

# HISTOMORPHOLOGICAL DIVERSITY OF SKIN ADNEXAL TUMOURS: CLINICAL CORRELATION AND DIAGNOSTIC IMPLICATIONS

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## ABSTRACT

**Background:** Skin Adnexal tumors (SATs) represent a diverse group of cutaneous lesions arising from hair follicles, sebaceous glands, and sweat glands. While most are benign, malignant variants though rare, carry significant clinical implications. Understanding their epidemiological distribution by age, gender, site, and incidence is essential for accurate diagnosis and management. **Methods:** A retrospective analysis of 36 histopathologically confirmed Skin Adnexal Tumors was conducted over a period of 5 years (January 2021 to December 2025) at Department of Pathology, UPUMS Saifai. Data were stratified by tumor type, gender, age group, incidence, and anatomical site and cases were reclassified according to WHO 2023 (5<sup>th</sup> edition). The findings were compared with published literature to identify similarities and regional variations. **Results:** In this study male predominance was observed (male-to-female ratio 2:1), with the majority of cases occurring in young to middle-aged adults. Pilomatrixoma was the most frequent lesion, followed by hidradenoma papilliferum and trichoepithelioma, while sebaceous carcinoma represented the rare malignant counterpart. The scalp was the most common site of involvement followed by face. **Conclusion:** Skin Adnexal tumors represent rare neoplastic entities, most of which are benign. SATs present with varied morphology but predictable epidemiological trends. Greater awareness among clinicians, supported by histopathological confirmation, remains essential for optimal patient care.

**KEYWORDS:** Skin Adnexal Tumors, Pilomatrixoma, Hidradenoma papilliferum, Sebaceous carcinoma.

## INTRODUCTION

Skin Adnexal Tumors (SATs) are uncommon neoplasms, which may be benign or malignant, arising from the skin adnexal structures such as the pilosebaceous unit, eccrine glands, and apocrine glands [1,2]. This broad category of tumors is histopathologically classified into four main types: follicular, sebaceous, eccrine, and apocrine [3,4]. Clinically, SATs often present as skin swellings with overlapping features, making accurate diagnosis based solely on physical examination challenging. Therefore, histopathological analysis is essential for definitive identification [5]. The wide range of histomorphological patterns can lead to terminological inconsistencies when describing the same tumor. Moreover, due to overlapping clinical and histological features, the final histopathological diagnosis may differ from the initial clinical impression [6].

The biological behaviour of SATs, whether benign or malignant, is the key prognostic determinant and guides therapeutic decisions. Accurate classification according to the World Health Organization's histological subtypes is crucial for appropriate management [7,8]. Additionally, certain SAT subtypes are linked to hereditary syndromes and may serve as early indicators of underlying genetic conditions, underscoring the importance of precise diagnosis [1,2,3].

Some benign SATs carry a risk of malignant transformation if left untreated, highlighting the need for timely recognition and intervention [9]. Notable syndromes associated with SATs include Birt-Hogg-Dube syndrome, Brooke-Spiegler syndrome, Cowden syndrome, Bazex-Dupré-Christol syndromes and Muir-Torre syndrome [9,10,11].

In the 2018 World Health Organization classification, several region-specific entities were incorporated into this group, including Paget's disease of the breast, extramammary Paget's disease, anogenital breast-like gland adenocarcinoma, hidradenoma papilliferum, and anogenital breast-like gland fibroadenoma [12,13]. While 5th edition of the WHO Classification of Skin Tumors (2022) introduced several important updates to the classification of skin adnexal tumors, reflecting advances in molecular pathology and diagnostic precision such as Cribiform carcinoma has been renamed to cribriform tumor, Adenosquamous carcinoma, previously listed under SCC subtypes, is now considered a squamoid eccrine ductal carcinoma. Several new entities have been

introduced like “Primary adnexal NUT carcinoma” “Digital papillary adenocarcinoma”. New molecular aberrations identified in non syndromic adnexal tumors aiding in differential diagnosis and potential therapeutic targeting. Nail unit tumors are now classified separately, with emphasis on adnexal differentiation and unique histopathologic features. [14,15]

## MATERIAL AND METHODS:

This retrospective observational study encompassed all the skin biopsies diagnosed as skin adnexal tumors between January 2021 and December 2025 in the Department of Pathology at Uttar Pradesh University of Medical Sciences, Saifai, Etawah, Uttar Pradesh. Data from 36 patients were retrieved from the Laboratory Information System (LIS). Demographic details of the patients including age, gender, site of the lesion and relevant clinical history were extracted from individual case files. Patients with inadequate clinical details were excluded from the study. Hematoxylin and Eosin (H&E) stained slides were independently reviewed by two pathologists at separate intervals and diagnoses were made according to WHO classification of skin adnexal tumor 5<sup>th</sup> edition 2023.

## RESULTS

A total of 36 skin adnexal tumors were studied over the course of this analysis. The overall distribution revealed a male predominance, with 24 cases (66.66%) in males compared to 12 cases (33.33%) in females. Certain tumors showed striking gender-specific patterns. Pilomatrixoma was seen exclusively in male patients, while sebaceous carcinoma was confined to females. Interestingly, tubular apocrine adenoma displayed an equal distribution across both sexes, highlighting its non-discriminatory occurrence.

Other tumor types, such as nodular hidradenoma, trichoepithelioma, trichofolliculoma, syringocystadenoma papilliferum, and hidradenoma papilliferum, demonstrated a mild male bias, though they were not restricted to one gender. Overall, the findings suggest that while adnexal tumors can occur in both sexes, certain subtypes may show distinct gender predilections, which could have implications for clinical suspicion and diagnostic approach. [Table 1]

Age stratification revealed that the 20–39 years age group harbored the largest proportion of cases (16 cases, 44.44%), followed by the 40-59 years group (11 cases, 30.55%). The 0-19 years group accounted for 5 cases (13.88%), while only 4 cases (11.11%) were seen in patients above 60 years. [Table 2]

In our series of 36 adnexal skin tumors, the most frequently encountered lesion was pilomatrixoma, accounting for 16.6% of cases. Both hidradenoma papilliferum and trichoepithelioma followed closely, each representing 13.8% of the total. Nevus sebaceus of Jadassohn contributed 11.1%, while nodular hidradenoma, trichofolliculoma, syringocystadenoma papilliferum, and nodular hidradenoma with eccrine differentiation were observed with equal frequency, each comprising 8.3% of cases. Less common tumors included tubular apocrine adenoma and malignant tumor e.g sebaceous carcinoma both seen in 5.5% of patients. Overall, the distribution highlights pilomatrixoma as the leading entity in this cohort, with a spectrum of other adnexal tumors occurring at lower but comparable incidences [Table 3]

In our cohort of 36 adnexal skin tumors, the scalp emerged as the most common site of involvement, accounting for one-quarter of all cases (25%). The face was the next frequent location, seen in 19.4% of patients. Lesions in the post-auricular region and neck were equally represented, each contributing 11.1% of the total. Tumors involving the eye and eyelid and the chest were less frequent, observed in 8.3% of cases each. Rare sites included the forehead, cheek, and gluteal region, all of which showed a similar incidence of 5.5%. [Table 4]

The adnexal tumors were classified according to their line of differentiation into three major categories: 1) Hair follicle differentiation: It accounted for 38.88% of the total cases. This group included pilomatrixoma, trichoepithelioma, and trichofolliculoma. Pilomatrixoma was the most frequent lesion among follicular tumors, while trichoepithelioma and trichofolliculoma were rare. Microscopically pilomatrixoma comprises of islands of basaloid cells showing abrupt keratinization without intervening granular layer and shadow cells or ghost cells. (Fig.1) 2) Sebaceous gland differentiation comprised of 16.66% of total cases and it included nevus sebaceus of Jadassohn and sebaceous carcinoma. Nevus sebaceus represented the benign lesion, microscopically it shows the hamartomatous proliferation of epidermis and adnexal structure, sebaceous glands are present higher up in the dermis and some of them may show direct opening into the epidermis without connection to hair follicles (Fig.2) whereas sebaceous carcinoma was the malignant counterpart in this category. Sebaceous carcinoma shows lobules or sheets of tumor cells separated by fibrovascular stroma. It can be divided into well differentiated, moderately differentiated and poorly differentiated on the basis of cytological atypia, mitosis and necrosis. (Fig.3). 3) Sweat gland differentiation was the most frequent differentiation (44.44%) and encompassed a diverse set of tumors including hidradenoma papilliferum (Fig.4), nodular hidradenoma, tubular apocrine adenoma, syringocystadenoma papilliferum and nodular hidradenoma with eccrine differentiation. All were benign in our series, reflecting the wide morphological spectrum of eccrine and apocrine tumors. [Table 5]

## DISCUSSION

Adnexal tumors represent a diverse group of cutaneous neoplasms arising from hair follicles, sebaceous glands, and sweat glands. In our series of 36 cases, we observed a male predominance (2:1 ratio), which is in contrast to several studies that report a slight female predominance in benign adnexal tumors [1,2,4,10].

The age distribution in our study showed peak incidence in the third and fourth decades, consistent with reports from India and other Asian countries where adnexal tumors are most frequently diagnosed in young to middle-aged adults [16,17]. Pediatric cases were relatively uncommon, and elderly patients accounted for only a small fraction, underscoring the tendency of these tumors to present earlier in life.

Diagnosing adnexal tumors is often challenging because of the sheer diversity of tumor types and their variants, the presence of multiple patterns of differentiation within a single tumor, and the added complexity of their nomenclature. [1] Within the spectrum of adnexal tumors, sweat gland differentiation was the most frequently observed (44.44%), followed by hair follicle differentiation (38.88%), while sebaceous gland differentiation was the least common (16.66%). These findings are consistent with the reports of Pujani M et al [1], Saleem R et al [4], Radhika K et al [16], Sharma A et al [18], and Gayathri SS et al [19]. In contrast, Kamyab-Hesari K et al [22] documented sebaceous tumors as the predominant type, a result that differs from most other studies in the literature. Table 6 shows the comparative analysis of several Indian studies with respect to the line of differentiation of skin adnexal tumors.

In this study, the site distribution revealed a predilection for the scalp and face, together accounting for nearly half of the cases. This finding is consistent with other series reporting that head and neck involvement is most frequently seen in adnexal tumors [1, 17] while other sites are extremities, trunk, axilla and face etc.

Out of 36 cases, we found only two malignant cases that is Sebaceous Carcinoma. Pujani et al [1] also found single case of Sebaceous Carcinoma in their study of 25 cases. It is observed that the incidence of adnexal tumors is very rare in Indian population which is documented by many studies. [1,16,19,20] Pilomatrixoma was the most common benign tumor encountered in our study followed by Hidradenoma papilleferum while Pujani M et al. [1] and Saleem R et al. [4] found Hidradenoma papilleferum most common benign tumor followed by Pilomatrixoma.

Overall, our findings reinforce the established epidemiological profile of adnexal tumors: male predominance, peak incidence in young adulthood, scalp and facial predilection, and pilomatrixoma as the most common subtype. While most lesions are benign, the presence of sebaceous carcinoma highlights the need for careful clinicopathological correlation and timely intervention.

## CONCLUSION

Our findings are consistent with published literature, reinforcing the need for histopathology as the gold standard in diagnosis. Recognizing the characteristic age, gender, and site distribution patterns can aid clinicians in early suspicion, accurate classification, and timely management. Although rare, malignant adnexal tumors such as sebaceous carcinoma demand heightened awareness due to their aggressive nature and potential for significant morbidity.

In summary, adnexal tumors present with varied morphology but predictable epidemiological trends. Histopathology remains the gold standard for diagnosis, and awareness of these patterns can aid clinicians in early recognition and management.

**Limitations of the study:** While this study provides valuable insights into the clinicopathological spectrum of adnexal tumors, certain limitations must be acknowledged. First, the sample size was relatively small (36 cases), which may limit the generalizability of the findings to larger populations. Second, the study was conducted at a single institution, and therefore the results may reflect regional referral patterns rather than the broader epidemiological profile and long-term follow-up was not available for all patients, restricting our ability to comment on recurrence rates, progression, or long-term outcomes of malignant adnexal tumors.

**Conflict of interest:** Nil

**Acknowledgement:** We would like to acknowledge the contributions of our technicians and residents.

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## TABLES

**Table 1: Tumor type with gender distribution**

| Sr. No. | Tumor type                                       | Male        | Female      |
|---------|--------------------------------------------------|-------------|-------------|
| 1       | Pilomatrixoma                                    | 6           | -           |
| 2       | Nevus sebaceous of jadasson                      | 3           | 1           |
| 3       | Sebaceous carcinoma                              | -           | 2           |
| 4       | Hidradenoma papilliferum                         | 3           | 2           |
| 5       | Nodular hidradenoma                              | 2           | 1           |
| 6       | Trichoepithelioma                                | 3           | 2           |
| 7       | Trichofolliculoma                                | 2           | 1           |
| 8       | Tubular apocrine adenoma                         | 1           | 1           |
| 9       | Syringoadenoma papilliferum                      | 2           | 1           |
| 10      | Nodular hidradenoma with eccrine differentiation | 2           | 1           |
|         | Total                                            | 24 (66.66%) | 12 (33.33%) |

**Table 2: Tumor type according to age**

| Sr. No. | Tumor type                                       | 0-19 yrs   | 20-39 yrs   | 40-59 yrs   | >60 yrs    |
|---------|--------------------------------------------------|------------|-------------|-------------|------------|
| 1       | Pilomatrixoma                                    | 2          | 2           | 1           | 1          |
| 2       | Nevus sebaceous of jadasson                      | -          | 3           | 1           | -          |
| 3       | Sebaceous carcinoma                              | -          | -           | 2           | -          |
| 4       | Hidradenoma papilliferum                         | -          | 2           | 1           | 2          |
| 5       | Nodular hidradenoma                              | -          | 2           | 1           | -          |
| 6       | Trichoepithelioma                                | 2          | 2           | 1           | -          |
| 7       | Trichofolliculoma                                |            | 1           | 2           | -          |
| 8       | Tubular apocrine adenoma                         |            | 1           | 1           |            |
| 9       | Syringoadenoma papilliferum                      | 1          | 2           | -           | -          |
| 10      | Nodular hidradenoma with eccrine differentiation | -          | 1           | 1           | 1          |
|         | Total                                            | 5 (13.88%) | 16 (44.44%) | 11 (30.55%) | 4 (11.11%) |

**Table 3: Tumor type with its incidence**

| S. No. | Tumor type                                       | No. of cases | Incidence % |
|--------|--------------------------------------------------|--------------|-------------|
| 1      | Pilomatrixoma                                    | 06           | 16.66       |
| 2      | Hidradenoma papilliferum                         | 05           | 13.88       |
| 3      | Trichoepithelioma                                | 05           | 13.88       |
| 4      | Nevus sebaceous of jadasson                      | 04           | 11.11       |
| 5      | Nodular hidradenoma                              | 03           | 8.33        |
| 6      | Trichofolliculoma                                | 03           | 8.33        |
| 7      | Syringocystadenoma papilliferum                  | 03           | 8.33        |
| 8      | Nodular hidradenoma with eccrine differentiation | 03           | 8.33        |
| 9      | Sebaceous carcinoma                              | 02           | 5.55        |
| 10     | Tubular apocrine adenoma                         | 02           | 5.55        |
|        | Total                                            | 36           | 100         |

**Table 4: Tumor type with its site of involvement**

| Sr. No. | Tumor Site     | No. of cases | %     |
|---------|----------------|--------------|-------|
| 1.      | Scalp          | 9            | 25    |
| 2.      | Face           | 7            | 19.44 |
| 3.      | Post auricular | 4            | 11.11 |
| 4.      | Neck           | 4            | 11.11 |
| 5.      | Eye and eyelid | 3            | 8.33  |
| 6.      | Chest          | 3            | 8.33  |
| 7.      | Forehead       | 2            | 5.55  |
| 8.      | Cheek          | 2            | 5.55  |
| 9.      | Gluteal        | 2            | 5.55  |
|         | Total          | 36           | 100   |

**Table 5: Distribution of cases according to line of differentiation**

| Sr. No. | Adnexal tumors                                   | Line of differentiation |
|---------|--------------------------------------------------|-------------------------|
| 1.      | Pilomatrixoma                                    | Hair follicle           |
| 2.      | Nevus sebaceous of jadasson                      | Sebaceous gland         |
| 3.      | Sebaceous carcinoma                              | Sebaceous gland         |
| 4.      | Hidradenoma papilliferum                         | Sweat gland             |
| 5.      | Nodular hidradenoma                              | Sweat gland             |
| 6.      | Trichoepithelioma                                | Hair follicle           |
| 7.      | Trichofolliculoma                                | Hair follicle           |
| 8.      | Tubular apocrine adenoma                         | Sweat gland             |
| 9.      | Syringocystadenoma papilliferum                  | Sweat gland             |
| 10.     | Nodular hidradenoma with eccrine differentiation | Sweat gland             |

**Table 6: Comparative analysis of SATs according to line of differentiation**

| Sr. No. | Study                   | Study duration | Year | Total cases | Sebaceous differentiation (%) | Hair follicle differentiation (%) | Sweat gland differentiation (%) |
|---------|-------------------------|----------------|------|-------------|-------------------------------|-----------------------------------|---------------------------------|
| 1.      | Present study           | 5 years        | 2026 | 36          | 06 (16.66%)                   | 14 (38.88%)                       | 16 (44.44%)                     |
| 2.      | Pujani M et al. [1]     | 4 years        | 2016 | 25          | 04 (16%)                      | 07 (28%)                          | 14 (56%)                        |
| 3.      | Sharma A et al. [18]    | 7.5 years      | 2014 | 56          | 12 (21.43%)                   | 20 (35.71%)                       | 24 (42.86%)                     |
| 4.      | Radhika K et al. [16]   | 11 years       | 2013 | 35          | 07 (20%)                      | 11 (31.43%)                       | 17 (48.57%)                     |
| 5.      | Gayathri SS et al. [19] | 3 years        | 2012 | 29          | 03 (10.3%)                    | 11 (37.93%)                       | 15 (51.72%)                     |

### FIGURES

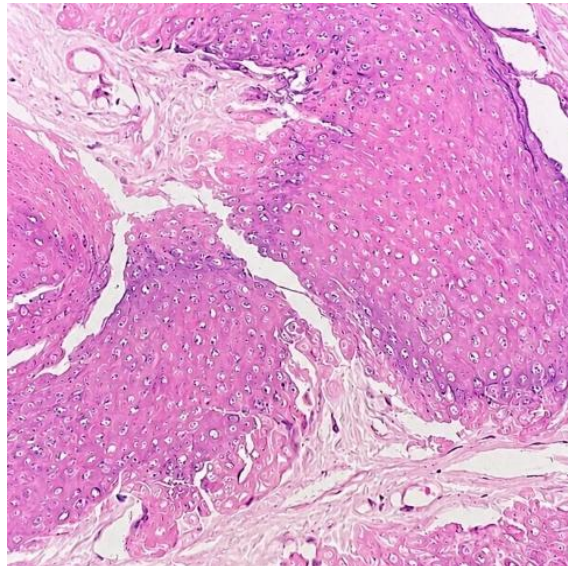


Fig. 1: Pilomatrixoma – Section shows ghost/shadow cells (H&E 400X)

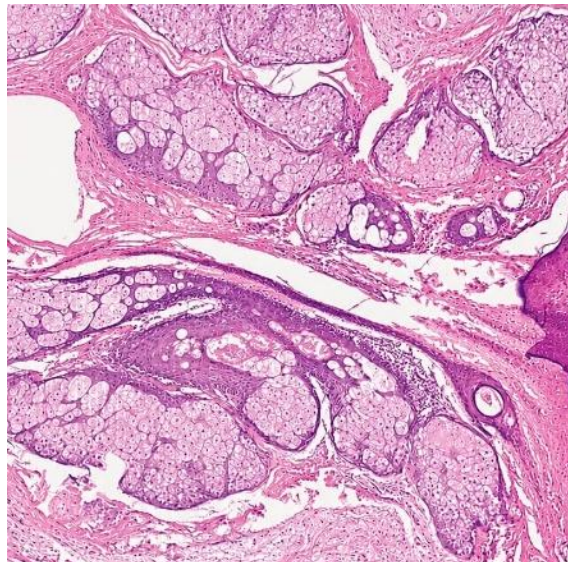


Fig. 2: Nevus sebaceous jadassohn (100X) : Section shows presence of sebaceous glands in the upper dermis with numerous mature sebaceous glands opening directly to the surface. (H&E 200X)

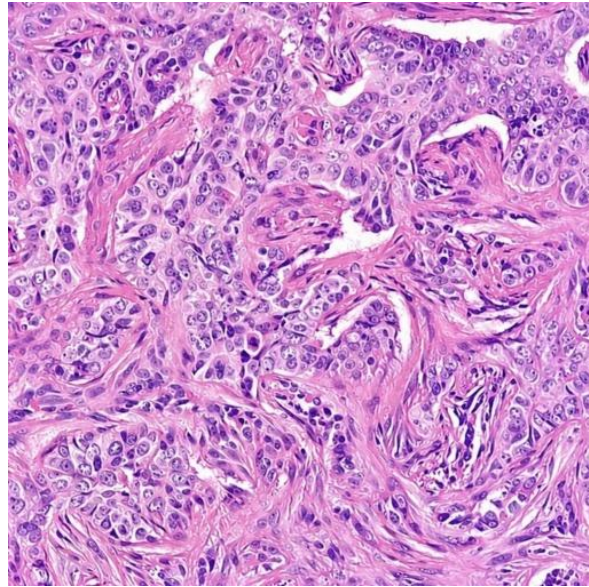


Fig. 3: Sebaceous carcinoma – Section shows highly pleomorphic tumor cells with prominent nucleoli, foamy cytoplasm, and atypical mitoses. (H&E 400X)

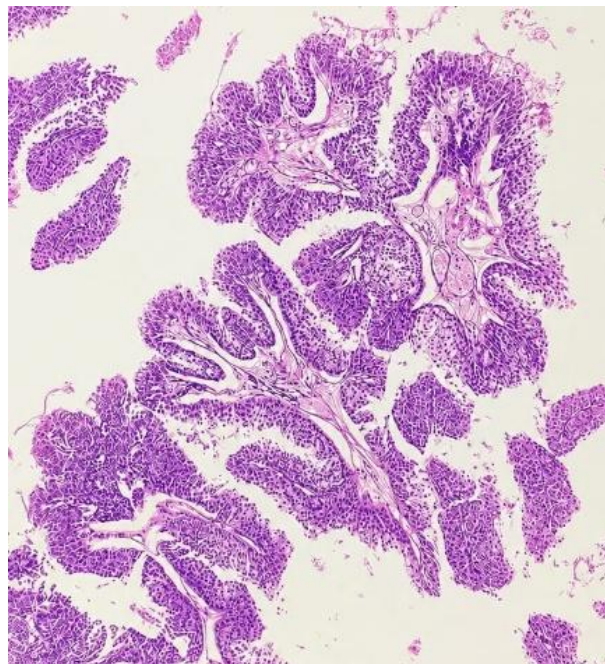


Fig. 4: Hidradenoma papilliferum - Section examined shows complex branching papillary and cystic structures lined by a double layer of epithelium. (H&E 200X)