CASE REPORT

ANNALS OF PUNJAB MEDICAL COLLEGE

Chondroid Syringoma of Cheek – A Case Report

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ABSTRACT

Chondroid syringoma is a rare, usually benign mixed tumor with prevalence as low as 0.001 % to 0.098% of all primary skin tumors. They can scarcely present as a malignant tumor. Benign Chondroid syringoma having size >3 cm has a high probability of transforming into malignancy. It is essential to rule out Chondroid syringoma since it is asymptomatic, misleading to diagnosis for other tumors. We report here the case of a middle-aged male having chondroid syringoma in the right cheek.

Keywords: *Chondroid Syringoma, Cheek tumor.*

INTRODUCTION

Chondroid syringomas (CS) are very rare, usually benign mixed tumors, with reported prevalence as low as ranging between 0.01% - 0.098% of all primary tumors of the skin.[1] Clinically, it cannot be differentiated from other tumors readily because of its asymptomatic nature. Histopathological evaluation of the tumor is mandatory for a confirmed diagnosis. Size varies from 0.5 cm to 3 cm, although larger lesions are reported in the literature.[3] They are mostly benign, but rare cases of malignant syringomas have been documented in the literature.[6] Treatment modality mainly involves the surgical excision of the tumor.[8]

CASE REPORT

A male patient aged 45 years having a history of remarkable swelling present on the right side of his face presented to the Oral and Maxillofacial Department of University of Lahore Teaching hospital, Lahore, Pakistan. The patient gave a history of asymptomatic swelling gradually increasing in size for the last 20 to 24 months. The past medical and drug history was insignificant. On clinical examination, an oval to round, mobile, well-circumscribed 3 x 2.5 cm diameter in size swelling present on his right cheek with superio-inferiorly extending 2 cm below the right lower eyelid till the right commissure of the lip, obliterating the nasolabial fold on the right side, mediolaterally extending only 2 mm far from the right ala of the nose, making alar nasal sulcus prominent, to 5.5 cm away from tragus. The overlying skin color, consistency, and temperature were standard. (Figure 1)

On palpation, the swelling was firm with no pain. Intraorally, there was a well-demarcated firm to hard swelling in the right cheek, which was bi-manually palpable. The overlying mucosa was normal. There was no blood or pus discharge. The right Stenson duct was patent. Oral hygiene was not satisfactory but no tooth was tender to percussion. The panoramic radiograph showed no sign of osseous or dental pathology. Nothing was aspirated on aspiration. Clinical differential diagnosis was pleomorphic adenoma, monomorphic adenoma, and dermoid cyst.

A contrast CT scan with a puffed cheek technique was done. It demonstrated a well-delineated multi-cystic lesion with actively enhancing substantial internal component measuring 33x31x24 mm (CC x AP x T) in a total and substantial internal component in the ventromedial aspect measuring 20 x 12 x 18 mm (CC x AP x T). The lesion was adjoining the skin with loss of fat plane anteromedially. There was no osseous involvement.

Under general anesthesia, using the intraoral right buccal mucosal incision, the lesion was exposed. It had well-demarcated lining and a fine plane for dissection.

(Figure 2) It was easily dissected out with finger dissection facilitated by gentle pressure from outside the cheek. The lesion was removed in total and subjected to the histopathological examination, which showed it to be chondroid syringoma. (Figure 4 & 5).

Figure 1: Extra oral view

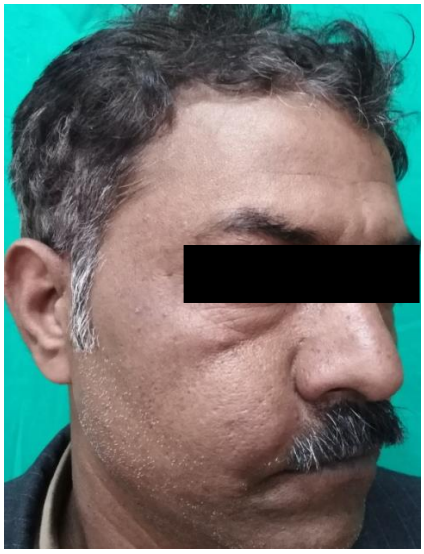


Figure 2: Per-operative tumor view

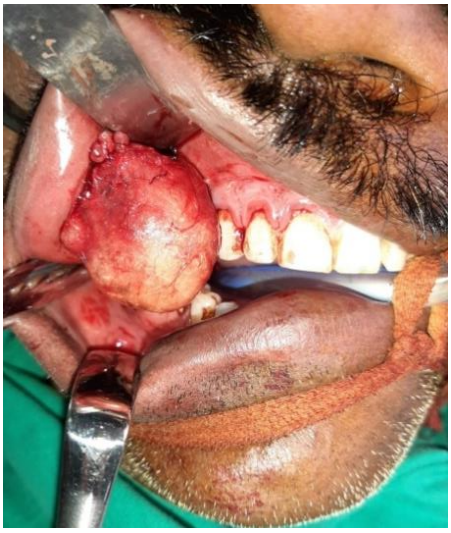


Figure 3: Resected specimen

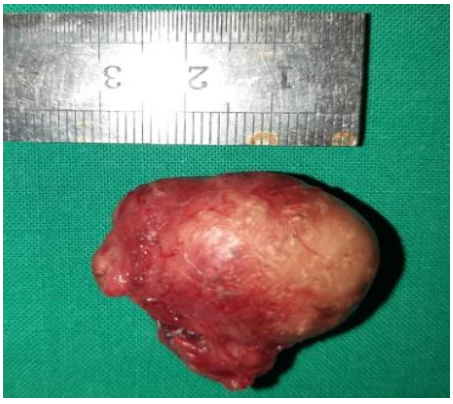


Figure 4: Histopathology slide 1

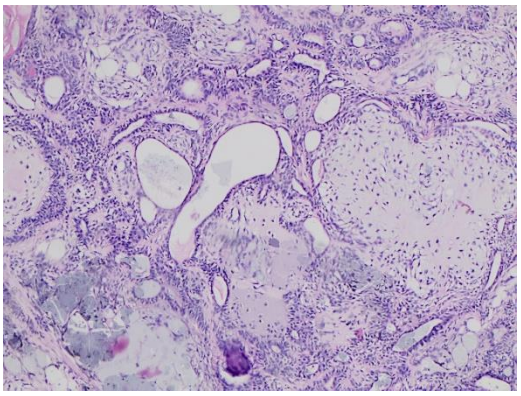
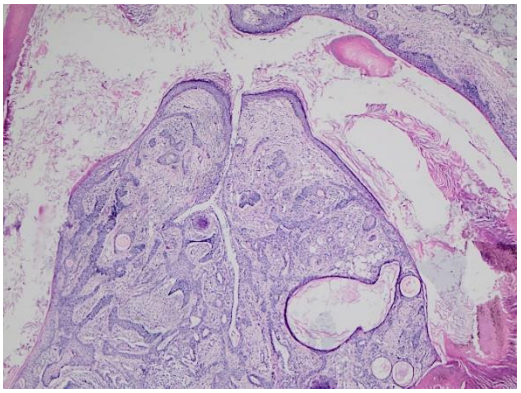


Figure 5: Histopathology slide 2



DISCUSSION

Benign chondroid syringoma was first described in 1859 by Billroth, which he named as "mixed tumor of the skin."[2] The literature suggests that tumor has a histological similarity to a pleomorphic adenoma of salivary gland origin. The term "chondroid syringoma" was described for the first time by Hirsch and Helwig in 1961. They noted, this tumor had characteristic histologic pattern showing elements of sweat gland which are stranded in the underlying stroma, which resembles cartilage.[4] A microscopic diagnostic criterion was proposed by them which included: (a) cuboidal or polygonal cells in a nest-like pattern; (b) structures having a lining of either two or more cuboidal cells arranged in rows of the intercommunicating tubuloalveolar structures; (c) ductal structures composed of one or two rows of cuboidal cells; (d) keratinous cysts may or may not be present; (e) an underlying matrix varying appearances in sections stained with hematoxylin and eosin.[4] Tendency of Chondroid syringoma to occur in the male population is twice as compared to females,[3] more common in middle-aged males.[2] In most cases, CS is benign; however, in the literature, its malignant variant is also documented. These malignant variants are common in females, mainly involving trunk and extremities. Their size grows more than 3cm and is locally invasive.[6]

It tends to follow an unpredictable course, approximately 50% presenting with local recurrences, 42% with nodal metastases, and 40% with distant metastases. The most commonly identified site of distant metastasis was the lung, followed by bone and brain.[7]

Due to its asymptomatic characteristic tumor resides mostly up to several years until it presents aesthetic complications or local trauma that drives the patient to seek a physician for evaluation.[2] Most of the time, the clinical diagnosis could be dermoid or sebaceous cysts, neurofibromas, dermatofibroma, or it can be associated with the salivary gland and could be pleomorphic adenomas. The confirmed diagnosis before excision of the lesion is usually not easy, and for that, either excision or biopsy is performed. For a very long time, the tumor is thought to be benign, but recent studies suggested that the tumor has the potential to transform into malignancy. There is no exact data regarding the rate of transformation of chondroid syringoma into malignancy. Literature suggests that tumors size more substantial than 3cm have more probability of malignant potential.[9]

The most reliable diagnosis must be the one confirmed by microscopic examination. The fine needle aspiration cytology (FNAC) is advocated to diagnose pathology before carrying out excision. However, a microscopic examination of excised tissue would be the most reliable and practical choice to establish a definitive diagnosis.[2] Due to the presence of lobules in tumors, it is essential to consider the adjacent margin of the healthy tissue while excising tumors to make sure that complete removal of the tumor is carried out to prevent a recurrence.[5] A routine follow-up is suggested because the tumor has been reported to reoccur in the range of 2.4% - 10%.[8]

CONCLUSION

CS is rare and mostly benign but has malignant potential. When a patient having facial subcutaneous skin lesion is inspected regardless of the patient's gender Chondroid syringoma should be included in differential diagnosis. The lesion must be well evaluated pre-operatively. Total excision with adequate safe surgical margins, maintaining the aesthetic and functional integrity to achieve patient satisfaction, is the mainstay treatment.

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