On-line Case Report

Just another sebaceous cyst?

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ABSTRACT

Two cases are presented where an incorrect diagnosis of a sebaceous cyst delayed the treatment of a more serious underlying problem. The history and examination findings pointed to the diagnosis in both cases. Although not rare entities in themselves, these cases illustrate the importance of formulating a differential diagnosis even when confronted with an apparently straightforward condition.

Keywords: Sebaceous cyst – Malignant melanoma – Carious molar

Case report I

A 78-year-old man had been treated with oral antibiotics for an 'infected sebaceous cyst' on the right lower back for

a number of weeks. He presented to accident and emergency with a painful, discharging lump on the back. A diagnosis of an acutely infected sebaceous cyst was made by the on-call general surgical team. He was taken

Figure 1 Case report 1 – recurrent malignant melanoma. (A) Pre-operative markings demonstrate the limits of the melanoma nodule and a 3-cm excision margin. Note the proximity of the nodule to the original excision scar. (B) Post-excision wound immediately prior to skin grafting. Excision of the nodule included a cuff of the underlying latissimus dorsi muscle due to macroscopic tumour invasion.

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Figure 2 Case report 2 – cutaneous odontogenic sinus. (A) The cutaneous appearance. (B) A carious molar tooth. (C) Orthopantomogram (OPG) demonstrating the carious tooth with associated peri-apical bone resorption.

to theatre for incision and drainage of the abscess. At operation, it was noted that the abscess was arising from a subcutaneous nodule which was biopsied. Histological analysis revealed a cutaneous deposit of metastatic melanoma. In 1984, the patient had had a 3-mm thick primary melanoma excised from his back, followed by a right axillary lymphadenectomy in 1985 for regional metastases (2 out of 17 nodes positive). In 1987, he had had a second primary melanoma (5-mm thick) excised from his left scapular area, and had remained well since. The patient has subsequently undergone wide excision of the melanoma deposit and skin grafting (Fig. 1).

Late recurrence of malignant melanoma (> 10 years from primary excision) occurs in 2.4% of cases.² Risk factors for late recurrence include melanomas of intermediate thickness and a superficial spreading growth pattern. The true cause underlying late recurrence is uncertain. The skin and subcutaneous tissue is a common site for metastasis of melanoma. These deposits can become ulcerated and be painful. Ablation or excision is the treatment of choice to relieve symptoms.

Case report 2

A 23-year-old man was referred to the plastic surgery outpatient department with a 12-month history of a 'recurrently infected sebaceous cyst' on the right cheek. The patient had been prescribed several courses of oral antibiotics without resolution of the lesion. The referring doctor was concerned about the appearance of a possible keloid scar on the face. Clinical examination revealed a scarred area of skin tethered to the underlying mandible.

Oral examination revealed a grossly carious molar tooth. The patient admitted to having neglected the tooth for over 18 months. Orthopantomogram (OPG) demonstrated the necrotic tooth with associated peri-apical bone resorption. A diagnosis of a cutaneous odontogenic sinus was made and the patient referred to a maxillo-facial surgeon for further management.

Cutaneous odontogenic sinus is a well-recognised, albeit uncommon, complication of a dento-alveolar abscess. Infection from an untreated or unresolved abscess will tend to follow the path of least resistance through the tissues. This is usually confined to the oral cavity but, if the infection spreads outside of the attachment of the buccinator muscle, a cutaneous fistula may result.³

Treatment of the underlying dental problem resolves the fistula; attention is subsequently directed to the residual facial scarring.

Discussion

The term sebaceous cyst is a misnomer and should only be applied to those cysts that develop in association with steatocystoma multiplex. The commonly diagnosed 'sebaceous cyst' is usually an epidermoid cyst. These are keratin-containing lesions usually seen in young and middle-aged adults that often occur in relation to a pilosebaceous follicle.¹ As such, they are usually found on the face, neck shoulders and back.

Epidermoid cysts arise within the dermis and are tethered to the epidermis. They are usually freely mobile over deeper structures.

In both of the cases presented, the history was key to arriving at a correct diagnosis. In case 1, the age of the patient would make a diagnosis of an epidermoid cyst less likely. In addition, he had a significant history of skin cancer. On examination, the lump in the back was immediately superior to the old melanoma excision scar, which could have suggested an association between the two.

Case 2 highlights the need to consider dental infection in the differential diagnosis of the aetiology of cutaneous lesions around the face.

Conclusions

Epidermoid cysts are common, and it is understandable why both patients were initially diagnosed as they were. However, there were many clues as to the true nature of the diagnosis in both the history and the examination.

Although making a diagnosis in retrospect is always straightforward, making a spot diagnosis ignores a fundamental principle of the surgeon-patient consultation.

Although not rare entities in themselves, these cases illustrate the importance of the history and examination in arriving at a differential diagnosis to avoid delay in appropriate treatment.

References

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