CASE REPORT

SWEAT GLAND CARCINOMA WITH LYMPHADENOPATHY

Tahir Khaleeq, Nazia Ishaq, Tanwir Khaliq
Department of Surgery, Pakistan Institute of Medical Sciences, Islamabad-Pakistan

Sweat gland carcinoma is a rare tumour, being almost 1% of primary skin lesions. The tumour has tendency to spread to regional lymph nodes and distant metastases has also been reported. Their exact incidence in Pakistan is not known. Treatment options are also not clearly defined though surgery is the initial treatment approach as adjuvant treatment has not been properly explored. We report a case of sweat gland carcinoma with lymphadenopathy.

Keywords: Lymphadenopathy; Chemotherapy; Surgery; Sweat gland carcinoma
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INTRODUCTION

Sweat gland carcinomas have been recorded in the literature as early as 1865.[1] Over the last three decades in the literature almost 220 cases of sweat gland carcinomas have been presented. With 57 years being the medium age, with an equal male-to-female distribution. Topographically, the tumour is located at the head (26%), lower limbs (32.9%) and the upper extremities (28%).Involvement of the trunk is rare.[2] In 1968 Berg and Mac Davitt provided classification of these tumours.[3] They are divided into porocarcinomas, syringomatous carcinomas, ductal carcinomas, adenoid, cystic and mucinous carcinomas. These tumours have also been divided as eccrine and apocrine. They are believed to show aggressive behaviour with distant along with Lymphatic metastases. Bone, lung and skin metastases are also common. The overall prognosis of these tumours is poor.

Surgery that includes wide local excision with or without lymph node dissection is the primary and main treatment. The role of Adjuvant therapy is not clearly understood but can have an important role as these tumours are known for their aggressive nature. Local control of these tumours can be achieved by Postoperative radiotherapy.[4] No exact treatment is available for systemic treatment but multiple chemotherapy agents have been tried.

CASE REPORT

A 65 years old patient known case of Parkinson, since 6 years not compliance of medications, presented to the General Surgery OPD of PIMS in December 2013 with a recurrent swelling in his left lower chest.

The swelling appeared 8 years ago which the patient claims was very small. It was painless and remained static for 7 years. Ten months back the swelling increased in size and became painful. No discharge was observed by the patient. The swelling had been excised twice in the past last surgery approximately 1 year back

On physical examination the swelling with a linear scar mark about 4×4 cm located 1cmto the left and below the xiphisternum on his left chest (Figure-1b and 1c) with surrounding eythema. No visible veins or skin discoloration was seen. The temperature of the swelling was normal. It was tender and the surface was smooth. The margins was distinct. It was irreducible, non-compressible and non-fluctuant. Transillumination test was positive.

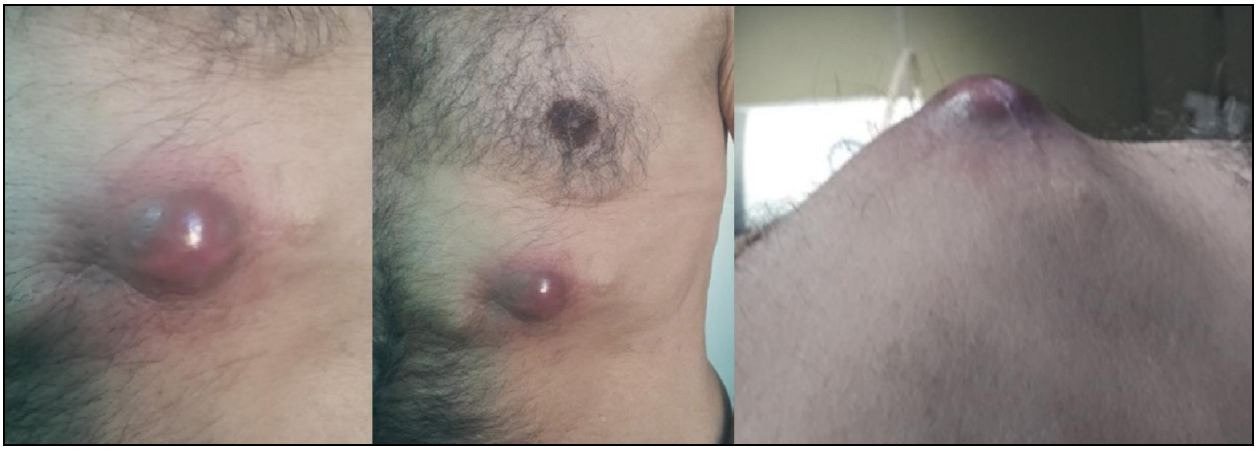

Figure-1: Swelling with erythema in the left lower chest

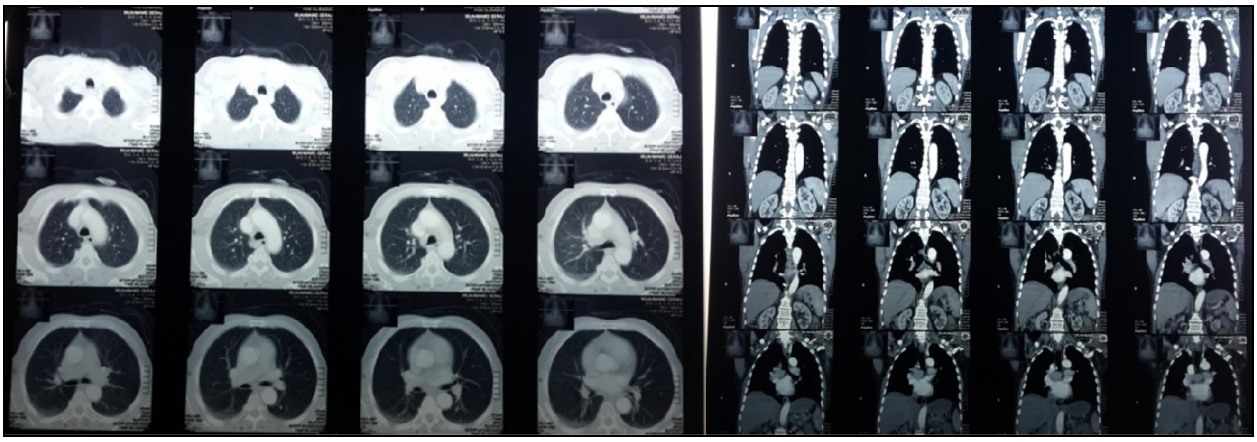

Figure-2: CT scan showing soft tissue mass in left lower chest

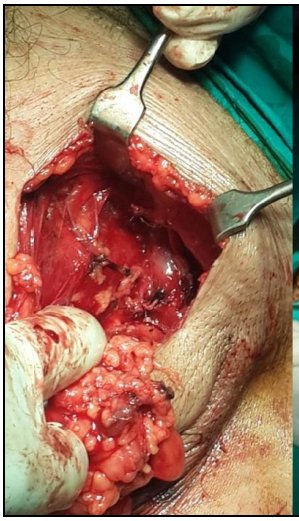

Figure-4a: Epplitical incision around lump.

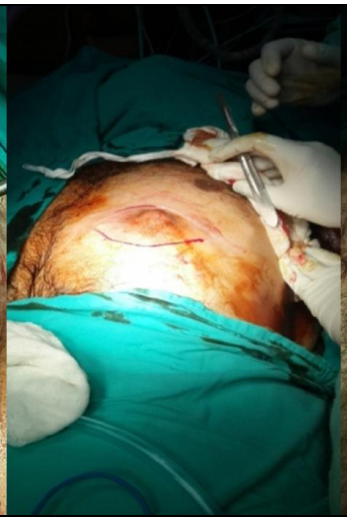

Figure-4b: axillary vein can be seen with the axillarylymphnodes

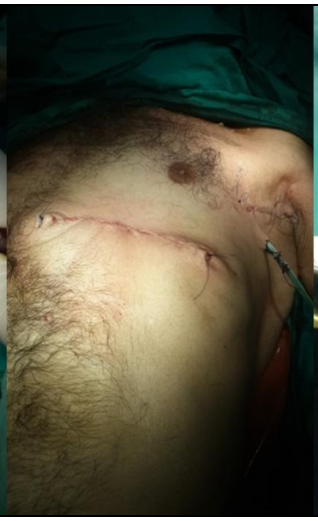

Figure-5: the swelling and the axillarylymphnodes

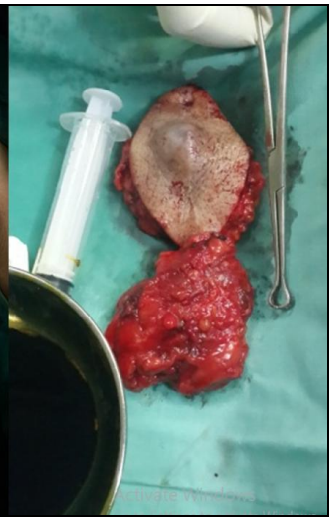

Figure-6: Post-operative

CT scan with and without contrast of the chest revealed positive findings of soft tissue mass in left lower chest with bilateral axillary, medistinal and right hilarlymphadenopathy (Figure-3a and 3b).

True cut biopsy revealed sweat gland carcinoma wide local excision was performed under general anaesthesia. After initial elliptical incision the entire lump along with healthy tissue was removed (Figure-4a). Axillary clearance was also done with separate oblique incisioninaxilla. Patient recovery was uneventful and discharged on 2nd post-portative day. Histopathology report revealed sweat gland carcinoma with all margins free of tumour .6 out of 16 lymphnode were positive for metastatic deposit.

DISCUSSION

Sweat gland carcinoma is an extremely rare carcinoma, representing almost 1% of primary skin lesions. It has been known since a long time but continues to be a dilemma due to the poorly understood pathogenesis and the fact that these tumours are more aggressive than squamous or basal cell carcinoma and that is why the diagnosis is commonly delayed due to the confusion and low incidence. Therefore early diagnosis can have major implications on response to treatment.

For diagnosis, studies have been done with sentinel node biopsy of axillas which revealed that lymphadenopathy is a common finding.[5]

Some international hospitals have considered surgery even in tumour of the metastatic setting.[6] Other studies have been found to produce positive results with response to both radiotherapy and chemotherapy out of which 5-Fluorouracil is an agent used.[7]

A case report of a similar patient in USA establishes local resection plus regional dissection as an ideal procedure on patients with lymph node

metastases. They also have established that postoperative irradiation may be helpful to increase local control and reduce incidence of distant metastases.[8]

Analysing all the available literature, we conclude that as this tumour has a five-year disease-free survival which is less than 30%[9] and therefore wide local excision is the treatment of choice for these rare sweat gland carcinomas. Multi agent chemotherapy can be thought of as an option for more extensive lesions but as in the present case, did not show much benefit, indicating a relative incurability of the tumour.

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Address for Correspondence:

Tahir Khaleeq, Department of Surgery, Pakistan institute of Medical sciences, Islamabad-Pakistan
Email: tahirkuz@live.com