

# Effective Treatment of Vulvar Syringoma with Topical Steroid: A Case Report

## Vulvar Syringomanın Topikal Steroid ile Etkili Tedavisi: Bir Olgu Sunumu

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#### Abstract

Syringomas are common intraepidermal sweat gland tumors. Lesions may involve the upper lip, axillae, hands and feet, abdomen, however vulvar involvement is relatively rare. Most of these neoplasms are asymptomatic and detected on routine gynecologic examination. There have been various treatment modalities such as surgical excision, cryosurgery, carbon dioxide laser ablation, topical atropine, corticosteroid or tretinoin applications. Because of complications of invasive treatments including scar and deformity, topical corticosteroids can be employ safely and effectively in treatment of vulvar syringoma. Therefore, in treatment of vulvar syringoma, local treatments should be used initially and invasive methots should be advised last choice.

Key words: **Vulvar syringoma; topical steroids; genital itching**

#### Özet

Syringoma sık görülen intraepidermal ter bezi tümörüdür. Lezyonlar üst ekstremitte, aksilla, abdomen, el ve ayaklarda sık görülmesine rağmen vulvar tutulum nadirdir. Bir çoğu asemptomatik olup rutin jinekolojik muayenede tespit edilir. Cerrahi eksizyon, kryoterapi, CO2 laser ablasyon, topikal atropin, kortikosteroid ve tretinoin uygulamalarını içeren tedavi modaliteleri mevcuttur. İnvasiv tedavi yöntemlerinin neden olduğu skar ve deformite gibi komplikasyonlardan dolayı, topikal steroidler vulvar syringomanın tedavisinde güvenli ve etkili bir şekilde kullanılabilir. Bu yüzden vulvar syringomanın tedavisinde başlangıçta lokal tedaviler düşünülmeli, invasiv tedavi metotları son seçenek olarak tavsiye edilmelidir.

Anahtar Kelimeler: **Vulvar syringoma; lokal steroidler; genital kaşıntı**

## Introduction

Syringomas are benign tumors of eccrine sweat gland derivation that occur frequently in women. These neoplasms usually develop at puberty. Clinically, they appear as multiple, tiny, firm, skin-colored papules. The sites of predilection are the eyelids, malar regions, neck and chest. Localization of syringoma to vulva is very rare. In the majority of cases with vulvar syringomas are asymptomatic and usually detected on routine gynecologic examination (1). Therefore, the diagnosis of vulvar syringoma is often overlooked. Vulvar syringomas should be included in the differential diagnosis of any multicentric papular lesion of the vulva, vulvar pain syndrome and pruritus vulvae.

Several methods have been previously used to treat vulvar syringomas; including excision (2), cryotherapy (3), electrosurgery (4) and carbon dioxide laser treatment (1). These invasive methods have some complications such as scarring, deformity, pigmentary changes, and delayed wound healing. Regarding non-invasive treatment methods, topical atropine (5), topical tretinoin (6) and topical corticosteroids (7) have been used successfully in the treatment of syringomas. However, the topical corticosteroids caused to recovery in the genital pruritus and vulvar lesions quickly in our patient. Therefore, after the diagnosis of vulvar syringoma with skin biopsy, non-invasive treatment modalities should be used initially. Invasive methods should be used in intractable vulvar pruritus.

In this paper, we report a 42-year-old woman who had severe pruritus secondary to vulvar syringoma which was treated with topical corticosteroids twice a daily for one month.

## Case Report

A 42-year-old multigravid woman was admitted to our clinic because of genital itching for two weeks. She had experienced intermittent vulvar pruritus for 10 years. She had been treated with different combined antifungal and antibiotic regimens but her complaints did not respond to these therapies. She had noted no change in her symptoms during menstruation. She had no history of eczema, contact hypersensitivity and systemic disease. She had no known family history of syringomas. She had been treated with unilateral salpingo-oophorectomy due to benign ovarian cyst 8 years ago. Physical examination revealed multiple soft, yellowish-to-skin-colored, 2–3 mm diameter papules on the left labia majus. (Picture 1-

left) In gynecologic examination, any suspicious similar lesions or another pathologic signs were not detected. Transvaginal sonography revealed no pathologic findings in genital systems. No similar lesions were detected elsewhere on her body. The results of laboratory tests and smear were normal. A biopsy of the vulvar lesions was performed after three days. Physical examination and microscopic examination revealed the typical features of syringoma. There were numerous tubular structures embedded in fibrous stroma in the papillary and reticular dermis. Based on these findings, the patient was diagnosed with vulvar syringoma. Immunohistochemical studies revealed no estrogen and progesterone receptors in the tumor cells. Following the histopathologic diagnosis, topical corticosteroid cream including 1 mg diflucortolone valerate and 10 mg isoconazole nitrate (Travocorte cream, Schering, Germany) was applied twice a daily on vulvar lesions for one month. Two weeks after the beginning of this treatment, a remarkable improvement was observed both objectively and subjectively in the patient's complaint. The papules of her left labium majus had become dramatically reduced and the pruritus had also rapidly disappeared. Four weeks after the onset of treatment, vulvar lesions disappeared and genital itching was ended (Picture 1- right). Furthermore, 6 months after the end of treatment, no signs of any recurrence were observed.



**Picture 1.** Yellowish papules with 2-3 mm diameter on the vulva before (left) and after (right) treatment of vulvar syringoma with topical steroid.

### Discussion

Syringomas are common intraepidermal sweat gland tumors which are most often found in adolescence years in women. Frequent sites of involvement include the lower eyelids and malar areas. Lesions may involve the upper lip, axillae, hands and feet, buttocks, submammary region, abdomen, thigh, however vulvar involvement is relatively rare (8). Most of these neoplasms are asymptomatic and detected on routine gynecologic examination. These lesions often present as small, multiple, bilateral, skin-colored papules over the labia majora and are often associated with increased vulvar discomfort and itching. In typical vulvar syringomas, the papules are bilateral and symmetrically distributed.

Immunohistochemical studies have detected intralésional progesterone and estrogen hormone receptors in these neoplasms. This suggests that cyclical hormonal changes are likely responsible for periodic exacerbation of genital pruritus during menstrual periods or pregnancy. However, our patient did not experience pruritic symptoms during menstruation.

Although the macroscopic appearance of vulvar syringoma is not pathognomonic, its histologic appearance is very diagnostic. The microscopic findings of syringoma include normal epidermis and dilated cystic sweat ducts embedded in a fibrous stroma in the dermis. Some of these dilated ducts have comma-like tails. Typically, two rows of epithelial cells line the duct walls.

With respect to histopathological features, syringoma must be distinguished from several conditions. Fox-Fordyce disease, epidermal cysts, senile angiomas, lichen simplex chronicus and condylomata acuminata, candidiasis, lichen sclerosus and atrophicus should be considered in the differential diagnosis of vulvar syringoma (9). Histological examination is essential in all cases of syringoma, as this is the only way to establish a definitive diagnosis and rule out malignancy. For this reason, to establish the diagnosis and to exclude malignancy, histological examination is required.

An ideal treatment of syringomas includes selective destruction with little damage to the normal tissue. But, this is not easy to do because main pathologic changes of syringomas are abnormally proliferated multiple eccrine glands which are located into deep dermis at various levels. There have been various treatment modalities such as surgical excision, cryosurgery, electrodesiccation, carbon dioxide laser ablation, topical atropine, corticosteroid or tretinoin applications. Surgical excision can remove syringomas completely, but scarring or deformity such as ectropion may be developing after wide excision. Cryosurgery has also many limitations in accuracy and may leave scarring or pigmentary changes.

Electrosurgery and carbon dioxide laser treatment can be performed with satisfactory results, but the lesions may recur. Because of these complications, topical corticosteroids can be employed safely in treatment of vulvar syringoma. In our case, cream with topical

corticosteroid was applied twice a daily on vulvar lesions for one month. Four weeks after the onset of treatment, vulvar lesions disappeared and genital itching was ended. In our opinion, in treatment of vulvar syringoma, local treatments should be used initially and invasive methods should be considered as a last choice.

In conclusion, it is important to keep syringoma always in mind during the investigation of differential diagnosis for papular lesions of the vulva. After the diagnosis of the vulvar syringoma, topical corticosteroids can be used easily without any complication. This treatment is a safe, easy, and effective option in the therapy of vulvar syringomas.

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