Pigmented polypoid lesion on the neck

A 31-year-old woman presented with a progressively enlarging polypoid lesion on her neck over the past year. On physical examination, the lesion appeared as a 1.0 × 0.5 cm, firm, asymptomatic, brown mass with a smooth surface [Figure 1]. Dermoscopic evaluation revealed a polymorphic vascular pattern with structureless pink, whitish, and brown areas [Figure 2]. The lesion was completely excised, and histological analysis demonstrated poroid cuticular cell islands associated with the epidermis, along with small pore structures within the tumour [Figure 3], as well as cytoplasmic melanin hyperpigmentation in tumour cells located at the periphery of the tumour islands. [Figure 4]. In immunohistochemical analysis, focal ductal and cytoplasmic staining with epithelial membrane antigen [Figure 5a], focal ductal-luminal staining with Carcinoembryonic Antigen [Figure 5b] and rare nuclear staining with Ki67 were observed.

Question

What is your diagnosis?

Figure 1: A brown solitary polypoid lesion with a smooth surface on the neck.

Figure 2: Polymorphic vascular pattern (red square) with accompanying structureless white-brownish areas (black circle) on hand-held polarised dermoscopy.

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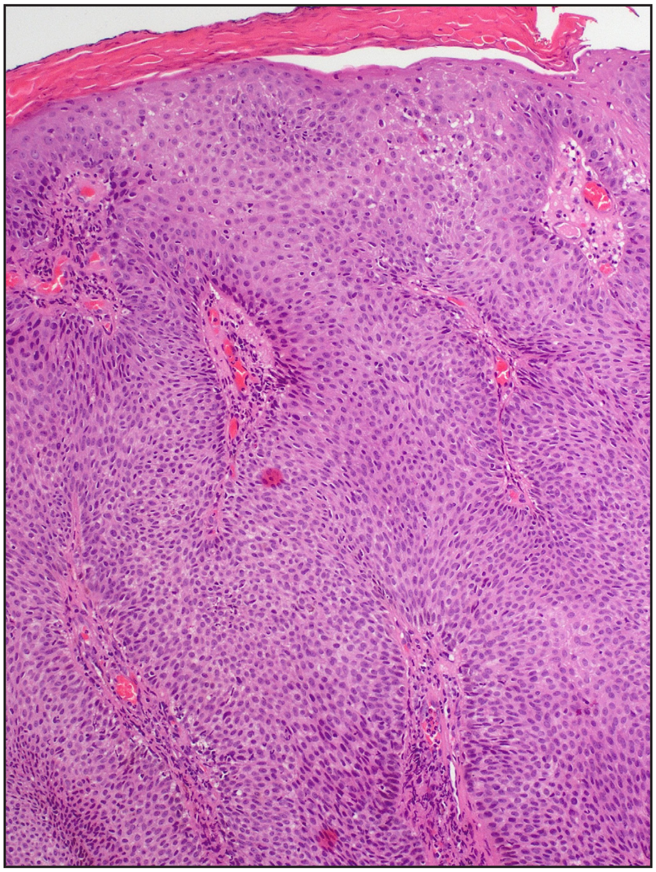

Figure 3: Tumour consisting of islands of poroid cuticular cells associated with the epidermis and containing small pore structures. (Haematoxylin and eosin staining, 100x).

Figure 4: Eccrine poroma with cytoplasmic melanin hyperpigmentation of tumour cells located at the periphery of the tumour islands, as indicated by the black arrows. (Haematoxylin and eosin staining, 40x).

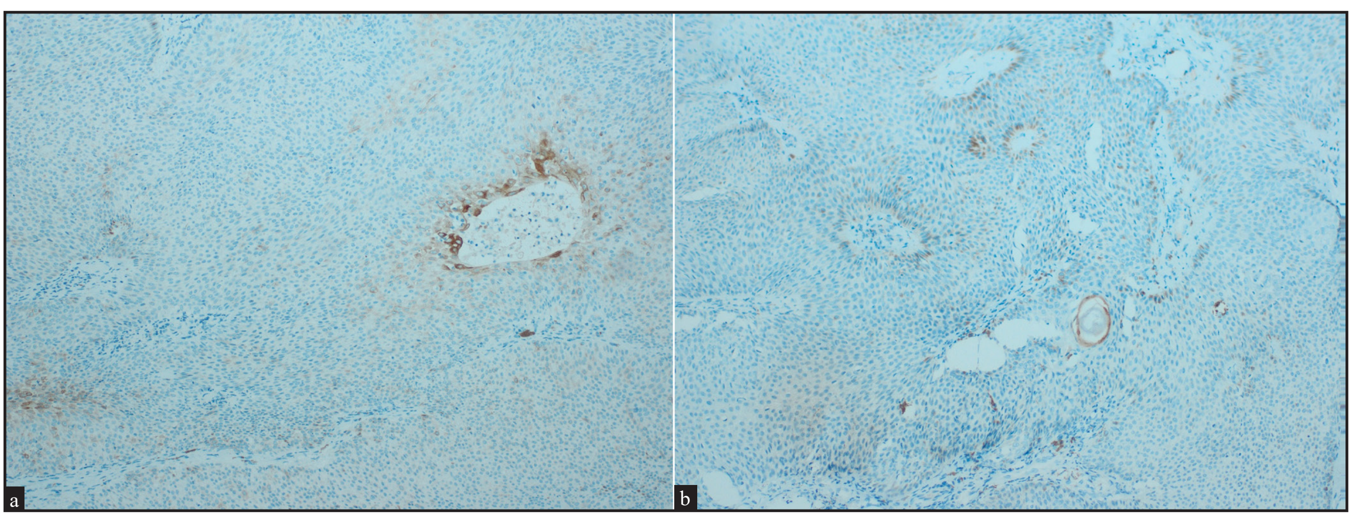

Figure 5: (a) Focal ductal and cytoplasmic staining with epithelial membrane antigen immunohistochemistry (100x); (b) Focal ductal-luminal staining with carcinoembryonic antigen immunohistochemistry (100x).

Answer

Diagnosis: Pigmented polypoid eccrine poroma

Discussion

Eccrine poromas are benign adnexal tumours originating from the intraepidermal portion of eccrine sweat glands. They most commonly occur in acral regions, such as the palms, soles or lower extremities and typically present as skin-coloured or erythematous papules, plaques or nodules.[1,2]

Pigmented variants of eccrine poromas are exceedingly rare, particularly those with polypoid morphology. To date, only a few case reports have been published in the literature,

Table 1: Pigmented polypoid eccrine poromas reported in the literature

Reference	Year	Sex	Age	Location
Wang *et al*.[1]	2008	Female	Congenital	Lower back
Lim *et al*.[2]	2018	Female	63 years	Multiple (Thigh, buttock, and face)
Bogomolets *et al*.[3]	2023	Female	30 years	Lower eyelid

involving the lower back, lower eyelids, and multiple sites, including the thigh, buttock, and face [Table 1].[1-3]

Polypoid forms of eccrine poromas have been associated with immunosuppressive conditions such as cancer, chemotherapy, and radiotherapy, with multiple lesions frequently reported in these cases.[2] In the present case, however, a solitary polypoid lesion was observed on the neck without any history of immunosuppression. Clinically, the lesion resembled a skin tag, which complicated the initial diagnosis. Nonetheless, dermoscopy played a crucial role in the preliminary assessment, revealing polymorphic vascular patterns, including chalice-form and cherry-blossom vessels, along with structureless pink, whitish, and brown areas.[4]

The frequent occurrence of eccrine poromas in acral regions is attributed to mechanical, environmental, or immunological stressors.[1] In our patient, the lesion developed on the neck, an area also vulnerable to localised friction and tactile trauma. This case may represent an example of an immunocompromised cutaneous district (ICD) following minor trauma, wherein the affected region becomes a "locus minoris resistentiae," possibly due to an isotraumatopic response to subclinical trauma.[5]

Given the potential for malignant transformation into eccrine porocarcinoma, timely diagnosis, complete excision, and close follow-up are crucial in the management of eccrine poromas. This case highlights the importance of considering eccrine poromas in the differential diagnosis of hyperpigmented polypoid lesions, particularly in non-acral locations.

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References

1. Wang SH, Tsai TF. Congenital polypoid pigmented eccrine poroma of a young woman. J Eur Acad Dermatol Venereol 2008;22:366-8.
2. Lim TM, Weir J, Fearfield L. Eruptive poromatosis in a patient with breast cancer. J Cutan Pathol 2018;45:708–710.
3. Bogomolets O, Rojczyk E, Hryshchenko R, Bogomolets C, Berezkin O. Pigmented poroma of the lower eyelid: A case report and literature review. Am J Case Rep 2023;24:e941975.
4. Espinosa AE, Ortega BC, Venegas RQ, Ramírez RG. Dermoscopy of non-pigmented eccrine poromas: Study of Mexican cases. Dermatol Pract Concept 2013;3:25-8.
5. Caccavale S, Kannangara AP, Ruocco E. The immunocompromised cutaneous district and the necessity of a new classification of its disparate causes. Indian J Dermatol Venereol Leprol 2016;82:227-9.