CASE REPORT

Rare presentation of sebaceous hyperplasia

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SUMMARY

A 23-year-old woman presented with an 8-month history of asymptomatic thickening of the central areola bilaterally and oily nipple discharge. On examination, there were yellowish-pink papules coalescing into plaques bilaterally. Biopsy showed ectopic sebaceous glands (Montgomery tubercles), known as *bilateral areolar sebaceous hyperplasia*.

BACKGROUND

Sebaceous hyperplasia is a common, benign skin condition involving hypertrophy of the sebaceous glands, often in middle-aged or older adults. These lesions can be single or multiple and manifest as yellow, soft, small papules with umbilication commonly on the central face (specifically, the nose, cheeks and forehead). Rarer variants of sebaceous hyperplasia affect the chest,¹ mouth,² scrotum,³ foreskin,⁴ penile shaft,⁵ vulva⁶ and areola.⁷ We report a case of bilateral areolar sebaceous hyperplasia, an unusual clinical presentation of this entity, which was first described by Catalano and Ioannides⁸ in 1985. Only 14 cases have been described previously (table 1).^{9–20}

CASE PRESENTATION

A healthy 23-year-old woman presented to our institution's Breast Diagnostic Clinic with an 8-month history of asymptomatic yellow thickening of the central areola bilaterally and nipple discharge, based on wetness in her bra cups. The patient noted the fluid had an oily texture. She reported no other breast symptoms or changes, and her family history was negative for breast cancer. Physical examination showed yellowish-pink papules coalescing into plaques at the base of both nipples. Both areolae were similarly affected, with the right areola completely encircled and the left nipple partially encircled with the papules (figure 1). The plaques were non-tender, non-pruritic and soft. No nipple discharge was present on clinical examination. No similar lesions were present elsewhere on the patient's skin, and the remainder of the physical examination was unremarkable.

INVESTIGATIONS

Sebaceous hyperplasia was suspected, but given its rarity, a 3 mm punch biopsy was obtained to provide histopathological confirmation. Histopathological evaluation (figure 2) showed ectopic sebaceous glands (Montgomery tubercles), confirming the clinical suspicion of areolar sebaceous hyperplasia. We concluded that the oily discharge in the patient's bra was sebum from the Montgomery tubercles rather than nipple discharge fluid.

TREATMENT

The treatment of areolar sebaceous hyperplasia continues to be cosmetic. In 2010, Tulbert and Brodell¹⁸ reported their experience using 100% dichloroacetic acid as a cosmetically acceptable treatment. They recommended that the condition reach a point of stability before treatment is considered.

OUTCOME AND FOLLOW-UP

The areolar plaques of the present patient seemed to stabilise about 1 year after diagnosis (figure 3), with minimal progression throughout the year. Cosmetic treatment was not pursued. The only concern was for the patient's future ability to breastfeed, due to the encroachment onto the nipple. Although sebaceous hyperplasia does not impair milk production or ductal behaviour, it could potentially affect infant latch-on. Therefore, we plan to continue monitoring for any changes and, if necessary, consult a lactation specialist to determine the anticipated impact of changes on breastfeeding.

DISCUSSION

Areolar sebaceous hyperplasia is a rare entity of unknown cause. Typically, ectopic sebaceous glands are considered asymptomatic variants of normal anatomy with no malignant potential. One case was reported in a woman with Donohue syndrome who had an ipsilateral simultaneous breast carcinoma, but no association between the breast carcinoma and the sebaceous hyperplasia was identified.¹⁹

The exact nature of areolar sebaceous hyperplasia continues to be controversial. Some authors describe hyperplasia of Montgomery tubercles¹³; others describe hyperplasia of sebaceous glands unrelated to the Montgomery tubercles.^{9 11 12} In the present case, Montgomery tubercles were observed; therefore, we agree with Fariña *et al*¹³ regarding the possible origin of this type of hyperplasia. However, cases have been reported in men,^{13 14} who according to some experts do not have Montgomery tubercles.²¹ Therefore, the nature of areolar sebaceous hyperplasia is still undefined.

Although its cause is unknown, areolar sebaceous hyperplasia is notable because in two of the reported cases, it occurred after pregnancy.^{8 17} A third case was thought to be secondary to a thermal injury to the areola during childhood.¹⁸

To the best of our knowledge, this is only the 15th reported case of areolar sebaceous hyperplasia documented in the literature, and this patient is among the youngest reported to have the condition.

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Table 1 Case reports of areolar sebaceous hyperplasia to date

Case number	Publication year	Authors and reference	Age, years	Sex	Distribution	Clinical morphological characteristics	Comments*
1	1985	Catalano and Ioannides ⁸	37	F	Bilateral	Yellow thickening	Observed after childbirth
2	1988	Sánchez Yus <i>et al</i> ⁹	59	F	Unilateral	Yellow papule	—
3	1993	Hammerton and Shrank ¹⁰	37	F	Bilateral	Yellowish-white papules	—
4	1994	Tsuji and Yamauchi ¹¹	43	F	Bilateral	Yellow papules	Presented with leukorrhoea and irregular menses
5	1996	Belinchón <i>et al</i> ¹²	42	F	Bilateral	Yellow plaque	—
6	1996	Fariña <i>et al</i> ¹³	49	M	Unilateral	Yellow thickening	—
7	2001	Kondo-Morita <i>et al</i> ¹⁴	37	M	Bilateral	Yellow thickening	—
8	2003	Krisp and Krause ⁷	52	M	Bilateral	Yellow thickening	—
9	2007	Bajaj <i>et al</i> ¹⁵	49	M	Unilateral	Yellow plaque	—
10	2007	Conde-Taboada <i>et al</i> ¹⁶	24	M	Unilateral	Yellow plaque	—
11	2008	Guillermo <i>et al</i> ¹⁷	43	F	Bilateral	Yellow plaque	Presented after childbirth
12	2010	Tulbert and Brodell ¹⁸	15	F	Unilateral	Yellow papules	Post-thermal injury
13	2012	Fernandez-Flores <i>et al</i> ¹⁹	32	F	Unilateral	Yellow, thickened plaque	Underlying ductal carcinoma, in patient with Donohue syndrome
14	2013	Errichetti <i>et al</i> ²⁰	32	M	Bilateral	Yellow plaques	—
15	2014	Present report	23	F	Bilateral	Yellow, thickened plaque	Associated with bilateral oily discharge

*En dash indicates not applicable.
F, female; M, male.

Figure 1 Areolar changes of the left breast on initial presentation.

Figure 3 Areolar changes of the left breast at 1 year after presentation.

Figure 2 Histopathological evaluation showing ectopic sebaceous glands (Montgomery tubercles).

Learning points

- Sebaceous hyperplasia is a rare, benign condition most commonly found on the central face but may appear in other anatomical locations as well.
- Sebaceous hyperplasia is not known to be associated with malignancy.
- Management of sebaceous hyperplasia is primarily cosmetic.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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