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Pre-Auricular Eccrine Acrospiroma: A Rare Case Report

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ABSTRACT

Eccrine acrospiroma is benign slow growing, generally cystic benign adnexal tumor. Malignant forms are rare but when present are associated with distal metastasis. It rarely occurs in paediatric patients. Head and extremities are most common sites. Biopsy is needed for diagnosis as the treatment of this condition includes wide local excision with margin clearance. Negative margin status is essential as this tumor tends to recur following excision.

INTRODUCTION

Eccrine acrospiroma also known as nodular hidradenoma or clear cell hidradenoma is a benign adnexal tumor arising from distal excretory duct of eccrine sweat glands. It is called eccrine acrospiroma because spiroma means adenoma of sweat glands and acro means topmost or end[1].

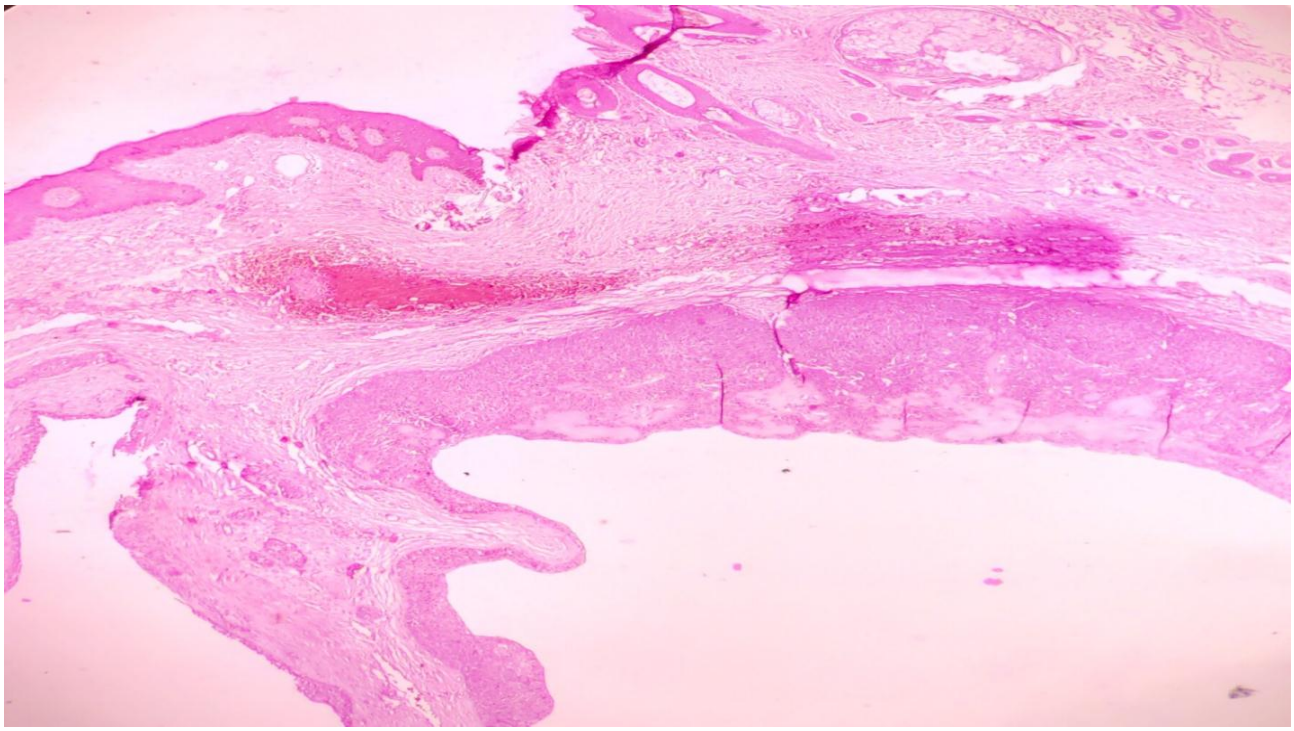
It generally occurs in adults however few paediatric cases have been reported. It is uncommon for these tumors to be painful and may recur when drained but rare to be malignant. Considering chances of malignant potential, adequate resection with negative margin status is essential in operative management. Eccrine acrospiroma could be misdiagnosed as cat scratch disease[2]. The lesion commonly appears as present as solitary plaques, nodules, orexophytic papules[3]. Most common site is upper extremities, head and face. Microscopically, the eccrine acrospiroma is distinguished from other sweat gland tumours by the presence of both clear and eosinophilic cells on H. & E. stained slides. It is generally non-encapsulated and contains varying amounts of hyalinised, myxoid, or fibroblastic stroma. The cells may be arranged in sheets, solid nests, lobules, tubules, or in squamoid whorls. Sometimes, Predominance of the clear-cell pattern may make the diagnosis difficult as the tumour may be confused with metastatic renal cell carcinoma[4]. Few cases in literature have also reported acrospiroma arising from breast.[5]. Lesions occurring in the axilla or breast may be confused with primary breast cancer or papillary neoplasm of breast[6]. Differential diagnosis for eccrine acrospiroma includes basal cell and squamous cell carcinomas, melanoma, metastatic tumour, dermatofibroma, haemangioma, leiomyoma and other cutaneous tumours[7].

Case report

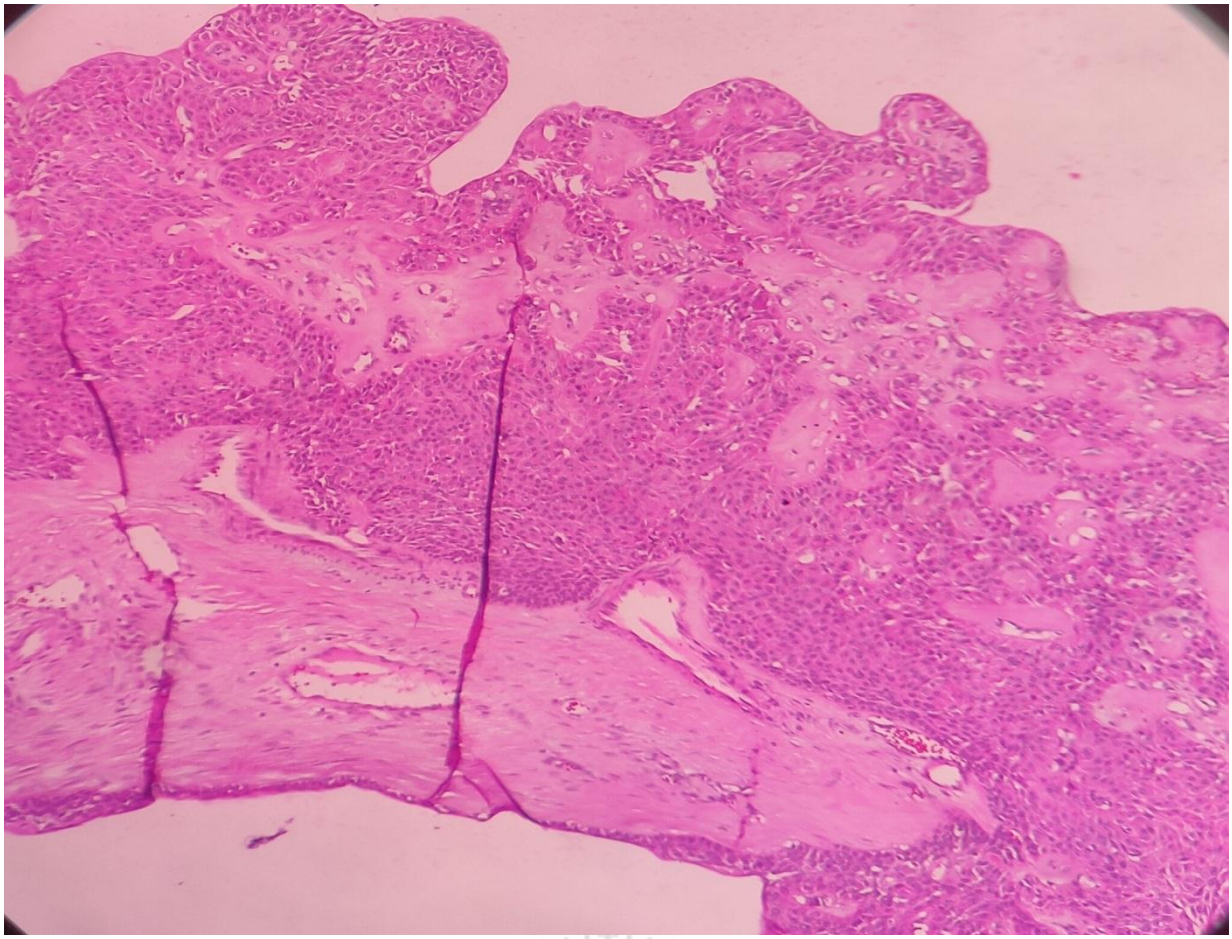
11 years old male came with history of right pre-auricular swelling since 2 months which increased gradually. History of fever/cough/ weight loss was absent. The swelling was non tender and not associated with any pain. On palpation the swelling was cystic, soft in consistency; clinically resembling sebaceous cyst. The cystic swelling was excised and sent for histopathological examination to pathology department.

We received excised pre-auricular cystic swelling, grossly which was measuring 2.5X1.5X0.9 cm in size. Cut surface revealed 3 cysts, each of diameter 0.3 cm surrounded by whitish rim of tissue.

Multiple H and E stained sections revealed stratified squamous epithelial lining with adenexal structures. Adjacent showed benign neoplasm comprised of nests and lobules of round to oval cells with uniform nuclei and clear to granular cytoplasm. Occasional cystic lumina with secretions and macrophages lined by columnar cells are seen. Areas of hemorrhage are seen. There were no evidence of atypia/ mitosis. Based on these findings it was reported as pre-auricular eccrine acrospiroma.



Photomicrograph A (10X) low power view showing cystic spaces with lining of stratified squamous epithelium. Underneath shows adenexal structures and fibrous stroma with focal areas of hemorrhages and adenoma comprised of round to oval cells with uniform nuclei and granular cytoplasm.



Photomicrograph B (10X) low power view showing round to oval monotonus cells with granular cytoplasm arranged in lobules. At place; they are forming lumina containing secretions.

DISCUSSION

Eccrine acrospiroma of the skin was first described by Liu in 1949 as clear cell papillary carcinoma of the skin. Subsequently, it was reported under various designations and the recent literature prefers the term clear cell hidradenoma, nodular hidradenoma or solid and cystic hidradenoma. Contrary to its initial description as a carcinoma, it represents a benign skin adnexal tumor. It usually presents as slowly enlarging, single, asymptomatic, firm, freely movably tumor or nodule[1]. The size of the tumour can range from 0.5 to 10 cm. The most common location is on the head and extremities. This tumour could be seen in a malignant form,and can cause distal metastasis .A biopsy of the growth and pathological evaluation is therefore essential. It commonly occurs in adults of age group 35 to 62 years. It is rare to find it in paediatric patient[2]. Malignant acrospiromas are highly invasive, having significant lymphatic and distant metastasis. The histopathological features of malignant acrospiroma

includes cellular atypia, frequent mitoses, infiltrative local growth, areas of necrosis, perineural invasion and angiolymphatic invasion. Grossly malignant tumors tend to be solid rather than cystic[3]. On ultrasound examination, the most commonly reported features in clue is a well defined predominantly cystic mass with a solid component or a mural nodule[5]. Localised tumours are best managed by wide local excision. It is crucial to achieve wide excision with negative margin status as these tumor have tendency to recur, Adjuvant chemotherapy and radiotherapy have only been proposed for malignant tumours and prognosis is generally poor in these patients with a five year survival of less than 30%[7].

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