P908

A case of an eccrine syringofibroadenoma: An unusual erythematous scaly plaque

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Eccrine syringofibroadenoma (ESFA) is a skin tumour of eccrine ductal differentiation, first described in 1963. It can mimic common inflammatory dermatoses. We present a case of ESFA to illustrate its typical clinicopathological features. A 61-year-old man presented to the dermatology department with an asymptomatic and well-defined plaque on his sole of his left foot. It was fixed, erythematous, and scaly, measuring 2.0 cm $\times$ 1.5 cm. The lesion had been described as eczematous, psoriasiform and Bowenoid on different occasions. Prior to the appearance of the plantar lesion, he had been taking metoprolol and ramipril to manage his ischaemic heart disease. There were no peripheral stigmata of psoriasis or relevant skin lesions elsewhere. It did not resolve with topical treatments, which included clobetasol propionate, miconazole and tacrolimus 0.1%. He had two non-diagnostic biopsies from the lesion. A fixed drug reaction was excluded histologically. Three and half years after his first consultation in the department, the third biopsy revealed thin anatomising strands of uniform small epithelial cells arising from the epidermis at multiple points. They enclosed a fibrovascular stroma, which contained scattered lymphocytes and plasma cells. The epithelial strands showed ductal differentiation. These features were consistent with ESFA. He declined to have the lesion excised. EFSA is a rare condition with less than 60 cases described in the literature. It has a varied clinical appearance and can be classified into 5 categories: (1) solitary ESFA, which is non-hereditary; (2) multiple ESFA in hidrotic ectodermal dysplasia; (3) multiple ESFA without associated cutaneous findings; (4) non-familial unilateral linear ESFAs; and (5) reactive ESFA associated with inflammatory or neoplastic dermatoses. The described ESFA corresponds to the first subgroup, solitary ESFA. The etiology of this condition is not known. Based on ultrastructural and immunohistochemical investigations, the exact site of origin of ESFA, is thought to be derived from or differentiate towards the acrosyringium or eccrine duct.

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P909

A case of atypical glomus tumor: Small malignant glomus tumor progressed from symplastic glomus tumor

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According to the criteria for atypical glomus tumor suggested by Folpe in 2001, malignant glomus tumor fulfills at least one of the following: deep location and size more than 2 cm, or the presence of atypical mitotic figures, or a combination of moderate to high nuclear grade and mitotic activity (5 mitoses/50 high power field). And symplastic glomus tumor displays marked nuclear atypia as its only unusual features. A 33-year-old woman presented with tender a 0.5 cm $\times$ 0.5 cm sized nodule on the dorsum of the right fourth midphalanx. The lesion had been present for approximately 6 months. The nodule was completely excised and histopathologic examination revealed feature of symplastic glomus tumor composed of uniform cells with pale or eosinophilic cytoplasm, well-defined margins showing marked focal nuclear atypia but no evidence of other features suggestive of malignancy. Four months later, the lesion was recurred on the same site. Reexcision was performed and histopathologic examination revealed that the tumor was well circumscribed with fibrous connective tissue composed of sheets of polygonal to round cell. Tumor cells contained small round vesicular nuclei with prominent nucleoli and variable amounts of cytoplasm. They exhibited marked cellular atypia and a high mitotic rate of 6 mitoses/10 high power fields. The majority of these cells were stained positively for smooth muscle actin, but negatively for S-100, Pan-CK, CD34, Desmin, and CD 68. The recurrent nodule was compatible with malignant glomus tumor according to the critera proposed by Folpe. We report a rare case of small malignant glomus tumor, which is considered to be progressed from symplastic glomus tumor on the finger.

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P910

Unusual nevus verrucosus presentation with multiple well-demarcated, symmetrical, large plaques in intertriginous areas

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An 18-year-old female presented for consultation with thick, yellow, well-demarcated, partially macerated and erythematous, verrucous plaques giving a foul odor in the bilateral axillae and entire vulva that were present from three months of age and had a major cosmetic and psychological impact. The patient reported that her brother had similar but less extensive lesions, diagnosed at another institution as inverse psoriasis. She had been treated with ciprofloxacin, isotretinoin, and cyclosporine and was currently on tazarotene when referred. Further treatment with fluconazole, erythromycin, and a trial of clobetasol propionate gel provided little relief. Bacterial cultures grew *Acinetobacter baumannii*, abundant beta hemolytic Streptococcus and abundant diphtheroids. The clinical differential diagnosis included inverse psoriasis, Hailey—Hailey disease, epidermal nevus, and pemphigus vegetans. Histopathology of the excised portions of the right axilla plaque demonstrated marked hyperkeratosis, compact orthokeratosis and broad columnar parakeratosis with numerous dense colonies of Gram-positive cocci and coccobacilli. These findings were consistent with an epidermal nevus with multifocal nevus verrucosus pattern and superinfection. Treatment after diagnosis consisted of shave excision of large portions of the plaques followed by cephalexin, mupirocin, and vinegar soaks.

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P911

Circumscribed palmar hypokeratosis: A new acral anomaly

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We report a case of a 62-year-old male with a history of a solitary erythematous circular patch on the left thenar eminence. The patient did not recall any antecedent trauma to the area, and the asymptomatic lesion had remained stable in size for more than 2 years. The lesion was sharply demarcated by a collarette of scale, and was depressed in comparison to the surrounding skin. A shave skin biopsy showed depression of the epidermis, with a sharp stair in the stratum corneum between the lesional and perilesional skin, corresponding to the scaly collarette. Hypogranulosis with overlying hypokeratosis and parakeratosis spanned the breadth of the lesion, sparing the acrosyringeal corneocytes. There was no evidence of cornoid lamellae, and immunostains for human papilloma virus (HPV) was negative. The clinical and histologic pattern is consistent with the diagnosis of a circumscribed palmar hypokeratosis. Circumscribed palmar and plantar hypokeratosis was first described in 2002, and since that time only a handful of cases have been reported. Middle-aged or elderly females are most commonly affected, and these lesions tend to occur on the thenar and hypothenar eminences, as well as rarely on the sole. Most are solitary depressions, but multiple lesions on the palm have been reported. These lesions frequently masquerade as porokeratosis or Bowen's disease, and skin biopsy is the only method to accurately make the diagnosis. In the original description, circumscribed palmar hypokeratoses were believed to be the result of focally deranged epidermal keratinization, perhaps arising from an abnormal keratinocyte clone. However, at least a subset cases seem to have occurred after trauma, either as the residua of an isolated injury or as a result of repetitive minor insults that may not be remembered by the patient. HPV type 4 was implicated as the inducing agent in one case, raising a third possibility that circumscribed palmar and plantar hypokeratosis represents one of a myriad of manifestations of human papilloma virus. To date, the reported course of these lesions is benign, and a single case has been reported to resolve clinically and histologically after prolonged treatment with calcipotriol. Although the observed clinical and histologic features of circumscribed palmar and plantar hypokeratoses is overwhelming benign, patients should be carefully followed up until the actual nature of this new and intriguing entity is revealed over time.

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