

LETTERS TO THE EDITOR

Smooth Muscle Hamartoma Mimicking Multiple Eccrine Hidrocystomas

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To the Editor:

Eccrine hidrocystomas are rare cystic ductal lesions of the eccrine sweat gland. They were described by Robinson¹ in 1983 as multiple lesions that appeared on the face of women who worked in hot and humid environments. In 1973, Smith and Chernosky² described another group of patients in whom the lesion presented singly or in small numbers. Since then, these forms of presentation have become known as the classic or Robinson type and the solitary or Smith type, respectively. They present clinically as transparent or slightly blueish vesicular papular lesions measuring between 2 and 4 mm, on the face and torso. The lesions typically improve in winter and worsen in summer when they are exacerbated by sweat-producing stimuli, such as exercise and a warm humid environment; they may also be exacerbated by hormonal abnormalities such as hyperthyroidism.³

Smooth muscle hamartoma is a benign process characterized by a proliferation of bundles of smooth muscle in the dermis. Almost all cases are congenital but acquired cases, such as ours, also exist. These acquired forms are extremely rare and very few cases have been reported in the literature; to date, we have found only 1 published case of lesions on the face.⁴

We present the case of a 38-year-old man who visited our department due to the progressive appearance over 4 years of multiple translucent, skin-colored papular lesions grouped on the right cheek (Figure 1). These lesions increased in size in summer and on exercise (associated with heat and sweat) and improved in winter. A clinical diagnosis

of multiple eccrine hidrocystomas was made and a biopsy was performed for confirmation. The biopsy revealed a smooth muscle hamartoma compressing the eccrine glands, thereby causing cystic ectasia of both the secretory coils and the eccrine ducts. Immunostaining with anti-actin antibodies and Masson-trichrome stain was positive in muscle fibers (Figure 2). Treatment was initiated with antiperspirant drugs (aluminum chlorohydrate, 20%) and produced a slight improvement; the patient's symptoms have since remained stable with no new lesions or growth of the existing lesions.

Although the pathogenesis of eccrine hidrocystoma is not well understood, some authors consider that the lesion is due to retained sweat resulting from obstruction of the eccrine duct.⁵⁻⁷ This is therefore true cystic ectasia of the dermal part of the eccrine duct. In our case, histology revealed a smooth muscle hamartoma that was compressing the excretory ducts of the eccrine sweat glands, thereby causing cystic dilation of the ducts and giving rise to lesions clinically suggestive of multiple eccrine hidrocystomas. This case supports the

hypothesis that hidrocystoma is not a true tumor but the result of the obstruction of the excretory part of the sweat gland; it would also explain why the lesions were unilateral in our patient—unlike previously published cases.

Treatment of solitary or Smith-type forms will essentially consist of surgical removal of the lesions. In multiple or Robinson-type forms, however, surgical treatment is not appropriate; several other therapeutic options have therefore been tried, with varying results. Patients should firstly be advised to avoid situations that trigger worsening of the lesions, such as exercise and very hot environments. Oral atropine has also been used, but the systemic side effects outweigh the benefits. However, topical



Figure 1. Multiple flesh-colored papules grouped on the right cheek.

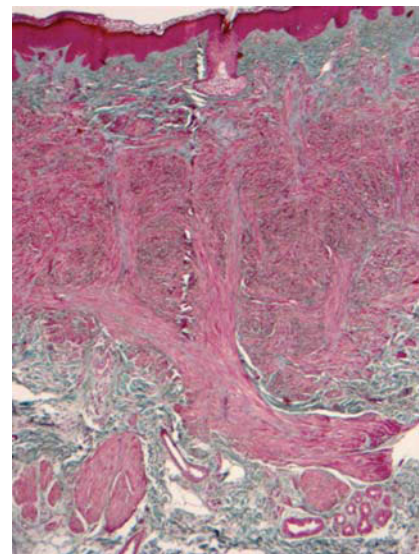


Figure 2. Masson-trichrome stain, $\times 10$. Histology revealed a smooth muscle hamartoma compressing the eccrine glands and causing cystic ectasia of both the secretory coil and the eccrine ducts.

application of 1% atropine has produced a response in some patients,⁸ but not in others.^{5,7} Other treatments include the use of CO₂ lasers or pulsed dye laser,⁹ destruction using electrodesiccation with a fine needle electrode, and injections of botulinum toxin.¹⁰ In cases where there was an underlying disorder such as hyperthyroidism, resolution of the disorder led to remission of the lesions.³

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Disseminated Lobular Capillary Hemangiomas

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To the Editor:

Lobular capillary hemangiomas are very common benign vascular lesions



Figure 1. Multiple sessile, violaceous lesions on the trunk.

that frequently occur following injuries to the gums, lips, nasal mucosa, face, fingers, and toes. More rarely these hemangiomas present in multiple or multifocal form, in some cases forming part of a paraneoplastic syndrome, but in other cases with no apparent underlying disease. Rarer varieties have also been described, such as subcutaneous or intravenous lesions. Lobular capillary hemangiomas have also been reported following the use of certain drugs such as oral retinoids.^{1,2}

We describe the case of a male patient aged 74 years with a history of long-standing malignant hypertension, chronic renal insufficiency due to nephroangiosclerosis, anemia of inflammation, and colonic polyposis with multiple polypectomies leading to histologic evidence of tubular or

tubulovillous adenomas. The patient was being treated with carvedilol, torsemide, acetylsalicylic acid, nifedipine, enalapril, and erythropoietin.

The patient reported the appearance, over a period of 4 to 5 years, of sessile cutaneous lesions and subcutaneous nodular lesions, soft in consistency, reddish-violet in color, variable in size (measuring 0.5 to 2 cm in diameter), and located mainly on the trunk and neck (Figure 1). There was no involvement of the mucosa.

Blood tests were normal with the exception of a hemoglobin level of 9.4 mg/dL. Biochemical analysis revealed creatinine of 3.22 mg/dL, urea of 114 mg/dL, and uric acid of 8.24 mg/dL, with all other values within the normal range.

Several lesions were excised for histologic studies, which revealed