Numerous yellow-brown papules over the trunk

A healthy 17-year-old white girl presented with numerous discrete brown to yellow colored papules that had arisen on the trunk 2 years earlier. The lesions were mildly pruritic. She was not on any medications at the time. Physical examination disclosed numerous skin-colored to yellow-brown 2-4 mm ovoid papules scattered over the anterior aspect of the thorax, mostly below the breasts and over the mid-abdomen [Figure 1]. A few lesions were seen in the axillae and on the anterolateral surface of the neck. The patient did not have other clinical cutaneous or systemic findings.

A skin biopsy specimen obtained from the abdomen of the patient revealed small ducts and epithelial cords within a dermis of normal-appearing connective tissue. The ducts were lined by two rows of flattened epithelial cells, the outer layer bulging outward to form solid chords [Figures 2 and 3].

WHAT IS YOUR DIAGNOSIS?

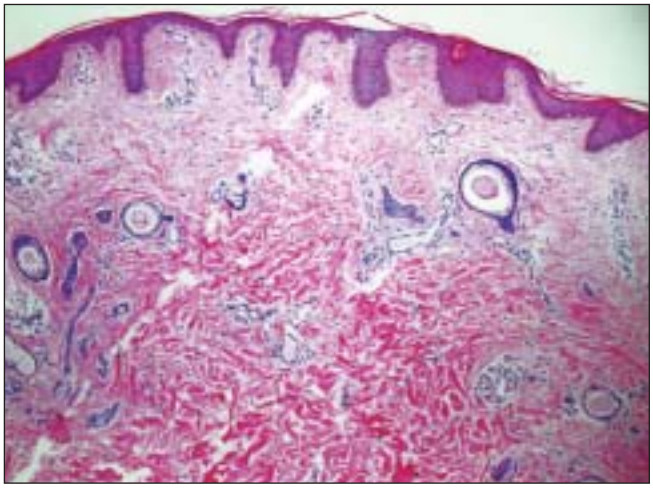

Figure 2: Proliferating multiple small ductular structures embedded in dense collagenous stroma (H and E, x100)

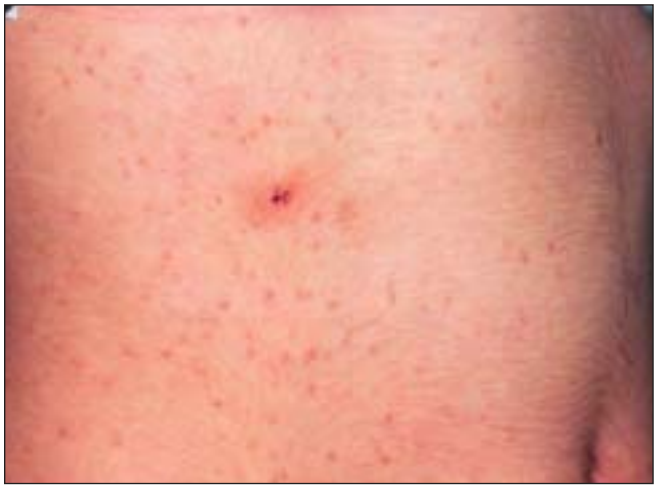

Figure 1: Multiple yellow-brown papules localized on the anterolateral surface of the trunk

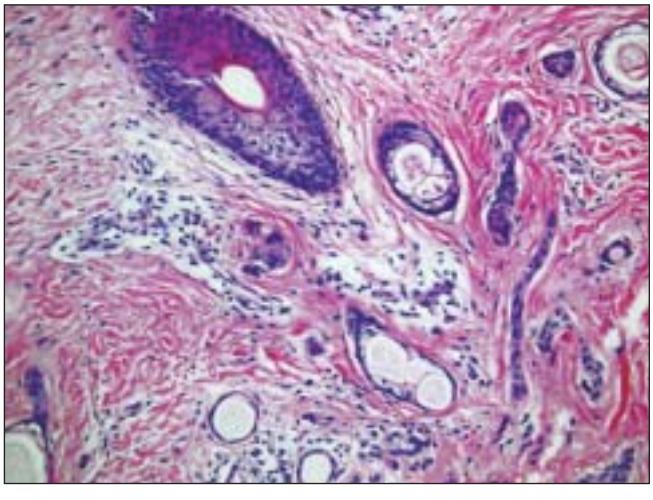

Figure 3: Small glandular structures lined by a double layer of flattened to cuboidal epithelial cells (H and E, x200)

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Diagnosis: Eruptive syringoma

DISCUSSION

Syringoma is a benign tumor of eccrine origin, first described by Biesiadecki and Kaposi[1] showing a differentiation toward intraepidermal eccrine ducts. Eruptive syringoma is a somewhat rare clinical variant, where numerous papules arise in successive crops on the anterior surface of the body.[1,2]

The skin lesions of syringoma consist of yellow to flesh-colored to brown 1-5 mm papules, which are commonly found on the eyelids. Other characteristic sites include the neck, chest, axillae, antecubital fossae, upper extremities, lower part of the abdomen and groins. They occur predominantly in women and may develop at any age, with a peak incidence between the third and fourth decades.[3] Histopathologically, the epithelial component of the proliferation is composed of cells with pale or pinkish cytoplasm arrayed as nests and tubules of relatively uniform size. Depending upon the exact plane of section, the nests of syringoma vary in shape and some nests may resemble a comma or a tadpole.[4]

Eruptive syringoma may clinically resemble lichen planus, flat warts, papuler mucinosis, xanthoma disseminatum and mastocytosis. However, the diagnosis can be easily made with the distinct histopathological findings.

Therapy for syringomas is unsatisfactory. Surgical, oral and topical treatments have shown limited results. Due to the number of lesions, electrocoagulation and cryotherapy are too laborious, yielding poor cosmetic results.[3] Symptomatic eruptive syringomas have shown poor or no response to topical and oral corticosteroids, topical antifungal agents and topical retinoids.[5] Successful treatment with 1% topical atropine resulted in disappearance of the pruritus and in a reduction in the size of the lesions.[6] However, the limitation of this treatment was that the patients had to be carefully evaluated for the side effects of atropine such as blurred vision, headache, palpitation, difficulty in micturition, reduced intestinal peristalsis, etc.

We have treated our patient with topical tretinoin. After 1 month, there was a significant improvement in the lesions; however, new lesions appeared during treatment. Although spontaneous involution of the lesions have been reported, it looks unlikely in our case.

Evren Sarifakioglu, Canan Gorpelioglu, Reyhan Bayrak*

Departments of Dermatology and *Pathology, Fatih University Faculty of Medicine, Ankara, Turkey.

Address for correspondence: Evren Sarifakioglu, Department of Dermatology, Fatih University Faculty of Medicine, Alpaslan Turkes Caddesi No.: 57, 06510, Ankara, Turkey. E-mail: evrenmd@yahoo.com

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