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Cephalic eccrine poroma and clinical polymorphism: About two cases

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Abstract
Eccrine poroma is a rare benign adnexal tumor originating from the intraepidermal portion of the eccrine sweat duct. While commonly found on acral sites such as the soles and palms, its occurrence in the cephalic region is rare and can lead to clinical misdiagnosis due to its resemblance to malignant lesions. This report presents two cases of cephalic eccrine poroma, each displaying distinct clinical and dermoscopic features. The first case involves a 47-year-old man with a dome-shaped, erythematous tumor on the scalp, previously treated for small cell carcinoma. Histological analysis confirmed eccrine poroma without malignancy. The second case is an 82-year-old woman with a keratotic plaque on the left temporal area, showing a polymorphous vascular pattern on dermoscopy. Histopathology again confirmed a benign eccrine poroma. Both lesions were excised completely with favorable outcomes. These cases highlight the clinical and dermoscopic polymorphism of eccrine poromas in atypical locations and underscore the importance of considering this diagnosis even outside classic acral areas. Due to its potential for malignant transformation, early recognition and complete excision are crucial. Histopathological confirmation remains the cornerstone for accurate diagnosis and management.

Keywords: Eccrine poroma, cephalic region, benign adnexal tumor, dermoscopy, porocarcinoma risk

Introduction

Eccrine poroma is a rare, benign tumor that originates from the intraepidermal portion of the eccrine sweat duct. While it most commonly appears on the soles of the feet — where eccrine glands are highly concentrated — it can occasionally develop in less typical locations. When this happens, its appearance may be misleading and raise concern for malignancy. We report two cases of eccrine poroma in the cephalic region, each with a distinct clinical presentation, illustrating the tumor's surprising diversity and the importance of keeping it in mind, even in uncommon locations.

Case Reports

Case 1

A 47-year-old man with a past history of small cell endocrine carcinoma of the anterior mediastinum — treated with chemo-radiotherapy and prophylactic cranial irradiation — presented with a lesion on the back of his scalp. He had noticed it slowly growing over the course of a year. On examination, the lesion appeared as a dome-shaped, exophytic tumor with a firm, erythematous surface and subtle posterior enhancement. It was painless, without ulceration or bleeding. No regional lymph nodes were palpable.

A skin biopsy revealed a sharply demarcated proliferation of epithelial cords connected to the epidermis, composed of uniform cells showing features of eccrine differentiation. There were no signs of malignancy. The lesion was completely excised, and the patient remained recurrence-free during follow-up.

Case 2

An 82-year-old woman, known to have generalized vitiligo, came in with a slowly enlarging plaque on the left temporal area. The lesion had been present for over a year and had progressively thickened. It was erythematous, slightly scaly, and keratotic to the touch. Dermoscopy showed a striking vascular pattern, with glomerular and hairpin vessels, milky red areas, and delicate white septa — creating an appearance reminiscent of “frog eggs.” There were no local or distant lymphadenopathies.

Histopathology confirmed the diagnosis of eccrine poroma, without any cytologic atypia. The lesion was excised with clear margins, and the postoperative outcome was favorable.

Fig 1: exophytic tumor with posterior enhancement next to the occipital bone

Fig 2: erythematous plaque with a keratotic surface on the face

Discussion

Although eccrine poroma was first described in 1956 by Pinkus and is traditionally associated with acral sites, it can occur anywhere on the body, including the scalp and face. In these unexpected locations, it often mimics more serious conditions like basal cell carcinoma, squamous cell carcinoma, or even amelanotic melanoma. This resemblance — both clinically and dermoscopically — frequently leads to misdiagnosis.

Dermoscopy is a helpful tool for raising suspicion. The hallmark is a polymorphous vascular pattern, often including two or more types of vessels — glomerular, hairpin, or linear-irregular — alongside milky-red areas or white septa. While not specific, these features should prompt consideration of eccrine poroma in the differential, especially when the lesion lacks pigmentation.

The diagnosis, however, remains histological. The tumor typically consists of uniform cuboidal cells, sometimes forming duct-like structures, arranged in broad anastomosing cords connected to the epidermis. Features of malignancy such as atypia or mitotic activity are absent in benign cases.

One important consideration is that eccrine poromas, though benign, can undergo malignant transformation into porocarcinoma — a risk that increases with long-standing or recurrent lesions. This underlines the need for early and complete removal. While superficial lesions may be treated with shave excision or electrosurgery, surgical excision remains the standard, especially in cephalic locations.

Fig 3: Several types of vessels (Glomerular vessels, hairplin vessels) in the border of the lesion

Conclusion

These two cases highlight how eccrine poroma can present in unusual ways and locations, mimicking malignant tumors both clinically and dermoscopically. Being aware of its diverse presentations — particularly outside acral sites — can help clinicians avoid misdiagnosis and ensure timely, appropriate treatment. Histological examination remains essential for a definitive diagnosis and to rule out malignancy.

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