



Fig. 10. Erythrokeratoderma congenitalis symmetrica progressiva?

Eccrine Spiradenoma

Presented by Gerd Michaëlsson

This 61-year-old gardener has had intensive tenderness under the left heel for the previous 5

years. Nothing is known about any related trauma. A slowly growing, soft swelling was noted at the same time in the tender area. During recent years the condition has been stationary, but when touched or when walking the swelling was intensively tender. Cold or heat had no influence on the symptoms.

The swelling was about 15 mm in diameter and the skin in this area was thin and shiny (Fig. 11). At biopsy it seemed that the growth was within a capsule and contained disintegrated tissue which, to a large extent, could be picked out. The biopsy specimen consisted of tumour tissue with quite tightly packed cells with large nuclei and sparse cytoplasm. The cells often formed narrow, tubular structures. Here and there the cells were arranged as in a sweat gland and in some areas there was an abundance of vessels. The diagnosis was eccrine spiradenoma. Glomus tumour was considered a relevant differential diagnosis. Considering the definite epithelial appearance and the sweat gland-like structure as well as the vessel appearance, the picture was interpreted more as an eccrine spiradenoma than glomus tumour.

Discussion

L. Juhlin: This is a very unusual location for an eccrine spiradenoma. When we first saw this lesion of the sole we thought it might be an eccrine poroma; however, this tumour is not or only slightly painful. The intensive tenderness of the patient's lesion and its histology strengthens a diagnosis of eccrine spiradenoma.

Scleredema Buschke

Presented by Hans Hammar and Lennart Juhlin

This 38-year-old bookstore assistant was healthy until October, 1969, when he had a bronchitis and complained of muscular weakness. He was treated with doxycycline for 10 days. In January, 1970, his muscular weakness increased and he had difficulty in breathing. He could not take more than a few steps at a time on stairways and could only ski about 500 metres on level ground. The skin on his face and over the upper part of his trunk became thick and firm. It was also dry and itching. On four occasions he suddenly and without warning felt his face flushing and he became dizzy

for half an hour. He was then referred to the skin clinic. The muscles underlying the firm and infiltrated skin areas were tender on pressure with signs of decreased muscular strength.

Laboratory studies: Analyses of blood, bone marrow and urine, as well as tests for liver and thyroid functions, were normal. ESR 2 mm/hour. Immunoglobulins G, A, M and E were normal. Routine catecholamines, 5-hydroxyindolacetic acid, 17-keto and 17-hydroxysteroid excretion was normal. There was no renal elimination of creatine and creatine phosphate kinase was normal in the blood. X-rays of lungs and heart normal. ECG normal. EMG showed slight signs of myopathy in muscles underlying the affected skin.

Hyaluronic acid in the affected skin was increased (0.24% of dry weight) and dermatan-sulphate 0.21%. Biopsies from the skin showed a normal epidermis, but the corium was thick with some infiltrate of lymphocytes and plasma cells around the vessels. The sweat and sebaceous glands were normal. In one biopsy there was a clear, deep-seated panniculitis. The muscle biopsy revealed normal musclefibres in most areas, but in a few places there were signs of degeneration with some hyalinization and a few small infiltrates of lymphocytes.

Discussion

L. Juhlin: The skin in scleredema is usually wood-hard, but it can also be less hard as in this case. We have also considered a diagnosis of dermatomyositis, but the patient had no changes around the eyes, no capillary changes around the nails, normal ESR all of which do not favour such a diagnosis.

B. Lagerholm: Is there any degeneration of the cross-striation of the muscles? If there are such changes, I would favour a diagnosis of dermatomyositis.

H. Hammar: The cross-striation of the muscle fibres was intact and the hyalinization was only very slight.

L. Juhlin: In scleredema, slight degenerative changes as found in this patient have been described as a common feature.



Fig. 11. Eccrine spiradenoma.

B. Lagerholm: Have you done any special staining of the skin such as with Alcian blue pH 4 to show hyaluronic acid?

L. Juhlin: Staining with alcian blue showed a slight blueing around the adenexa. There was no mucin-like material. Freeze-dry sections stained with toluidine blue at pH 5 showed several mast cells, but the ground substance appeared normal, although I think it is difficult to judge any edema or increase from the histology slides. The chemical determination revealed about twice as much hyaluronic acid in the affected skin.

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