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(CASE REPORT)

A CASE REPORT OF A SCALP MULTIPLE PILAR CYSTS

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ABSTRACT

Pilar cysts, is a form of sebaceous cysts, and are mostly benign often commonly found on the scalp, back, and face. They are seen more among women and carry a very low malignant potential. These lesions arise due to the buildup of keratin in the skin pore, blocking the exit port of sebaceous gland secretions. This is a case of a 53 year-old female with a long-standing history of recurrent pilar cysts who presented to the outpatient surgical clinic for assessment of cysts for removal. A successfully surgical excision was done with no complication.

Keywords: Pilar Cyst, Scalp Region, Dermal Cysts, Female Patient, Recurrent

1 INTRODUCTION

Pilar cysts or Trichilemmal cysts are part of the sebaceous cysts family and occur in about 10% of the population and can be found anywhere on the body most commonly located on the scalp.[1,2]

These cysts are benign and very rarely become malignant. The tumor form of pilar cysts is known as proliferating trichilemmal cysts, which occur in 3% of cases [1,2]. They are firm, slow-growing dermal cysts, and are the most common skin cysts that occur when a hair follicle gets blocked by keratin and old shedding skin cells. They are lined by stratified squamous epithelium lacking a granular cell layer with the lumen filled with keratin and breakdown products.[1,2]

2 CASE PRESENTATION

A 53 years old female who presented with a 12 years history of recurrent scalp swelling that was non painful and progressively increased in size ,no associated systemic abnormalities and no family history of such swelling. Last excision was done 2 years ago and histology confirmed pilar cyst. The current mass measures 3.0 x 2.0 cm, it is longitudinal, firm, mobile and located on the left frontal area of the scalp. Baseline investigations done were essentially normal. Following this, she was worked up for surgery under local anaesthesia. Post operative periods were uneventful and the wound healed without any complication. A firm to soft grayish white mass was submitted for histopathological examination. The excised mass is partly skin covered that measure 3.5x2.5x1.5cm, soft to firm and cut surface show cystic areas with thin wall(figure 1). Histopathology examination show multiple cysts that are lined by squamous epithelial cells with no granular layers and the lumen contains eosinophilic compact keratin (see figure 2). No dysplastic nor maligant cells were seen.

Figure 1: Partly skin covered grayish white mass with cystic area.(see arrow).

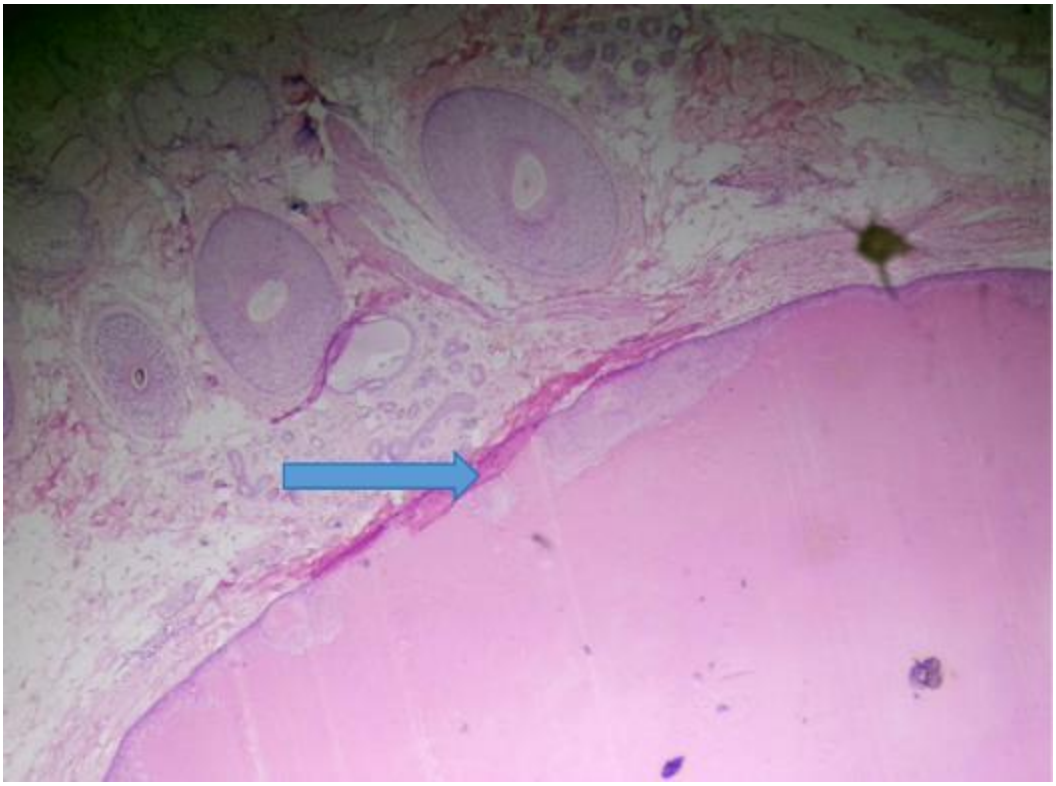

Figure 2: Cyst lined by squamous epithelial with central compact keratin(see arrow).

3 DISCUSSION

pilar or trichilemmal cysts, is a subtype of sebaceous cysts and are seen commonly especially in less than 10% of the population, primarily affecting the skin of the scalp. Their malignant potential is almost impossible. It has no racial predilection and commonly seen in young more often in women than men[1]. The presentation is sporadic or inherited as an autosomal dominant trait. Patients with a genetic predisposition to pilar cysts are often younger and often present with multiple lesions simultaneously[1]. Our patient in this study had the cyst seen on the scalp when she was in her 40s which was surgically removed. The Congenital once are linked with mutations in the phospholipase C delta one gene (PLCD1)[3]. Unfortunately, our patient did not partake in any genetic studies to determine any genetic origin.

Pilar cysts are firm, slow-growing subcutaneous nodules that take several years to develop. They are most common on the head, especially the scalp[4]. They are lined by stratified squamous epithelium lacking a granular cell layer and filled with keratin and breakdown products[4]. In our index case, she first noticed her present painless cysts in her 40s and she agreed the lesion was slowly growing with no form of complication after surgery.

The treatment of pilar cysts involves surgical excision of the cysts and the wall and this produces maximum benefit, leading to a decreased probability of recurrence[4]. Enucleated cysts generally appear as firm, smooth, white nodules as previously reported[4] and this finding is also similar to our index case. The main stay of definitive diagnosis of this lesion is histology which was done and reported in our case.

4 CONCLUSION

Cystic lesions, regardless of etiology, call for intervention, either for cosmetic reasons or for evaluation of a neoplastic process. Genetic testing for PLCD1 was not done to confirm the genetic origin but it is suspected that the pilar cysts observed in our patient are possibly non hereditary due to the time of occurrence and no family history of a similar cyst. Surgical excision and subsequent histopathological confirmation is always recommended.

STATEMENTS ON COMPLIANCE WITH ETHICAL STANDARDS

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Disclosure of conflict of interest

The authors declare no conflicts of interest regarding this manuscript.

Statement of informed consent

The authors certify that they have obtained all appropriate patient consent forms. The patient gave consent for images and other clinical information to be reported in the journal. The patient understands that names and initials will not be published and due efforts will be made to conceal their identity.

Author(s) contribution(s)

Richard Kelechi Samuel, Vinishe Yakubu Sabo, Joseph Ozovehe Bello were involved in Conceptualization, diagnosis, writing and revising the manuscript for intellectual content.

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