ABSTRACT

Objectives: 1) To describe an unusual case of a giant chondroid syringoma of the nose; 2) To define clinical, laboratory, and histologic features of chondroid syringoma; 3) To discuss treatment and follow-up care for patients with chondroid syringoma.

Study Design: Case presentation and literature review.

Methods: A patient with a chondroid syringoma of the nasal ala was studied. Clinical history, laboratory data, imaging studies, and histopathology were reviewed.

Results: A 43-year-old male presented with a 4-year history of a slowly growing mass on his left nasal ala. Fine needle biopsy favored a benign neoplasm. The patient was taken to the operating room for resection. Negative margins were obtained, and the wound was closed with a local rotation flap. The diagnosis of benign chondroid syringoma was made upon histopathologic examination of the surgical specimen. The patient recovered uneventfully from surgery and have been no signs of recurrence on follow-up examinations.

Conclusion: Chondroid syringomas are rare, benign tumors of apocrine glands that most commonly occur in the head and neck region. We present the largest reported case of chondroid syringoma of the external nose. The treatment of choice is surgical excision with negative margins. Functional and aesthetic units should be maintained whenever possible. The specimen should be examined closely to confirm the diagnosis and to rule out malignancy.

INTRODUCTION

Chondroid syringomas, also known as pleomorphic adenomas or mixed tumors, are rare, benign tumors of apocrine glands. They are composed of epithelial and mesenchymal tissues. These lesions occur most commonly in the head and neck region. We report an unusual case of a giant chondroid syringoma of the nose. Based upon our review of the literature, this is the largest documented case of a chondroid syringoma of the external nose.

CASE PRESENTATION

A 43-year-old male presented with a 4-year history of a slow-growing mass on his left nasal ala. Upon exam, the lesion was a firm, non-tender, moderately ulcerated, cylindrical mass measuring 1.5 cm (diameter) by 3.5 cm (length) (Figure 1). He denied pain, trauma or previous surgery to the area. The remainder of the physical exam was within normal limits. Fine needle aspiration was performed, narrowing the diagnosis to either a syringocystadenoma papilliferum or chondroid syringoma. Surgical excision of the mass was performed under general anesthesia. The diagnosis of benign chondroid syringoma was made upon histopathological examination of the surgical specimen (Figure 2A and 2B). Negative margins were obtained, and the wound was closed with a local rotation flap (Figure 3). The patient recovered uneventfully from surgery, and there have been no signs of recurrence on follow-up examinations (Figure 4).

DISCUSSION

Chondroid syringomas present as slow-growing, painless, subcutaneous or intracutaneous nodules in middle-aged adult males. The incidence reported in the literature ranges from 0.01 to 0.098 percent of all primary skin tumors. The tumor has been found on most parts of the body, with the majority involving the skin of the head and neck region. Most lesions are small and range between 0.5 to 3 cm.

Larger tumors are extremely rare as the tumors are usually excised before causing significant cosmetic and functional impairment. Larger lesions may become ulcerated and bleed, and in our case, was what prompted the patient to seek medical treatment. Chondroid syringomas do not present in a distinctive manner. As a result, the tumor is often initially confused with more common dermatologic skin disorders such as sebaceous cysts, dermoid cysts, neurofibromas, dermatofibromas, basal cell carcinoma, histiocytoma, and seborrheic keratosis. The definitive diagnosis is usually made upon histopathologic examination after surgery.

Malignant chondroid syringomas are extremely rare, occurring more commonly in females and on the extremities, with a high rate of metastasis to regional lymph nodes, bones, and visceral organs. Atypical histological findings such as cytologic atypia, increased mitotic figures, infiltrative margins, and tumor necrosis are considered signs of malignant transformation.

The treatment of choice is surgical excision with negative margins. Important functional and aesthetic units should be maintained whenever possible. The specimen should be examined closely to confirm the diagnosis and checked for malignancy. Routine follow-up is recommended as recurrence rates have been reported in 2.4 to 10 percent of cases. In most cases, recurrence occurs as a result of incomplete excision.

REFERENCES