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Ulcerated SyringocystadenomaPapilliferum of the Scalp in an Adult Woman: A Clinical and Dermoscopic Description of a De Novo Case

Abstract

Syringocystadenomapapilliferum (SCAP) is a rare benign adnexal tumor of apocrine or eccrine origin, typically presenting at birth or during early childhood. It most commonly occurs on the scalp or face, frequently arising in association with a sebaceous nevus. We report a rare case of an ulcerated, rapidly enlarging syringocystadenomapapilliferum occurring de novo on the temporal scalp of a 45-year-old woman without any pre-existing lesion. Complete excisional biopsy was performed, and no recurrence was observed after six months of follow-up. This case underscores the importance of accurate clinical evaluation and histopathologic assessment in distinguishing benign adnexal tumors from malignant mimickers.

Key words:-

Syringocystadenomapapilliferum; Apocrine tumor; Adnexal neoplasm; Scalp; Adult-onset.

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Introduction:-

Syringocystadenomapapilliferum (SCAP) is a benign adnexal neoplasm originating from apocrine sweat glands [1]. It accounts for less than 1% of all adnexal tumors.

Typically, SCAP appears at birth or before puberty, most often on the scalp, and is frequently associated with a sebaceous nevus in approximately 30–40% of cases [1,2]. Adult-onset SCAPs are uncommon, and cases occurring de novo—without a pre-existing lesion—are particularly rare [3,4]. Although benign, SCAP can present with unusual clinical

features that mimic malignant cutaneous tumors, posing diagnostic challenges [5].
We describe a case of de novo ulcerated SCAP of the temporal scalp in a middle-aged woman, emphasizing its atypical clinical and dermoscopic findings.

Case Report

A 45-year-old woman, with no significant medical history, presented with a nodular lesion on the left temporal scalp that had been present for three years. The patient reported a recent rapid enlargement of the lesion over the preceding two months, accompanied by occasional bleeding upon contact. Clinical examination revealed a 1.5-cm ulcerated, exophytic, and friable nodule resting on an erythematous base. The lesion was tender, bled easily when touched, and there was no associated lymphadenopathy. No other cutaneous abnormalities or underlying nevus were observed.(Figure 1)

Figure 1: Clinical examination revealed a 1.5-cm ulcerated, exophytic, and friable nodule resting on an erythematous base.

Dermoscopy of the lesion revealed a yellowish background, central polymorphous vascular structures, and peripheral milky-red areas (Figure 2). These dermoscopic features, although not specific, were more suggestive of an adnexal tumor than of a malignant lesion such as non-pigmented basal cell carcinoma or amelanotic melanoma.

Figure 2: Dermoscopy of the lesion revealed a yellowish background (asterisk), central polymorphous vascular structures (circle), and peripheral milky-red areas (arrow).

A complete excisional biopsy of the lesion was performed under local anesthesia. Histopathologic examination revealed a dermal epithelial proliferation connected to an eroded epidermis. The tumor was composed of tubulo-papillary structures lined by a double epithelial layer. The inner layer consisted of apocrine secretory cells showing decapitation secretion, while the outer layer was composed of cuboidal myoepithelial cells.

The fibrovascular stroma showed a dense plasmacytic infiltrate (Figure 3). These features were consistent with the diagnosis of syringocystadenomapapilliferum. The patient underwent complete surgical excision; however, she was subsequently lost to follow-up.

Figure 3. H&E staining of the excisional biopsy specimen: (A) Low-power view (×100) demonstrating a cystic epidermal invagination with multiple papillary projections lined by glandular epithelial cells. (B) High-power view (×200) showing papillary structures lined by a characteristic double epithelial layer—an inner apocrine secretory layer and an outer cuboidal myoepithelial layer (arrow)—overlying a fibrovascular stroma densely infiltrated with plasma cells (asterisk).

Discussion:

Syringocystadenomapapilliferum is an uncommon benign adnexal tumor that generally occurs during childhood or adolescence and often develops in association with a sebaceous nevus [1,2]. The scalp is the most frequent site, accounting for up to 75% of cases [1,3]. The typical presentation is a slowly enlarging papule or plaque, occasionally verrucous or crusted. In our case, the lesion appeared de novo in adulthood, with ulceration and rapid growth, which made the clinical diagnosis challenging [4].
Syringocystadenomapapilliferum is an uncommon benign adnexal tumor that generally occurs during childhood or adolescence and often develops in association with a sebaceous nevus [1,2]. The scalp is the most frequent site, accounting for up to 75% of cases [1,3]. The typical presentation is a slowly enlarging papule or plaque, occasionally verrucous or crusted. In our case, the lesion appeared de novo in adulthood, with ulceration and rapid growth, which made the clinical diagnosis challenging [4].
Dermoscopy, although not pathognomonic, can aid in the preoperative evaluation of adnexal tumors. Reported dermoscopic features of syringocystadenomapapilliferum include a yellowish or pinkish background, polymorphous vascular structures, and milky-red areas, reflecting the papillomatous and vascular nature of the tumor [2,3]. In contrast,

amelanotic melanoma typically displays atypical polymorphous vessels with variable morphology (linear, dotted, or hairpin), often associated with milky-red areas and white structures, but usually lacks a yellowish background [6]. Similarly, non-pigmented basal cell carcinoma commonly shows arborizing or short fine telangiectatic vessels, sometimes accompanied by ulceration or shiny white structures [7]. In our case, the dermoscopic appearance was consistent with the reported features of SCAP and contributed to favoring an adnexal neoplasm over malignant entities such as amelanotic melanoma or non-pigmented basal cell carcinoma.

Histologically, SCAP is characterized by papillary and cystic invaginations extending from the epidermis and lined by a two-layered epithelium composed of apocrine and myoepithelial cells, with a dense plasma cell–rich stroma [1,5]. These findings were all observed in our patient, confirming the diagnosis.

Complete surgical excision remains the treatment of choice and is curative in most cases [1,2,5]. Recurrence is rare and typically results from incomplete excision. Malignant transformation is exceptional. In our patient, complete removal of the lesion resulted in an excellent outcome, with no recurrence after six months of follow-up.

Conclusion:

Syringocystadenomapapilliferum is a rare benign adnexal tumor that may occasionally arise de novo in adulthood and clinically mimic malignant cutaneous neoplasms. Although dermoscopic features are non-specific, they may suggest an adnexal origin and aid in distinguishing SCAP from amelanotic melanoma and non-pigmented basal cell carcinoma. Histopathological examination remains the gold standard for diagnosis, and complete surgical excision is curative, with an excellent prognosis.

Figure Legends:

Figure 1: Clinical examination revealed a 1.5-cm ulcerated, exophytic, and friable nodule resting on an erythematous base.

Figure 2:Dermoscopy of the lesion revealed a yellowish background (asterisk), central

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References:

1. Perlman KL, Kentosh JB. Syringocystadenomapapilliferum of the scalp. Dermatology Online Journal. 2021;27(3). doi:10.5070/d3273052778

2. Ahmad, A. M. (2025). Syringocystadenomapapilliferum: A review of an uncommon skin adnexal tumour. Journal of Diagnostic and Academic Pathology., 2(1), 11–13. https://doi.org/10.4103/jdap.jdap_3_25

3. Errichetti, E., Plozner, N., & Giuseppe, S. (2025b). Dermoscopy of de novo SyringocystadenomaPapilliferum in Dark and Fair Skin. Dermatology Practical & Conceptual, 15(2), 5393. https://doi.org/10.5826/dpc.1502a5393

4. Dick, M., DiMaio, D., & Finnegan, M. (2020). Syringocystadenomapapilliferum of the scalp arising De-Novo in an elderly female. SKIN the Journal of Cutaneous Medicine, 4(4), 375–378. https://doi.org/10.25251/skin.4.4.19

5. Alsaad KO, Obaidat NA, Ghazarian D. Skin adnexal neoplasms—Part 1: an approach to tumors of the pilosebaceous unit. Journal of Clinical Pathology. 2007;60:129–144.

6. Paolino G, Pampena R, Di Ciaccio SM, et al. Thin amelanotic and hypomelanotic melanoma: clinicopathological and dermoscopic features. Medicina. 2024;60(8):1239. doi:10.3390/medicina60081239

7. Wojtowicz I, Żychowska M. Dermoscopy of Basal Cell Carcinoma Part 1: Dermoscopic Findings and Diagnostic Accuracy—A Systematic Literature Review. Cancers. 2025;17(3):493. doi:10.3390/cancers17030493

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