**Case No. 12**

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**Patient:** A 19 year-old Thai man from Ang-thong

**Chief complaint:** A lump on the right chin for 7 years

**Present illness:**  
The 19-year-old man presented with a lump on the right chin for 7 years. He had no symptom, just noticed an obvious asymmetrical chin. The lump gradually increased in size. He denied any history of prior injection of any substances into his chin.

**Past history:** Unremarkable

**Family history:** None of his family members experienced the same condition.

**Dermatological examination:**  
Solitary non-tender, skin-colored, soft, immobile nodule on the right side of the chin.

**Physical examination:** Otherwise within normal limit

**Histopathology:**  
Section displays increased number of eccrine structure and numerous capillary channels surrounding or intermingled with the eccrine structure in the deep dermis. Fatty tissue and pilar structure are incorporated in the lesion.

**Diagnosis:** *Eccrine Angiomatous Hamartoma*

**Treatment:** Surgical excision

**Discussion:**  
Eccrine angiomatous hamartoma (EAH) is a benign nodular or plaque-like tumor of hamartomatous nature characterized by the proliferation of eccrine and vascular structures. EAH is primarily a disease of the young, with onset usually during childhood and adolescence. The disease shows no gender or racial preponderance.

The etiopathogenesis remains unknown. Some reported cases have suggested the faulty interaction between differentiating epithelium and the underlying mesenchyme gives rise to abnormal proliferation of adnexal and vascular structures in congenital forms. Late onset lesions have been associated with recurrent trauma.

EAH typically manifests as a single, flesh-colored, blue-brown, or reddish papule, plaque, or nodule, although uncommonly, multiple lesions or hyperkeratotic, verrucous variants are also seen. EAH is usually asymptomatic, although pain and hyperhidrosis have been reported to occur in 42% and 34% of cases, respectively.

EAH must be differentiated from vascular malformations, tufted angioma, smooth muscle hamartoma, glomus tumor, blue rubber bleb nevus, and macular telangiectatic mastocytosis.

The definite diagnosis of EAH requires microscopic evaluation. A histopathological hallmark is the proliferation of eccrine and vascular structures, capillaries in particular. The criteria for the diagnosis of EAH proposed by Pelle et al. were: (1) hyperplasia of normal or dilated eccrine glands, (2) close association of the eccrine structures with capillary angiomatous foci, and (3) variable presence of pilar, lipomatous, mucinous and/or lymphatic structures. Smith et al. also proposed the existence of three histological variants of EAH, namely follicular, lipomatous and mucinous. Immunohistochemistry showed that the eccrine coils and ducts were stained positively for CEA, S-100 and EMA.

The natural course of EAH is slow growing at the same rate as the rate of growth of the patient. Pain may occur in rapid growth or increase in lesion. EAH may response to hormonal stimulation, onset or exacerbation of EAH occurs during puberty or pregnancy.

Surgical excision is the treatment of choice for patients with cosmetic issue, progressive enlargement of the lesions, or undesirable symptoms such as disabling pain or excessive hyperhidrosis. Pulsed-dye laser and Nd: YAG laser have been performed without much improvement. Botulinum toxin might be considered in localized hyperhidrotic cases.

Our case was typical of EAH in histopathology, demonstrating proliferation of eccrine and vascular structures. The surgical excision was performed for the cosmetic concerns.
References: