# Kondroid Şiringoma : Bir Olgu Raporu

## *Chondroid Syringoma: A case report*

Firdevs Veziroglu*, Derviş Yılmaz**, Uğur Koçer, Elif Özer****


## Özet

Kondroid Şiringomalar (derinin benign miks tümörü) yavaş büyüyen ve pleomorfik adenomalarla karıştırılabilen nadir görülen tümörlerdir. Bu olgu raporunda sağ yanağında büyük bir şişliği olan 46 yaşındaki erkek hasta sunulmuştur. Lezyon tamamen eksize edilmiş ve histopatolojik inceleme sonucu kondroid şiringoma olarak rapor edilmiştir.


**Anahtar Kelimeler:** Kondroid Şiringoma, pleomorfik adenoma


## Abstract

Chondroid syrinpomas (benign mixed tumor of the skin) are uncammon tumors usually presenting as a slow growing mass and can be confused with pleomorphic adenomas clinically. This report presents a 46 years old man with a large swelling an his right cheek. The lesion was completely excised and histopathologic examination concluded as chondroid syringoma.


**Key Words :** Chondroid syringoma, pleomorphic adenoma


* Yrd. Doç. Dr. Firdevs Veziroglu,Başkent Üniversitesi Dişhekimliği Fakültesi Ağız - Diş - Çene Hastalıkları ve Cerrrahisi A.D., Ankara

** Prof. Dr. Derviş Yılmaz Gazi Üniversitesi Dişhekimliği Fakültesi Ağız - Diş - Çene Hastalıkları ve Cerrrahisi A.D., Ankara

*** Prof. Dr. Uğur Koçer, Ankara Eğitim ve Araştırma Hastanesi, 1. Plastik ve Rekonstrüktif Cerrahi Departmanı, Ankara

****Dr. Elif Özer, Ankara Eğitim ve Araştırma Hastanesi, Patoloji Departmanı Ankara

Tumors with mixed cell types can arise from either salivary glands or sweat glands and most commonly occur in the head-and-neck region of middle-aged men. As their clinical presentations and histological appearances are similar, these tumors are often difficult to distinguish [1-7]. Tumors that arise from salivary glands are more commonly referred to as pleomorphic adenomas, whereas those that arise from sweat glands are referred to as chondroid syringomas [1].

Chondroid syringoma although rare, must be included in the differential diagnosis of subcutaneous lesions in the head and neck. To eliminate misdiagnosis of these tumors clinical, radiological, and pathological evaluation are essential.

## Case report

A 46-year-old man was presented with a complaint of large swelling in his right cheek. Bimanual palpation was revealed a firm, mobile, well-circumscribed mass in the right posterior buccal region lateral to the upper molars causing asymmetry extraorally. No ulceration of the skin and the oral mucosa were observed. There was no associated lymphadenopathy, facial pain or facial muscle weakness. Medical history was revealed no systemic, familial disease and evidence of trauma to this area.

Panaromic radiography was indicated a radiolucent area in the retromolar region and ascending ramus adjacent to this lesion (figure 1). This radiolucency was thought to be the extension of this lesion that caused destruction in the mandibular bone. However, CT scanning was revealed a well circumscribed mass located in the cheek that has attachment to the osseous structures of the mandible (Figure 2).

The patient was operated under general anesthesia. With mucosal incision, firm, well encapsulated mass was completely excised from the buccal space intraorally. The patient had an uneventful postoperative course and experienced no facial nerve deficit. There was no recurrence during the 36 months of the follow-up period

## 3. Diagnosis

The gross appearance of the surgically removed neoplasm was measured approximately 40mm X 25mm X 20mm in size. Histopathologic examination was macroscopically showed solid, nodular cream color mass which has a smooth surface. Microscopical examinations was revealed tubular structures with double layer epithelial cells and cystic structures with one layer squamose epithelium in the chondromixoid stroma of the lesion (figure 3). The tumor nests were composed of cuboid or polygonal cells with abundant eosinophilic-staining cytoplasm forming ducts and trabecular cords. Eosinofilic material and keratin were detected in the lumen of cystic structures (figure 4). There was no ne-

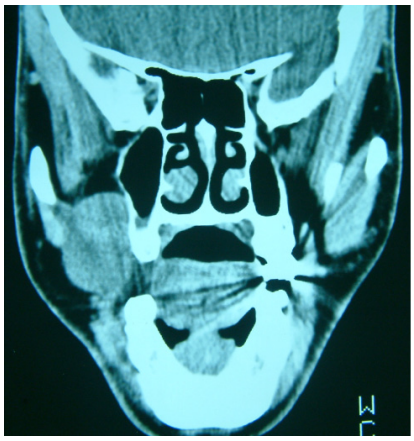

**Figure 1-** Coronal CT displaying borders of well circumscribed tumoral lesion on the right cheek. The lesion was not related with maxillary or mandibular bone.

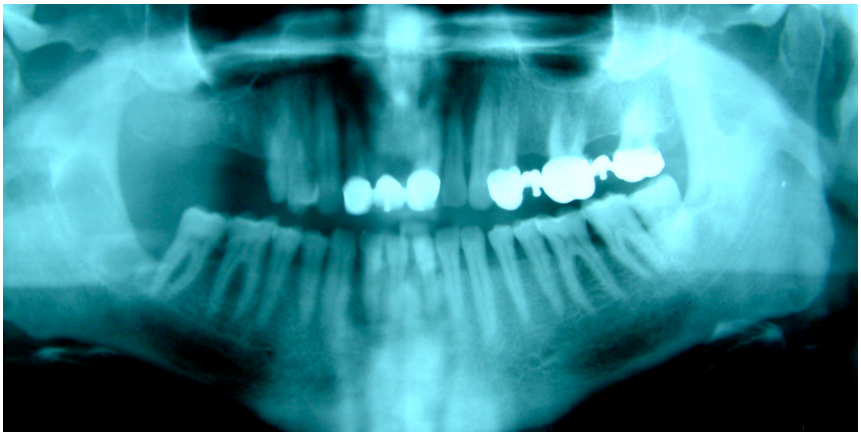

**Figure 2-** Panoramic radiography of the patient showing radiolucent areas in the right posterior mandibular region.

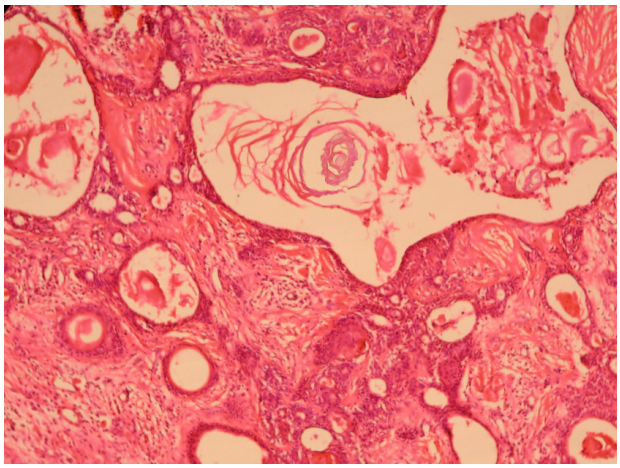

**Figure 3-** Eosinofilic material and keratin exist in the lumen of cystic structures. There was no necrosis or hemorrhage. (H&E)

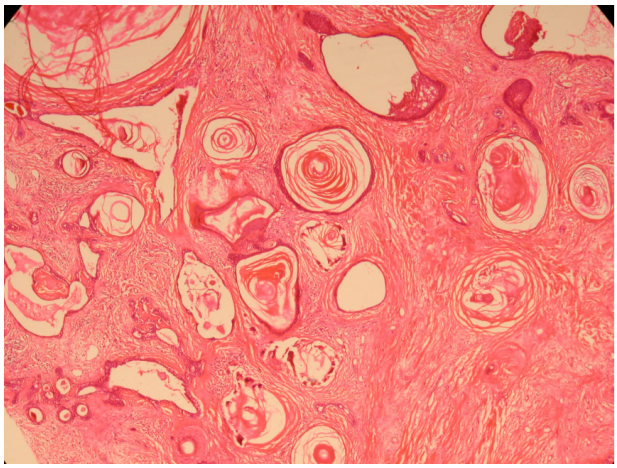

**Figure 4-** Biphasic pattern resulting from well-differentiated ducts and myxochondroid stroma is characteristic. (H&E)

crosis or hemorrhage. Histopathologic diagnosis was concluded as ''benign chondroid syringoma''. No evidence of malignity was detected

## 4. Discussion

It is originally described by Billroth in 1859, than Hirsch and Helwig introduced the term "chondroid syringoma" for this sweat gland tumor in 1961. It is a rare tumor of people between 20-60 years old and characteristically presenting as an asymptomatic, slow growing mass which consist of intradermal or subcutaneous nodes. The chondroid syringoma is usually a small, painful, non-ulcerated, solitary, benign skin tumor that is slow growing and localized in the dermis or subdermis[1, 8]. The lesion is commonly mobile and distinct from the surrounding tissues [3]. These lesions are 5 to 30 mm in diameter, firm, attached to the surrounding dermis, but have no attachment to the inferior tissues. The incidence of chondroid syringoma is reported to be less than 0.01% among the primary skin tumors [5]. The male to female ratio is 2:1 [1, 6, 7]. They aren't tending to recur and malignancy rate is extremely rare [9]. The malignant forms are commonly of younger patients localized on the trunk or the extremities [1, 5]. Malignant forms are often larger than 3 cm in diameter [10]. Total excision is the management, and recurrence does not occur unless residues are left [2, 4, 8]. Rare cases of more aggressive or malignant forms have been reported [11-13].

In the present case report, initial differential diagnosis was included lipoma or plemorphic adenoma. The most common differential diagnoses include epidermoid cysts, mucoceles, adnexal tumors and granulomatous process [5, 6]. The differential diagnosis also requires the elimination of basal cell carcinoma or epidermoid cysts.

Pleomorphic adenomas are the most common tumors arising in the salivary glands. They generally involve the major salivary glands, especially the parotid glands, but they also can arise in the minor salivary glands of the palate, the buccal mucosa, and the upper lip[8,10,14,15]. Chondroid syringomas, on the other hand, are thought to arise either from eccrine or apocrine glands. They also occur within the head and- neck region but are more frequently found on the nose, cheek, upper lip, scalp, forehead, and chin [1,4,16]. In chondroid syringomas, the histologic appearance of malignant mixed tumors also differs in that pleomorphism and necrosis are evident, and the mitotic rate is increased.

As chondroid syringomas have a nonspecific clinical presentation, they are rarely considered in the differential diagnosis, and, histologically, they can be mistaken for pleomorphic adenomas of the salivary glands. Therefore, in the diagnosis of a tumor in the head-and-neck region, it must be considered whether the lesion originated from sweat gland or salivary gland. Both tumors are benign, but recurrence may occur as a result of incomplete removal.

## Kaynaklar


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**Yazışma Adresi:**

Dr. Firdevs Veziroğlu,
Başkent Üniversitesi Dişhekimliği Fakültesi 11. Sokak No: 26 Bahçelievler / ANKARA
Tel: 0 312 215 13 36
Fax: 0 312 215 29 62
e-mail: fveziroglu@yahoo.co.uk