CONFLICTS OF INTEREST

The authors have nothing to disclose.

FUNDING SOURCE

None.

DATA SHARING STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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https://doi.org/10.5021/ad.2020.32.5.434

Syringoma Localized to the Umbilicus

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Dear Editor:

Syringomas are relatively common and benign appendageal tumors derived from the eccrine glands. Syringomas typically appear on the eyelid, but rarely can arise on the skin in other areas[1]. Although eruptive syringomas may also involve the periumbilical area, it is very rare for the lesions to be only limited to this region. Here, we report a rare case of a patient with periumbilical syringomas.

A 25-year-old male presented with numerous quiescent, localized papules in his periumbilical area, with a history

Received June 18, 2019, Revised October 13, 2019, Accepted for publication November 6, 2019

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of several years. On physical examination, there were multiple 1～2 mm sized, firm, light-brown colored papules in the periumbilical area (Fig. 1A). A closer examination with a dermoscope revealed multiple pink to whitish areas surrounded by finely pigmented network (Fig. 1B). The histopathological examination revealed multiple ductal and small cystic structures, dispersed within a fibrous connective tissue stroma in the upper dermis. The ductal and cystic spaces were lined by 1 to 2 rows of flattened epithelial cells (Fig. 1C). The patient was diagnosed with localized periumbilical syringomas, however he refused further management.

A syringoma is an organoid tumor with an intraepidermal eccrine ductal differentiation[2]. Typical lesions are multiple, flesh colored to yellow-brown dermal papules that may be soft or cystic in appearance and are movable over the subcutaneous tissue. Syringomas occur about twice as frequently in females and may either be localized or generalized in distribution[3]. The skin of the eyelids and the malar regions are the most common sites of involvement, although syringomas may also appear on the neck, anterior chest, axillae, arms, and abdomen[3-5]. However, syringomas localized solely to the periumbilical area have never been reported in literature.

The diagnosis is uncomplicated in syringomas involving a preferred site such as the lower eyelids. However, syringomas occurring in unusual locations are likely to be misdiagnosed, as e.g. Fox-Fordyce disease. But the lesions in Fox-Fordyce disease are smaller, more conical, and periodically very pruritic. Epidermal cysts or milia also could be confused with syringomas. They are usually fewer in number, more whitish and yellowish in appearance, and there are often one or more lesions with a characteristic central punctum in epidermal cysts[5]. Flat warts also occur as multiple, yellow-brown, small papules, but they have a hyperkeratotic flat-topped surface with confluent features and gradually spread by scratching or trauma. Clinically, it may be possible to distinguish, but biopsy is an essential diagnostic tool to prevent unnecessary treatments that waste the patient's time and resources.

Dermoscopic findings of periorbital syringoma show ivory to white colored homogenous areas with poorly defined borders, which were also observed in our case. The difference is that the hyperpigmented network is more prominent in our case because of the structural characteristics of the umbilicus.

Our report is of interest due to the unusual appearance of syringomas only involving the periumbilical area. We suggest that syringomas should be considered during the diagnosis and management of patients presenting only with papular lesions of the periumbilical area. To our knowledge, this is the first such reported case.

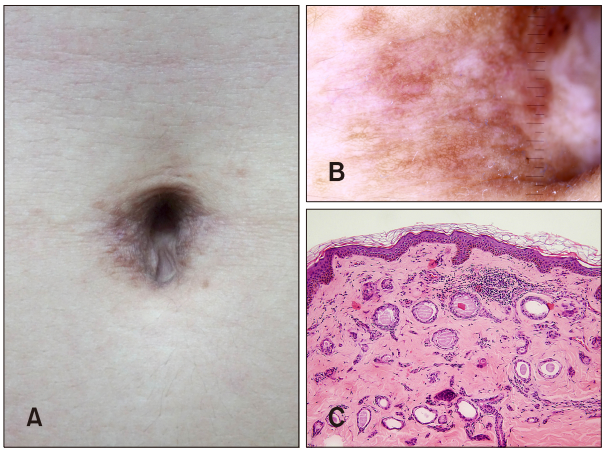

Fig. 1. (A) Multiple, small, slightly raised, brown colored papules located in the periumbilical area. (B) Multiple whitish to pink areas and fine pigmented network were observed under the dermoscope. (C) The histopathological examination showed multiple ductal and small cystic structures embedded within a fibrous connective tissue stroma. The ducts were lined by 1 to 2 rows of epithelial cells. Some ducts showed a "tadpole"-like appearance (H&E, ×100). We received the patient's consent form about publishing all photographic materials.

CONFLICTS OF INTEREST

The authors have nothing to disclose.

FUNDING SOURCE

This paper was supported by Fund of Biomedical Research Institute, Jeonbuk National University Hospital.

DATA SHARING STATEMENT

This article is a brief case report, and data sharing is not applicable.

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https://doi.org/10.5021/ad.2020.32.5.436

A Case of Cutaneous Metastases of Salivary Duct Carcinoma Mimicking Radiation Recall Dermatitis

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Dear Editor:

A 62-year-old male presented with a two-month history of purpuric indurated plaques on the neck (Fig. 1). Itching sensation was mild and intermittent. A year ago, he was diagnosed with salivary duct carcinoma (SDC) of the right submandibular gland. He underwent a modified radical neck dissection and right submandibular gland resection. After the surgery, he received radiotherapy on the neck. Purpuric indurated plaques occurred at the previous radiation field. At first we had a suspicion of radiation recall dermatitis because the lesion was confined to the previous radiation field and also the clinical feature of the lesion resembled radiation recall dermatitis rather than cutaneous metastasis or chronic radiation dermatitis. So we checked his medication history, including chemotherapy and antibiotics. However he had taken only some opioid analgesics and probiotics. For a precise diagnosis, skin biopsy was performed on his neck. Histopathologic findings showed infiltrative growth of irregular glandular structures with mucinous material in the dermis but no evidence of radiation recall dermatitis was revealed. Besides the lesion was positive for CK-7 in immunohistochemistry (Fig. 2). Thus a diagnosis of cutaneous metastases of SDC was made. Afterward the patient was referred to the oncology department for further management.

SDC is a rare and very aggressive malignant tumor. SDC arises most often in the parotid gland, followed by the submandibular gland and less frequently in the minor salivary gland. SDC has a high rate of distant metastasis but cutaneous metastases from the malignancy is very rare[1]. There are several cases of cutaneous metastases from SDC of parotid gland and only one reported case of cutaneous metastasis from SDC of submandibular gland globally[2].

Radiation recall dermatitis occurs on the sites of previously irradiated skin after a patient is exposed to triggering medications such as chemotherapy or antibiotics[3]. There is only one case similar to our case in the English literature. In the case of Kim et al.[4], the patient presented with erythematous edematous plaques on the previous ra-

Received September 19, 2019, Revised November 4, 2019, Accepted for publication December 3, 2019

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