Case letters

Multiple apocrine hidrocystomas: a florid presentation*

Iara de Almeida Resende[1]
Patrícia Mafra Lazzari[1]
Samuel Henrique Mandelbaum[1]
Flávia Regina Ferreira[2,3]

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Dear Editor,

Hidrocystoma is a benign tumor originating from the apocrine gland, being an adenoma of this gland, unlike the eccrine hidrocystoma that results from a ductal dilatation by retention of secretions. It presents as translucent, round, small, painless vesicles with fluid content in their interior.[1] Traditionally, they are divided into solitaries (Smith type) and multiples (Robinson type).[2] Clinical differences that help in their diagnosis are: apocrine is usually solitary, larger, with a bluish color, although translucent and generally located on the face, especially on the lower palpebral region (cysts of Moll's glands) near the cilia and lacrimal drainage pathway; eccrine may be solitary or multiple, may increase with heat and decrease in the cold, translucent or opaque, with a more frequent location, on the lower eyelids but above the palpebral skin.[3] They are also found on other regions such as ear, trunk, scalp, and upper limbs. Generally, they occur in adults, especially females, after the 4th decade of life. The case reported is of a 62-year-old male, white patient, who sought a dermatology clinic with the following complaint: "lumps on the face for more than five years." At the dermatological examination, there were skin-colored papules and nodules on the periocular region, with a shiny surface, translucent appearance and rare telangiectasias (Figure 1 and 2). An excisional biopsy of a nodule was performed and the histopathological examination showed a cystic lesion with a thin layer of cuboidal epithelial cells with apocrine features and amorphous liquid content, with no signs of malignancy (Figure 3). Surgical excision of the lesions was scheduled, but patient did not return to the service.

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[1] Department of Dermatology, Santa Casa de São José dos Campos (SP), Brazil.
[2] Discipline of Dermatology, Department of Medicine, Universidade de Taubaté, Taubaté (SP), Brazil.
[3] Dermatology Service, Hospital Universitário de Taubaté, Universidade de Taubaté,Taubaté (SP), Brazil.

Mailing Address:
Iara de Almeida Resende
E-mail: iara.almeidaresende@gmail.com

Its pathogenesis seems to result from obstruction of the sweat duct just above the glandular groove (deep dermis) due to an inflammatory process or trauma. The diagnosis is initially clinical, followed by histological confirmation. Histologically, apocrine hidrocystomas are unilocular or multilocular dermal cysts with one or more layers of epithelial cells showing bulbous protrusions and luminal secretion by decapitation.[4] It may also have papilliferous projections, being covered by two layers of secretory cells. The inner cells are columnar and show eosinophilic cytoplasm with typical bulboapical expansions.

The main clinical differential diagnoses include: molluscum contagiosum, nodulocystic basal cell carcinoma, hidradenoma, nevocytic nevus, blue nevus, syringoma, hordeolum, chalazion, epidermal cyst. Treatment can be done through surgical excision, shaving and electrocoagulation, cryosurgery or even CO_2 laser, motivated by the unsightly aspect of the lesions.[5] ❑

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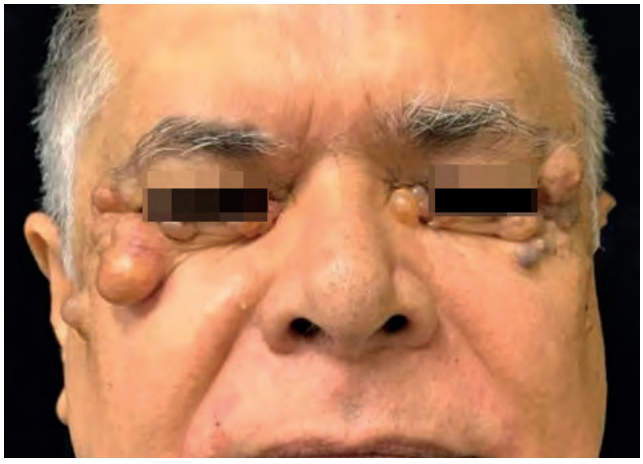

Figure 1: Bilateral periocular region – skin-colored papules and nodules, with translucent shiny surface

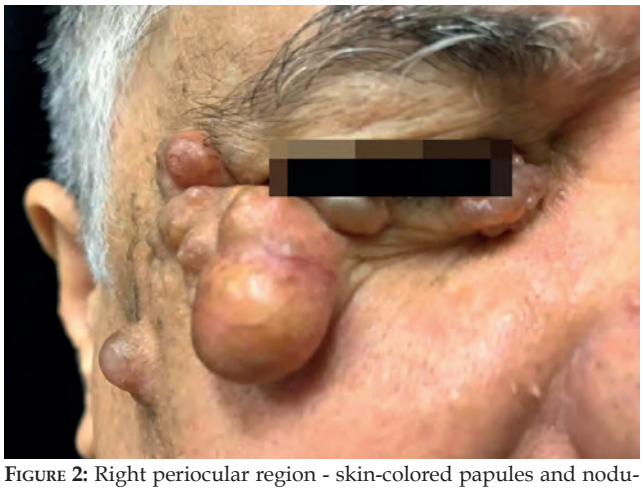

Figure 2: Right periocular region - skin-colored papules and nodules, with translucent shiny surface

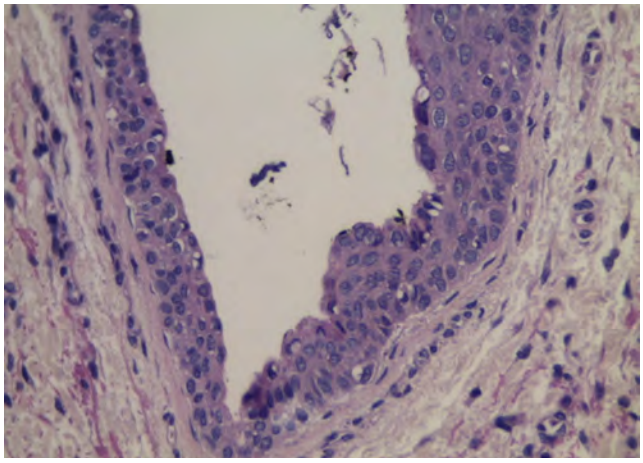

Figure 3: Secretion by apocrine decapitation. (Hematoxylin and Eosin, x100)

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AUTHORS' CONTRIBUTIONS

Iara de Almeida Resende — ORCID 0000-0003-0041-031X
Approval of the final version of the manuscript; Conception and planning of the study; Elaboration and writing of the manuscript; Obtaining, analyzing and interpreting the data; Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied; Critical review of the literature; Critical review of the manuscript

Patrícia Mafra Lazzari — ORCID 0000-0002-7655-9818
Elaboration and writing of the manuscript; Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied; Critical review of the manuscript

Samuel Henrique Mandelbaum — ORCID 0000-0002-4631-4828
Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied

Flávia Regina Ferreira — ORCID 0000-0001-5679-4282
Approval of the final version of the manuscript; Elaboration and writing of the manuscript; Critical review of the manuscript

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Coexistence of segmental vitiligo, scleroderma *en coup de sabre* and cleft lip on the same hemiface: association with mosaicism?*

Heloísa Del Castanhel Ubaldo[1]
Caio César Silva de Castro[1,2]

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Dear editor,

Segmental vitiligo (SV) and localized scleroderma (LE) are characterized by localized cutaneous lesions, with a primarily autoimmune etiology. Cleft lip constitutes a congenital anomaly that is usually solitary, but can be associated with several syndromes. We report the case of a patient with left-sided cleft lip at birth, left periorbital segmental vitiligo at 6 years old, and scleroderma *en coup de sabre* (SCS) on the left hemiface at 22 years old.

A female patient presents a linear scleroatrophic lesion located on the left forehead, compatible with SCS, by the age of 22. She presents a history of left-sided cleft lip at birth and SV on the left periorbital region, with poliosis of eyebrows and eyelashes, which began at 6 years old and stabilized at the same age (Figures 1 and 2). There is a discrete asymmetry between the hemifaces, without signs of subcutaneous, muscular, or bone atrophy beyond that presented in the SCS area. There is also a report of morphea on the upper back, with probable onset at 3 years old, currently with improvement in the sclerosis condition and histological aspect that is suggestive of post-inflammatory alterations. Other comorbidities were denied, as were allergies. There is a positive family history for vitiligo. Formal clinical and laboratorial evaluation excluded other autoimmune diseases. She underwent 31 narrow-band UVB phototherapy sessions, by the age of 18, with satisfactory cutaneous repigmentation in the SV area. Residual poliosis was also resistant to topical treatment with 0.03% bimatoprost.

The association between vitiligo and scleroderma is historically observed and described in the literature, in an attempt to find a link between these two conditions. Vitiligo is characterized by cutaneous and mucous depigmentation due to selective loss of epidermal melanocytes.[1] When asymmetric, with a typical unilat-

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[1] Dermatology Service, Hospital Santa Casa de Curitiba, Curitiba (PR), Brazil.
[2] School of Medicine, Pontifícia Universidade Católica do Paraná, Curitiba (PR), Brazil.

Mailing Address:
Caio César Silva de Castro
E-mail: caio.castro@pucpr.br