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## Malignant eccrine breast spiradenoma. A case report and literature review



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### ABSTRACT

**INTRODUCTION:** Eccrine spiradenomas are rare adnexal tumours of the skin that originate in the sweat glands. There are only three cases, including ours, diagnosed as malignant transformation in the breast. **PRESENTATION OF CASE:** We present a case of an asymptomatic 48 year old woman in whom the lesion was detected on the basis of breast cancer prevention programme. The metastatic study detection and the sentinel lymph node biopsy were negative so wide excision of the mass was performed with no further treatment. After 32 months of follow-up, there is no evidence of recurrent or metastatic disease in our patient.

**DISCUSSION:** The lesions usually show a typical history of a long-standing unchanged cutaneous solitary nodule that becomes enlarged. The imaging findings of breast eccrine spiradenomas have not been clearly demonstrated. Diagnosis is based in histopathological findings of malignant focus.

A large list of uncommon dermatological skin malignancies and breast benign lesions can mimic malignant eccrine spiradenomas (MES); therefore, determination of immunophenotype allows narrowing differential diagnosis. Distant metastases portend an ominous prognosis. The mainstay of treatment is surgical removal with wide excision margins. Radiation and hyperthermic chemotherapy can also be administered to prevent focal recurrence. Due to the high risk of developing metastases, close follow up of these patients for early detection of recurrence should be carried out.

**CONCLUSION:** Eccrine spiradenomas are rare adnexal tumours of the skin. Intraparenchymatous breast location is especially infrequent. Diagnosis is based on histopathological examination. MES metastasizes (40%), so a close follow up is recommended.

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### 1. Introduction

Eccrine spiradenomas are rare adnexal tumours of the skin that originate in the sweat glands. Only a few cases have been reported, being described for the first time by Kersting and Helming [1]. Though the majority of eccrine spiradenomas involve the head, trunk, and extremities [2], they can also appear all throughout the skin, mostly as painless solitary nodules. Most interestingly, intraparenchymatous breast location is especially infrequent.

Our case report is a malignant eccrine spiradenoma (MES/spiradenocarcinoma) diagnosed in an asymptomatic woman on the basis of breast cancer prevention programme. Because of its rare incidence and lack of imaging workups, there are only two previous reports of malignant breast spiradenoma. Our aim is

therefore to discuss the main characteristics of it, and to review the literature available on this issue.

### 2. Presentation of case

A 48-year-old woman, asymptomatic, with no medical history of interest, presented in a mammography made as part of a breast cancer screening programme a lesion in the left upper-breast. The physical examination showed no palpable abnormalities, neither significant cutaneous change.

Plain radiographs revealed no calcifications in the superficial soft tissue. Mammography (Fig. 1) demonstrated a well-defined, isodense nodule located in the upper-outer quadrant of the left breast. No axillary lymphadenopathy was evidenced.

Sonographic examination of the patient was performed. Longitudinal and transverse scans with colour Doppler images were obtained. The images (Fig. 2) showed a well-defined lobulating mass measuring 18 × 13 × 15 mm with homogeneous hypo echogenicity. In the colour Doppler sonography no high vascular

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Fig. 1. Mammography shows a well-defined, isodense nodule.

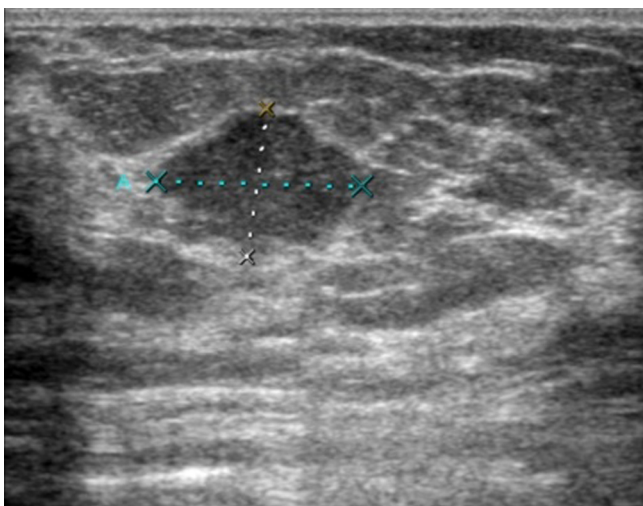


Fig. 2. US shows a well-defined hypoechoic mass.

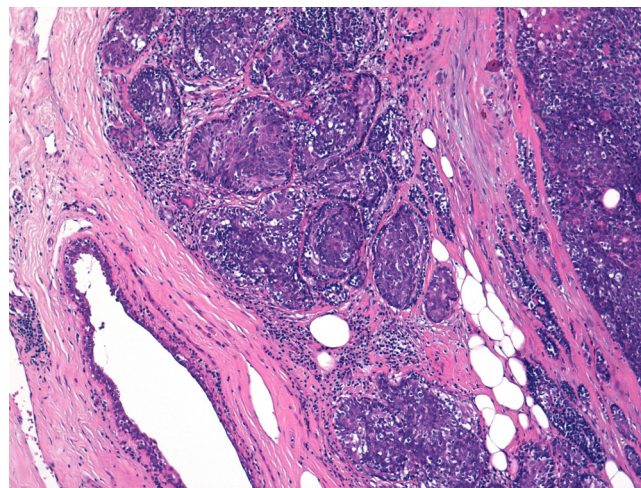


Fig. 3. Benign area is composed of two cell population.

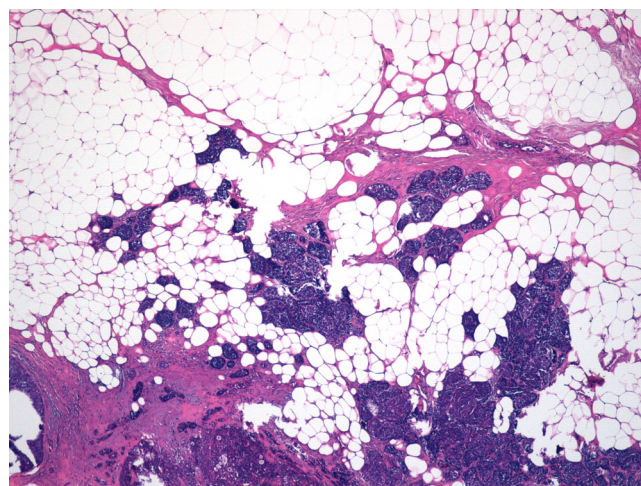


Fig. 4. Area of malignant transformation.

cytoplasm without epidermal connection. The histopathological examination confirmed the diagnosis of eccrine spiradenoma [1].

Subsequently, total excision of the mass was performed with free resection margins. Intraoperative radiologic control of the excised lesion showed integrity of the nodule with broad resection margins.

Macroscopically the sample measured 4 × 2.5 cm in which on serial sectioning a 2 × 1.5 cm white nodule was noted.

Microscopic examination showed cells arranged in ragged sheets, nests, cords, and solid masses along with occasional irregular glandular structures. Two distinct cellular components were identified. Benign areas, was seen as sharply demarcated lobules composed of 2 cell populations (peripheral basaloid cells and central pale cells) arranged in nests with focal cystic changes. Adjoining to this 2-cell population focus (gradually or abruptly) proliferation cells with histopathological malignant characteristics transited to solid masses of a homomorphous large cell population with hiperchromatic and pleomorphic nuclei, eosinophilic cytoplasm (Fig. 3). Mean number of mitotic figure was 10-15HPF (high power fields). Invasion of the surrounding tissues characterize malignant transformation (Fig. 4). However, no lymphovascular or perineural invasion was recognized. The overlying epidermis was unremarkable.

Immunohistochemically, both cellular areas exhibited p63 and were positive for smooth muscle actin (SMA). Focal reactivity for

flow was seen. Fascial planes were preserved. Axillary lymph nodes maintained preserved echostructure with cortical thickness less than 3 mm.

The patient underwent a US-guided 14-gauge core needle biopsy for pathologic evaluation. A histologic examination of these showed a characteristic biphasic population of outer small cells with darkly staining nuclei surrounding larger cells with pale

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