Giant epidermoid cyst over the male breast

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Abstract

Epidermoid cyst is commonly known as sebaceous cyst. It is the most commonly encountered cyst of the skin. Epidermoid cyst over the breast is uncommon. Punctum is the hallmark for clinical diagnosis. Local excision with primary closure is the treatment of choice. Biopsy is mandatory in giant cyst to exclude malignancy.

Introduction

Epidermoid cyst of the breast is uncommon.[1] It is commonly encountered over the face and back either by a dermatologist or general surgeon in day to day practice.

Case Report

A 48 years old male presented with swelling over the right side of breast that underlies nipple areola complex (NAC) since last 6 years. Swelling was gradually increasing in size. No other significant history was available. On examination swelling was 10×10 cm cm in size with visible punctum, well defined margin and indentation was positive (Figure 1). Inferior margin of the swelling was ulcerated and discharging foul smelling material. Adjacent skin was normal. Cyst was excised with elliptical incision and sent for histopathological examination (HPE). No evidence of malignancy was found in HPE and diagnosis was consistent with epidermoid cyst.

Discussion

Epidermoid cysts are the most commonly encountered small, spherical, slightly compressible, dome shaped cyst of the skin.[2] Epidermoid cysts are commonly referred as sebaceous cyst. Common age of Presentation is young adult male and common site are scalp, face, and back.[3] clinical diagnosis can be made from black, keratin filled punctum in the center.[4] Epidermoid cysts are unilocular but giant cyst may be multilocular. Epidermoid cyst on the very unusual location should raise the suspicion of Gardner syndrome. Size varies from 0.5 to 5 cm. Epidermoid cyst may result from proliferation of epidermal cells within a circumscribed space of the skin. The source of epidermis is usually the infundibulum of hairfollicle, as the lining of the two structures is identical.[4] Cyst wall is composed of true stratified squamous epithelium and keritinocyte shed from the wall results in collection of white cheesy material with unpleasant smell. Important diagnostic feature, they are attached to the skin but are mobile over underlying structure. Epidermoid cysts are usually asymptomatic and slowly growing, but they may become inflamed or secondarily infected, resulting in pain and tenderness. Spontaneous rupture of the cyst wall leads to discharge of soft, yellow, foul smelling material in to the dermis. Punctum is a portal of entry for various skin commensals as well as pathological organism. Entry of pathologic organism explains why epidermoid cyst become frequently inflamed and infected. Epidermoid cysts are benign cyst, rarely squamous cell carcinoma (SCC), basal cell carcinoma, *mycosis fungoides*, and melanoma have developed in epidermoid cysts.[5] Some syndrome like Gardner syndrome and basal cell naevus syndrome are associated with epidermoid cyst occasionally. Differential diagnosis includes: milia, lipoma, dermoid cyst, pilar cyst etc. Treatment decision depends upon condition of cyst. If cyst is infected, it should be incised and drained first followed by complete excision once inflammation subsides. It is important to excise the cyst completely as failure to do so results in recurrence. Epidermoid cysts on the breast are uncommon, long standing cyst may become giant due to neglect on the part of patients. Giant epidermoid cysts are more prone or likely to develop cancer.[6-8]

Conclusion

Local excision through elliptical incision is the treatment of choice for Giant Epidermoid cyst. Histopathological examination is required to exclude the malignancy.

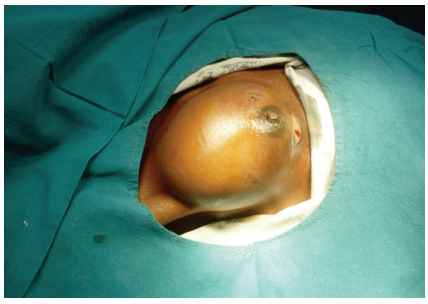

Figure 1. Visible punctum over giant epidermoid cyst.

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References

1. Bergmann-Koester CU, Kolberg HC, Rudolf I, et al. Epidermal cyst of the breast mimicking malignancy: clinical, radiological, and histological correlation. Arch Gynecol Obstet 2006;273:312-4.
2. Cruz AB, Aust JB. Lesions of the skin and subcutaneous tissue. In: Hardy JD, Kukora JS, Pass HI, eds. Hardy's Textbook of surgery. Philadelphia: Lippincott, 1983:319-28.
3. Habif TP. Habif's Clinical Dermatology. 4th ed. St. Louis, MO: Mosby; 2004.
4. Fujiwara M, Nakamura Y, Ozawa T, et al. Multilocular giant epidermal cyst. Br J Dermatol 2004;151:943-5.
5. Swygert KE, Parrish CA, Cashman RE, et al. Melanoma in situ involving an epidermal inclusion (infundibular) cyst. Am J Dermatopathol 2007;29:564-5.
6. Debaize S, Gebhart M, Fourrez T, et al. Squamous cell carcinoma arising in a giant epidermal cyst: a case report. Acta Chir Belg 2002;102:196-8.
7. I. Wani, B. Bhat, I. Mir, et al. Giant Sebaceous Cysts of scalp: A Case Report . The Internet Journal of Dermatology. 2008 Volume 6 Number 2.
8. Chiu MY, Ho ST. Squamous cell carcinoma arising from an epidermal cyst. Hong Kong Med J 2007;13:482-4.