ECRONICON OPEN ACCESS

DENTAL SCIENCE
Case Report

Case Report: Chondroid Syringoma of the Cheek

Dina Amin[1]*, Abdullah Al-Gorashi[2] and Rahaf Y Al-Habbab[2]

[1]Assistant Consultant Al-Noor Specialist Hospital, Saudi Arabia, Clinical fellow University of Alabama, USA

[2]Department of Oral and Maxillofacial Surgery, King Fahd Hospital General, KSA

***Corresponding Author:** Dina Amin, Assistant Consultant Al-Noor Specialist Hospital, Makkah, Saudi Arabia, Clinical fellow University of Alabama at Birmingham, USA

Received: April 20, 2014; **Published:** May 02, 2015

Abstract

Chondroid Syringoma is a rare mixed tumor of subcutaneous tissue thought to arise from sweat glands with a striking resemblance to pleomorphic adenomas that in contrast originate from salivary glands. Chondroid Syringomas are predominantly benign with low recurrence rate, though malignant forms have also been reported. A 50-year-old female patient presented with a slowly, enlarging painless mass in the right cheek over a three year period. A surgical excision was performed under sedation and the histopathological examination was consistent with Chondroid syringoma. There were no signs or symptoms of recurrence over a 2 years period of follow up.

Keywords: *Cheek; Chondroid Syringoma; Eccrine gland tumor; Mixed skin tumor; Pleomorphic Adenoma; Syringoma*

Introduction

Chondroid syringoma is a sweat gland benign tumor, which is 1st in 1859 by Billroth; as a mixed tumor of skin [1], but the term Chondroid syringoma was 1st introduced in 1961 by Hirsch and Helwig. It is a rare tumor that arises from the eccrine sweat glands, with anincidence of less than 0.01-0.098% in the head and neck which is the most common area [2]. We are presenting a rare case of Chondroid syringoma in the check.

Case Report

A 50-year-old female presented to Oral & Maxillofacial Surgery Clinic inking Fahad General Hospital, Jeddah, Saudi Arabia, for evaluation of left face swelling. Her chief complaint was she can't see well because of the growing swelling in her left check. she believed that the swelling was there since 20 years, and for the past 3 years it reached the current size which bothers her because it obstruct her visual field (Figure 1). She visited our clinic 3 years ago, she had a biopsy at that time and diagnosed as Chondroid syringoma, surgical treatment was discussed with her but she refused it.

Physical examination showed two firm, painless, mobile masses on the left cheek, covered by normal skin. Masses were bounded superiorly with the left lower eyelid, and medially with the ala and lateral wall of the nose, occupying the whole midface to the zygomatic eminence. Computerized Tomography (CT) was obtained and showed 1 x 1 cm superior and 2 x 2.5 cm inferior masses (Figure 2a and 2b). Numbness over the infraorbial area was present, with normal function of the buccal and zygomatic branches of the facial nerve. Intraoral examination showed normal mucosa, with no bulging or swelling. A second Biopsy was taken in the clinic from one of the masses under local anesthesia to rule out any malignant transformation; and the histopathology report revealed two possible differential diagnosis, pleomorphic adenoma and Chondroid syringoma (Figure 3).

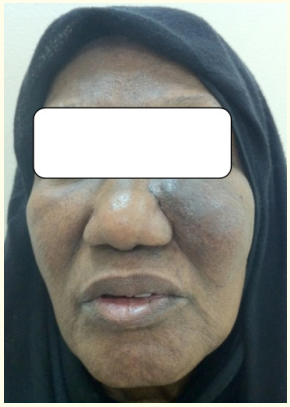

Figure 1: *50 years old female complaining from swelling in her left check. Note the scar of old biopsy.*

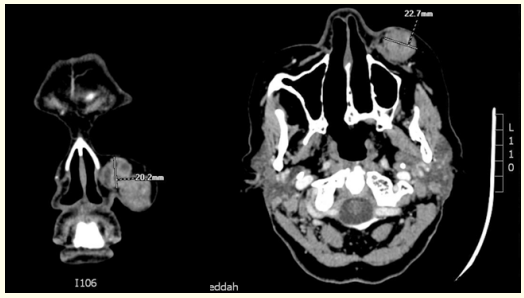

Figure 2a & 2b: *CT scans.*

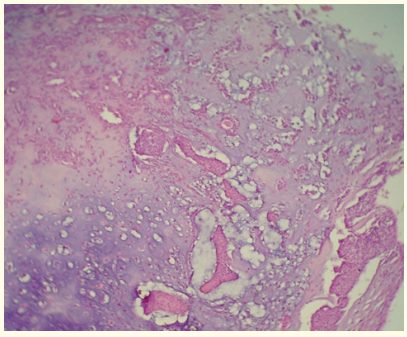

Figure 3: *Histopathology slide.*

A decision was made to excise the lesion under intravenous sedation because of the severe lung fibrosis and compromised general medical condition of the patient. Both masses were accessed using Modified Weber Ferguson Approach, blunt dissection with infraorbital nerve preservation was done, and both tumors were excised completely. Gross examination showed two well-circumscribed, firm tumors, surrounded with capsule-like tissue (Figure 4). A cosmetic fat distribution was then performed to minimize the defect size followed by soft tissue suspension and cosmetic facial closure. The patient was discharged the following day, 2 years follow up without any sign of recurrence and normal neurosensory function of the left infraorbital nerve (Figure 5).

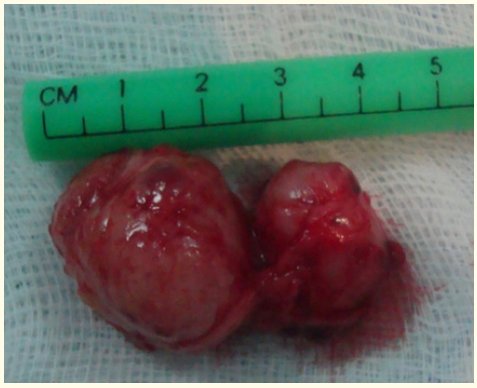

Figure 4: *Lesion dimension after removal.*

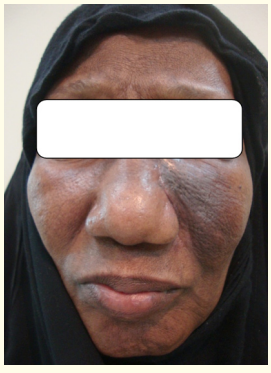

Figure 5: *Follow-up clinical picture.*

Discussion

Chondroid syringoma as 1st described by Billroth has a histologic resemblance of pleomorphic adenoma of salivary gland origin [1]. It is believed to originate from both secretory and ductal segments of sweat gland [3]. It is a rare benign tumor with incidence less than 0.01-0.098 % [2].

The largest reported case series (134 cases) was by Stout and Gorman [4], they reported a slight male predominance with 2:1 male to female ratio and a head and neck prevalence; the most common areas are nose, check, upper lip, scalp, forehead, and chin [4-7]. There are reported cases in the axillary region, trunk, abdomen and external genitalia [4].

They are usually presented as an asymptomatic, slow growing, firm, non-ulcerating, subcutaneous, or dermal nodules, the smallest reported case was 0.5 cm but 3 cm was reported as well [5,6].

It is difficult to diagnose the lesion clinically; biopsy is mandatory in order to establish a sound clinical diagnosis. Lesions such as neurofibroma, dermoidcyst, sebaceouscysts, dermatofibroma or salivary gland pleomorphic adenoma can be in the surgeon's mind as a differential diagnosis [5].

Malignant Chondroid syringoma is an extremely rare skin tumor that warrants different preoperative workup. The 1st reported case of malignant Chondroid syringoma in the face was in 2005 [8]. It has a different clinical presentation than its benign counterpart; with female predominance 1.7:1 ratio; 60% occur in the extremities, and 20% in the head and neck (scalp, ear and neck) [8]. Malignant Chondroid syringoma metastasize by lymphatic spread to regional lymph nodes and by hematogenous spread to lung, liver, brain and bone [8-10]. Malignant transformation of a long standing benign Chondroid syringoma is also reported. Biopsy is extremely important for these cases to rule out malignant variant because preoperative evaluation for malignant Chondroid syringoma should consist of head and neck, chest, abdomen and pelvis Computed Tomography (CT). Although Fine needle aspiration cytology (FNA) can be a useful alternative to open biopsy [8].

Surgical excision with 3-4 mm of normal tissue is the optimal treatment for benign Chondroid syringoma, recurrence rate for an adequately excised tumor is rare. As for the malignant variant a more aggressive surgical treatment is recommended [5-8].

Conclusion

We present an interesting case report of a rare mixed tumor of Eccrine gland origin, Chondroid syringoma. Due to the rare incidence of the benign and malignant Chondroid syringoma; it would be easily to misdiagnose these cases. Cooperation with an excellent pathologist is warranted.

Conflict of Interest

Authors confirms that this article has no conflict of interests

Acknowledgments

For Dr. Robert S. Glickman (Professor, Department of Oral and Maxillofacial Surgery, New York University, USA) for his endless support.

Bibliography

1. Chen AH., *et al*. "Chondroid syringoma of the head and neck: Clinical management and literature review". *Ear, Nose & Throat Journal* 75.2 (1996): 104-108.
2. Hirsch P and Helwig EB. "Chondroid syringoma, mixed tumor of skin, salivary gland type". *Archives of Dermatology* 84 (1961): 835-847.
3. Sungur N., *et al*. "An unusual Chondroid syringoma". *Dermatologic Surgery* 29.9 (2003): 977-979.
4. Stout AP and Gorman JG. "Mixed tumors of skin of the salivary gland type". *Cancer* 12.3 (1959): 537.
5. Zev Schulhof., *et al*. "Giant Benign Chondroid Syringoma of the Cheek: Case Report and Review of the Literature". *Journal of Oral and Maxillofacial Surgery* 65.9 (2007): 1836-1839.
6. KaanGunduz., *et al*. "A Rare Case of Atypical Chondroid syringoma of the Lower Eyelid and Review of the Literature". *Survey of Ophthalmology* 51.3 (2006): 280-285.
7. Nathan HB and Matthew AB. "Chondroid syringoma of the nasal soft tissue triangle". *Otolaryngology Head and Neck Surgery* 140.4 (2009): 606-607.
8. Ronald A., *et al*. "Malignant Chondroid Syringoma of the Face: A First Reported Case". *Otolaryngology Head and Neck Surgery* 133.2 (2005): 305-307.

9. Kiely JL., *et al*. "Malignant Chondroid syringoma presenting as multiple pulmonary nodules". *Thorax* 52.4 (1997): 395-396.
10. Matz LR., *et al*. "Metastasizing Chondroid syringoma: case report". *Pathology* 1.1 (1969): 77-81.

Volume 1 Issue 4 May 2015
© All rights are reserved by Dina Amin., *et al.*