

CLINICAL SCIENCE LETTERS

Presentation of Syringomas and Lichen Amyloid as a Reactive Dermatosis

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To the Editor:

A 48-year-old Latin American woman, with no past history of interest and no known allergies, was seen for pruritus of the skin that had started several years earlier and that got worse in winter. The only findings on physical examination were moderate cutaneous xerosis and linear erosions and excoriations caused by scratching, predominantly on the limbs. Daily treatment with emollients and oral antihistamines (hydroxyzine) was prescribed.

Three months later the patient was referred back to our dermatology department due to persistence of the pruritus and the appearance of new skin lesions despite the treatment prescribed. Examination of the patient revealed diffuse hyperpigmented maculas over the area of the scapulae, posterior aspect of both arms, abdomen, and anterior aspect of the thighs. The skin creases, face, and neck were not affected. The skin surface of the affected areas showed diffuse thickening, together with flat, skin-colored papules (Figure 1). In addition, on both forearms, the thorax, and the upper part of the abdomen there were hyperpigmented papules that were grouped but not confluent (Figure 2).

Skin biopsies were taken from lesions on the right forearm and abdomen, representing the 2 types of papules described.



Figure 1. Flat, skin-colored papules.

Histological study of the forearm lesion revealed epidermal hyperplasia suggestive of chronic scratching together with the presence in the dermis of ductal structures lined by a double layer of epithelial cells; some of these structures had comma-like peripheral structures (Figure 3), compatible with the diagnosis of syringoma.

The abdominal biopsy also showed psoriasiform epidermal hyperplasia, and immunohistochemical study



Figure 2. Syringomas on the forearm.

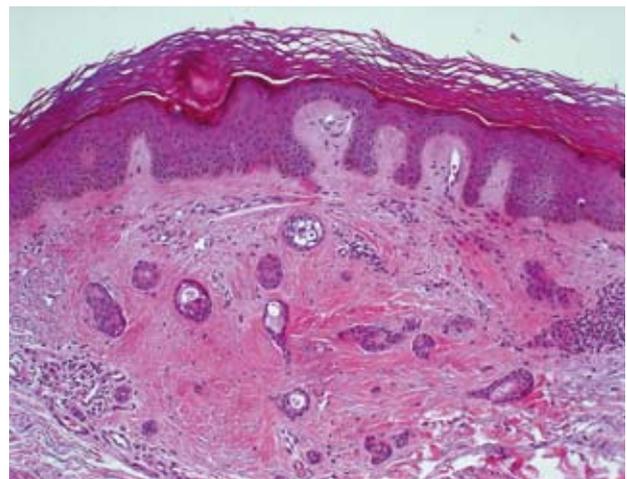


Figure 3. Comma-like ductal structures in the dermis (hematoxylin-eosin, $\times 10$).

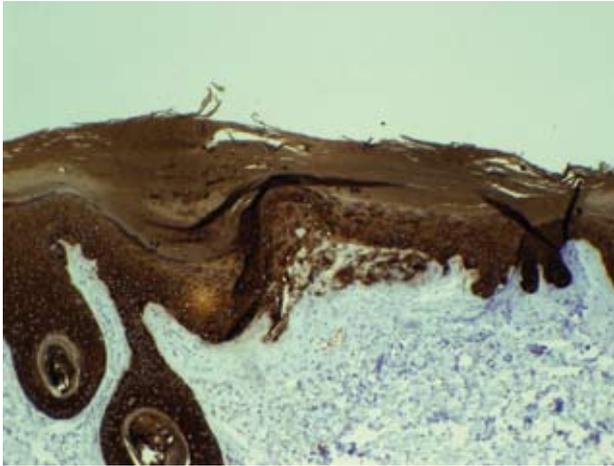


Figure 4. Stain with antibody 34βE12 showing amyloid deposits (×20).

with antibody 34βE12 confirmed the presence of deposits of amyloid substance limited to the upper dermis (Figure 4), a finding consistent with lichen amyloid.

There were no abnormalities in the blood tests. Treatment was prescribed with topical corticosteroids (betamethasone dipropionate), oral antihistamines, and skin emollients, leading to an improvement in the lesions except for the syringomas, which persisted unchanged.

Discussion

Syringomas have typically been considered to be benign tumors of the eccrine glandular epithelium. They usually develop during puberty, affecting the eyelids, axillas, the periumbilical area, and the pubis. They have been reported less frequently on the vulva, hands, and scalp, and very rarely in exclusively acral sites or in a linear distribution.^{1,2}

Eruptive syringomas present earlier, during the first decade of life, in the form of outbreaks that affect the neck, thorax, and abdomen. However, other patterns of onset or appearance have been reported in recent years: in sun-exposed areas,³ in the skin in areas of radiation therapy,⁴ and in association with various dermatoses that give rise to pruritus, such as eczema and nodular prurigo. All this suggests different triggers for syringomas, indicating a reactive nature.

Guitart et al⁵ reported 2 cases of patients with eczema, in whom biopsy showed histological findings suggestive of syringoma. This led them to propose the term syringomatous dermatitis and to suggest that the origin of the disorder could be an inflammatory skin condition, that is, a reactive rather than a neoplastic hyperplasia of the eccrine glands.

Corredor et al⁶ presented a patient with a tumor on the chin in which histology revealed features of both nodular

prurigo and syringomas in the same lesion, also suggesting a reactive origin.

Garrido-Ruiz et al⁷ reported a case of pubic syringomas developing after depilation of this area, reinforcing the idea of an inflammatory process as the trigger for syringomatous hyperplasia.

Finally, we present the case of an adult woman with intense pruritus and initially with no skin lesions, who developed papules of lichen amyloid and syringomas in areas of intense scratching.

Lichen amyloid is a primary form of cutaneous amyloidosis, of uncertain etiology. Some authors have suggested a genetic predisposition,⁸ but a large number of the patients who suffer this disorder report no family history, although they do describe a chronic irritant skin disorder that appears to act as the trigger. And there are authors who consider the disorder to be due exclusively to the repetitive scratching.⁹

Although our patient stated that her mother had suffered from an undefined pruriginous dermatosis, both the lesions of lichen amyloid and the syringomas only arose after intense scratching.

With this case, we consider that the simultaneous appearance of syringomas and papules of lichen amyloid in areas of scratching supports the reactive nature of syringomas, as suggested previously in the literature by other authors.

Although a number of cases of syringomas associated with pruriginous dermatoses (eczema, nodular prurigo) have been published, as has already been discussed, this is the first case to our knowledge in which their appearance has been associated with lichen amyloid, suggesting scratching as a common trigger.

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Conflicts of Interest

The author declares no conflicts of interest.

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Tattoo-induced Pigmentation in a Sentinel Node in a Patient With Melanoma

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To the Editor:

In patients with melanoma the most common cause of dark pigmentation of lymph nodes is metastases from the tumor. However, the finding of pigmented lymph nodes in these patients is not always a reliable sign of metastasis, as there are other causes that can give rise to this phenomenon.

A 33-year-old man with a history of schizophrenia was referred to our department to perform wider surgical resection and selective biopsy of the sentinel lymph node. This patient had undergone excision of a melanocytic lesion in the interscapular region; clinical atypia was present and the pathologic study was compatible with a superficial spreading melanoma with ulceration and a Breslow index of 0.7 mm. The rest of the dermatologic examination was completely normal, with the exception of the presence of a dark blue-grayish tattoo on the right arm. There were no palpable locoregional lymph nodes and no organomegaly. Preoperative lymphoscintigraphy showed drainage towards both axillas, with a single sentinel lymph node in each territory. During the operation, a sentinel lymph node of dark color was identified in the right axilla and there were 3 adherent adjacent lymph nodes that were also pigmented but with no radioactivity uptake. The 4 lymph nodes were excised in case they were metastases from the melanoma. The pathologic study of the lymph nodes of the right axilla showed reactive lymphadenitis with sinus histiocytosis and abundant deposits of dark pigment (Figure 1). Immunohistochemistry (S100 and human melanoma black-45) excluded infiltration of the lymph nodes by tumor cells. Histological study of the sentinel lymph node from the left axilla and of the extended surgical margins showed no pathological findings. The pigmentation of the right axillary lymph

nodes was related to the tattoo that the patient had on the upper limb of that side (Figure 2).

Melanoma is a malignant tumor that has the potential to spread to the lymph nodes. At the present time, selective biopsy of the sentinel lymph node is used for staging the tumor. The pathological state of the sentinel lymph node is the strongest independent prognostic factor in terms of overall survival in patients with clinical stage I or II melanoma. Early radical lymphadenectomy is indicated in cases with a positive lymph node on pathologic evaluation.¹

Tattooing is a popular cosmetic practice in Western countries.^{2,3} In permanent tattoos, the pigment is deposited in the dermis. Pigment particles migrate through the lymph vessels and are deposited in the lymph nodes, both within histiocytes and extracellularly.² The methods used

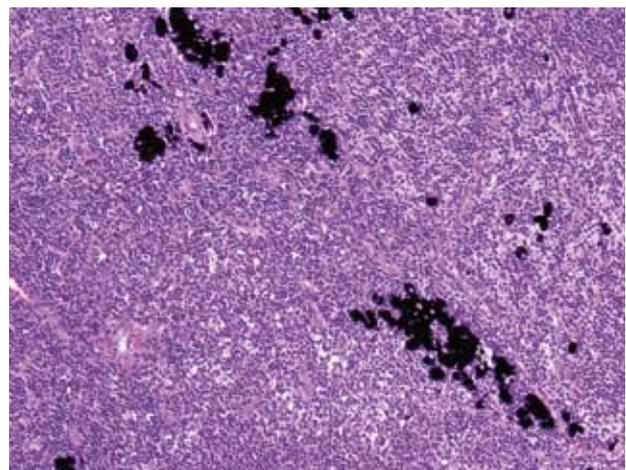


Figure 1. Granules of pigment in the macrophages and in the extracellular areas of the lymph node (hematoxylin-eosin, $\times 10$).