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SEBACEOUS CYST : AN UNUSUAL SITE OF PRESENTATION & CASE REPORT

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KEYWORDS :

INTRODUCTION

Sebaceous cysts , also known as epidermal inclusion cysts , are slow growing bumps under the skin that often occur on scalp , face , ear , trunk , back or groin area .These are benign, encapsulated subepidermal nodules filled with keratin material however 1% of these can transform into malignancies such as squamous cell carcinoma & basal cell carcinoma. The term Sebaceous cyst is a misnomer since the cyst does not involve the sebaceous glands. Sebaceous cysts are the most common cutaneous cysts and typically occur in the 3rd & 4th decades of life. These are twice as common in males as compared to females.

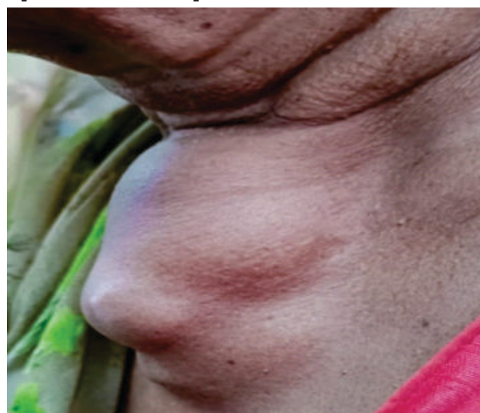
We present the case of a Sebaceous cyst diagnosed in a 60 year old female patient who presented with the complaint of a neck mass along with dyspnea and dysphagia for which she underwent excision with a satisfactory clinical outcome.

Case Presentation

A female patient in her sixties presented to the outpatient clinic of the ENT Department with the chief complaint of neck mass along with dysphagia and dyspnea. The patient was apparently well 6 months ago when she developed a midline neck mass which initially was a small swelling and gradually increased in size to reach up to the present size.

The swelling was associated with fever on and off since 3 months without chills, night sweats, rigor. The patient gave a history of pain and redness over the swelling which was pin pricking in nature and got relieved after taking medication. There was no history of any discharge, itching, trauma, insect bite on the site. There was no history of similar mass elsewhere in the body.

The patient also gave history of dyspnoea since 2 months & dysphagia since 1 month. There was no history of decreased food intake and appetite loss during this period. There was no history of bone pain and backache in the patient. The patient was non-hypertensive, non-alcoholic, non-smoker with no alteration in bowel & bladder habits. No similar complaints were reported in the family.

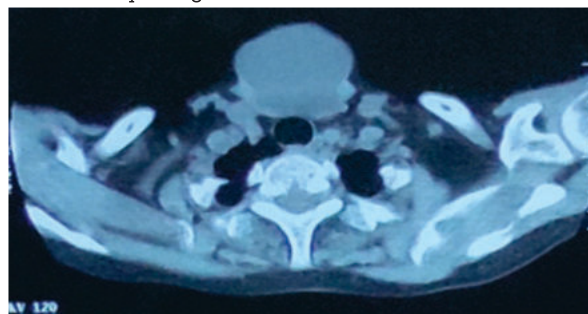


On examination, a large irregular nodular mass was present in the midline of the neck which was flesh coloured to yellowish, approximately 10x7 cm in size with irregular margins & smooth edges, tender to touch, cystic to feel, firm in consistency, non-discharging.

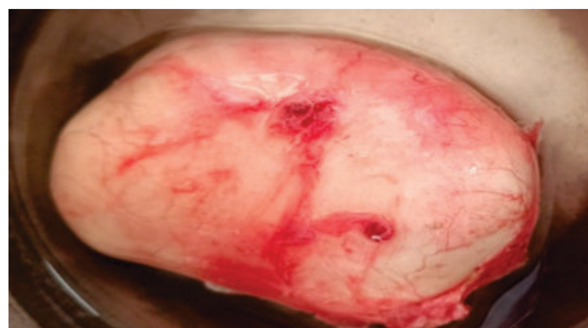
The physical examination enclosed no cervical lymphadenopathy and no goitre. The mass did not move up and down with deglutition and respiration.

Fine Needle Aspiration Cytology showed squamous epithelial debris which contained kerato-hyaline granules suggestive of sebaceous cyst.

For further evaluation, a CT-scan of neck with contrast injection was ordered. The CT scan showed a heterogeneously hypoechoic lesion in the deep sub-cutaneous plane over the neck in the midline above the supra sternal notch compressing the trachea as well as the oesophagus. The lesion showed posterior enhancement. On colour doppler, there was no internal vascularity. There was presence of inflammation of the surrounding fat as well. These findings were suggestive of infective sebaceous cyst with inflammatory changes.

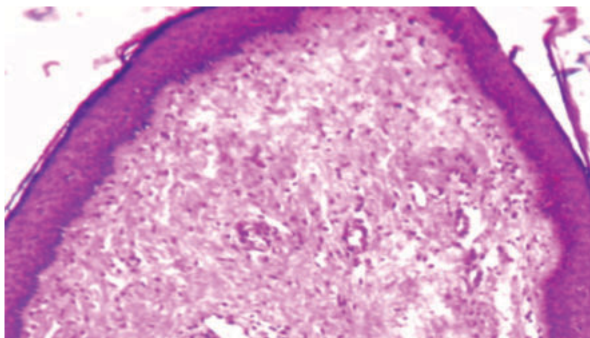


The patient underwent the surgical excision of the sebaceous cyst under general anaesthesia. An elliptical incision of small diameter was given in the neck 2 finger breadth above the supra sternal notch and sub-platysmal flap was raised. The cyst was identified and separated from the underlying structures. Excision of the cyst was hence done. Corrugated rubber drain was placed and the incision was closed with silk 3-0 non-absorbable sutures after haemostasis was achieved.



The postoperative course was uneventful. The patient received antibiotics and paracetamol along with anti-reflux medication during the course of hospital stay. Liquid and semi-solid foods were given for 3 days which were later switched to solids. Dressing & drain were removed on the post operative day2. The patient was discharged from the hospital after 5 days. Suture removal was done after 7 days of the surgery.

Histopathology confirmed the diagnosis of a sebaceous cyst which was characterized by a cystic lesion lined by cornified epithelium containing lamellated keratin without calcification or nuclear atypia along features of inflammation.



The patient presented to the ENT Outpatient clinic with chief complaints of neck mass since 6 months along with dyspnoea for 2 months and dysphagia since 1 month.

FNAC was done which showed features s/o sebaceous cyst.

Contrast enhanced CT scan of neck was done which was suggestive of sebaceous cyst with inflammatory changes.

Surgical excision of the cyst was done.

Postoperative period was uneventful.

CONCLUSION

Sebaceous cysts in the neck are rare entities which may be life threatening if associated with symptoms like dyspnea and dysphagia due to the compression of the trachea and oesophagus respectively or involvement of major blood vessel.

Although clinical manifestations are not specific, imaging techniques help set the diagnosis. However, pathology examination is crucial to rule out lymphomas. Surgical management is the treatment of choice especially when the cyst is associated with compressive symptoms.