

POROMA: A Case Presentation

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Abstract: Poromas though not very common, have a tendency to become malignant. So they should be treated as early as possible to prevent any morbidity and mortality.

Keywords: poroma, eccrine origin, benign, skin involvement, usually painless, propensity to become malignant, excision, follow up

1. Introduction

Poromas are benign growths of poroid differentiation, usually originates from terminal duct of sweat gland. Previously thought to be of eccrine origin (1) there are cases with apocrine, serous and follicular differentiation (2). The exact etiology of poroma is unknown. Long term radiation exposure has been suggested to trigger the development of poroma (3). Benign poroma may undergo malignant progression to become porocarcinoma. Immunosuppression, exposure to chemical agents and chronic light exposure are thought to be factors that increase the susceptibility to develop eccrine porocarcinoma (4). In primary skin lesions, sweat gland tumors account for around 1% cases. Eccrine and apocrine poromas are believed to account for around 10% of these (5, 6). They are benign adnexal tumors that occur on skin and does not affect any other tissues of the body (7).

Poromas present as solitary, dome shaped nodules, papules and plaques on palms and soles in middle age with no gender differentiation (8). Uncommonly lesions may be pigmented or vascular and bleed on touch.

Poromas are very well circumscribed tumors (9). Biopsy reveals broad columns of basaloid cells in upper dermis with multiple connections to the overlying epidermis. The stroma is characteristically richly vascular, foci of necrosis and mitosis may be seen in poroma. The spectrum of changes in poroma ranges from intraepidermal lesions (hidracanthoma simplex) to epidermal - dermal lesions and predominantly

dermal lesions (dermal duct tumors) (10). Poroma typically presents as an asymptomatic mild, solitary, slow growing papule, nodule or plaque with colour varying from skin colour to red to brown to bluish (11). Rarely mild tenderness is present.

Treatment of poroma is optimal but curative as it is a benign adnexal neoplasm. Deeper lesions may be cured with simple excision but electrosurgical destruction may be the cure for superficial lesions.

2. Case History

A 21 year old male presented to surgical opd on 20/08/2020 with complaint of mass over left anterior chest wall since one month which was initially small and later progressed to the size of 2*3 cm. It was at the level of left 6th ICS near mid clavicular line. It was reddish in colour with visible sinus without any discharge. The patient has no complaint of malaise, loss of weight, anorexia, any blood discharge. Ultrasonography suggestive of neoplastic lesion involving left anterior chest wall. FNAC suggestive of malignant adnexal tumor. Based on that surgical excision with broad tumor margins was done. Histopathology report was suggestive of benign adnexal lesion: Eccrine Poroma. All sutures were removed after 7 days with gaping present for which daily dressing was done followed by no further management with no complaint to the patient regarding poroma excision even after 1 year of excision.





3. Discussion

Poromas are often misdiagnosed as other skin neoplasms because their clinical presentations are non specific and variable (12). Poromas are usually painless. Poroma may resemble pyogenic granuloma, soft fibroma, verrucous vulgaris hemangioma, pigmented naevus, basal cell carcinoma, squamous cell carcinoma. However diagnosis is confirmed by histopathological examination only which decides the further course of management

4. Conclusion

Poromas have tendency to progress to become porocarcinoma. So timely intervention in the form of surgical excision and histopathological diagnosis to confirm prevent morbidity and mortality in these patients. Poromas are not just related to palm and soles and can occur at any other site of the body skin and even in younger age group.

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