocrine sweat glands [1]. It is mostly manifested by a slow-growing, painless, well defined subcutaneous or intradermal nodule measuring 0.5 cm to 3 cm in diameter. CS is more common in middle-and advanced-aged men [2].

Case Synopsis

A 43-year-old man presented to our clinic with the complaint of an asymptomatic nodule on the dorsum of the nose for 8 months. Cutaneous examination revealed a solitary, flesh-colored, non-tender, translucent, telangiectasic, nodule of 10 mm diameter (**Figure 1**). The patient had no systemic or co-existing skin disease. The patient denied a history of trauma to the site. Routine laboratory tests were unremarkable, including complete blood count and liver function tests. The lesion was totally excised. Histopathological examination was notable for epithelial islets embedded in the chondroid matrix in the dermis (**Figure 2**). The patient was diagnosed with chondroid syringoma in light of the clinical and histopathological findings.

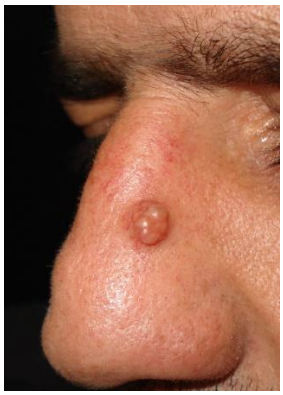

Figure1. *Clinical photograph of a solitary, translucent, telangiectasic, lobular nodule 10 mm in diameter on the nose.*

Case Discussion

CS is generally located on the head and neck, particularly nose, cheeks, and upper and lower lips. It is rarely seen on hands, feet, axilla, penis, vulva, or scrotum [1, 2]. In our case, the lesion was located on the nose.

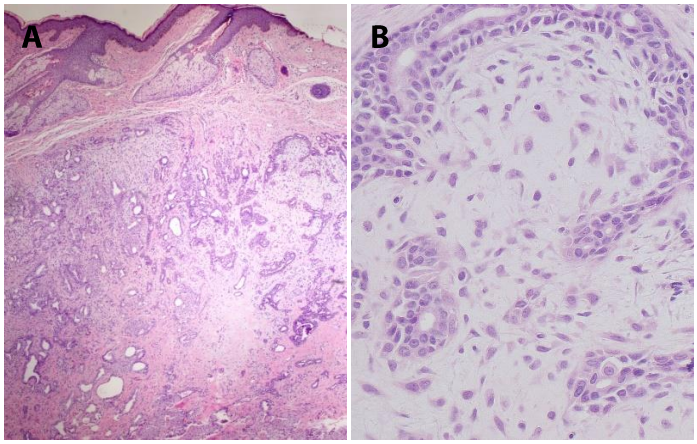

Figure2. *Histopathological examination reveals epithelial islets embedded in the chondroid matrix in the dermis.* (**A**), *(H&E, 40×). Figure3: Histopathological examination reveals epithelial islets embedded in the chondroid matrix in the dermis.* (**B**), *(H&E, 400×).*

CS is histologically characterized by a combination of epithelial and mesenchymal components. The epithelial components consist of nests, islands, ducts, and tubular structures. These structures may show sebaceous or squamous differentiation, albeit rare. The myoepithelial cells in the chondromyxoid stroma may be cuboidal, stellate, or spindle-shaped. The stroma may involve adipose or osteoid tissue [3, 4]. The differential diagnosis should include skin lesions such as dermoid cyst, neurofibroma, dermatofibroma, hystiocytoma, pilomatricoma, sebaceous cyst, and basal cell carcinoma [1-3]. In our patient, the provisional diagnosis was pilomatrixoma or basal cell carcinoma, but histopathological diagnosis of CS was made.

CS is typically a benign tumor, but malignant cases are rarely reported in the literature. Malignant types are more common in women and characterized by rapid growth and location of the lesion on the trunk and extremities [5]. Owing to the risk of local recurrence and malignant transformation, the best therapeutic approach for CS is total excision with adequate surgical margins followed by long-term follow-up [1, 5]. Accordingly, the nodule in our patient was totally excised and no recurrence was observed in a three-month follow-up period.

Conclusion

Chondroid syringoma should be considered in the differential diagnosis of slow-growing cutaneous and subcutaneous nodules on the face and neck. Patients should be closely followed up owing to the risk of malignancy.

References

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