Atypical Skin Tumor: Perianal Giant Epidermal Cyst. Case Report

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ABSTRACT

Epidermoid cysts are benign, slow-growing lesions that arise from the epidermis. They mainly affect young men and middle-aged adults. They occur more frequently on the face, neck and trunk, being atypical in the perineal region, extremities, bones and breast. We present a 45-year-old man with a 3-year evolution perianal tumor that causes discomfort in hygiene and itching. Magnetic resonance imaging shows a cystic lesion without involvement of the anal canal. Complete excision was performed. It is important to rule out other conditions such as abscesses, pilonidal cyst, and neoplasms. Complete surgical excision of these lesions, without fractures and with their capsule, is the rule to avoid recurrences.

Keywords: *Perianal Tumor; Epidermoid Cyst; Epidermal Cyst; Infundibular Cyst; Inclusion Cyst; Keratin Cyst*

INTRODUCTION

Epidermoid inclusion cysts are the most common skin cysts. They can occur anywhere on the body, most frequently the face, neck, and trunk, and are unusual in the perineal region, extremities, bones, and breast. They appear as nodules under the skin and usually have a visible central hole.[1-3]

They typically affect young and middle-aged adults, mostly men, and can occur from inflammation around the pilosebaceous follicles or from deep implantation into the epidermis due to blunt or penetrating surgery or injury.[4,5] They are usually asymptomatic, however, they can become inflamed or infected and their malignant transformation is unusual.[3,5]

CASE REPORT

A 45-year-old male patient is presented with a 3-year evolution perianal tumor that increased in size in this period and caused hygiene discomfort and itching. There is no history of surgery or trauma to the perineum. His personal history reveals only hypothyroidism. Physical examination shows a lesion located in the left anterolateral quadrant, firm, with sharp edges, mobile, not adherent to the deep planes, painless on palpation, without signs of acute complications (Fig. 1).

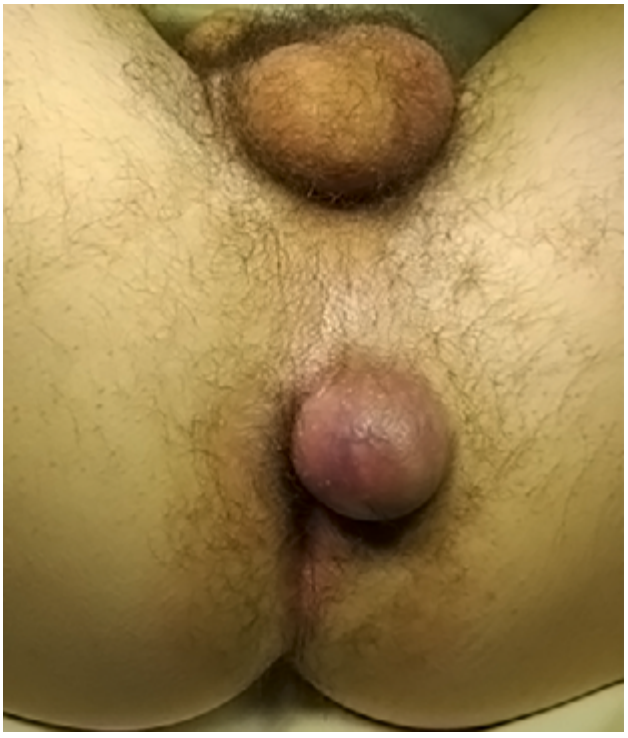

Figure 1: Lithotomy position. Lesion in the left anterior quadrant, without involvement of the anal canal.

Magnetic resonance imaging (MRI) shows a nodular, rounded image with sharp edges, with a homogeneous signal, hyperintense in T2 and intermediate in T, slightly hyperintense in diffusion, without significant restriction of ADC (Fig. 2). Makes subtle contact with the left anal margin and does not affect the anal canal. It measures 35 x 40 mm in the axial plane and 50 mm in the cephalocaudal plane. Surgical procedure: spinal anesthesia, lithotomy position, anoscopy without evidence of involvement of the anal canal, losangic incision over the lesion, dissection up to the cyst wall and ectomy. Wound closure

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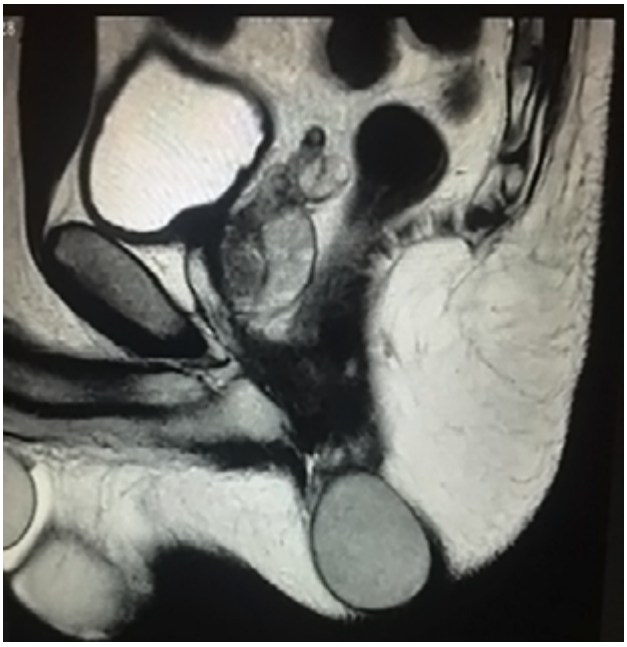

Figure 2: MRI showing a nodular, rounded, homogeneous image with sharp edges.

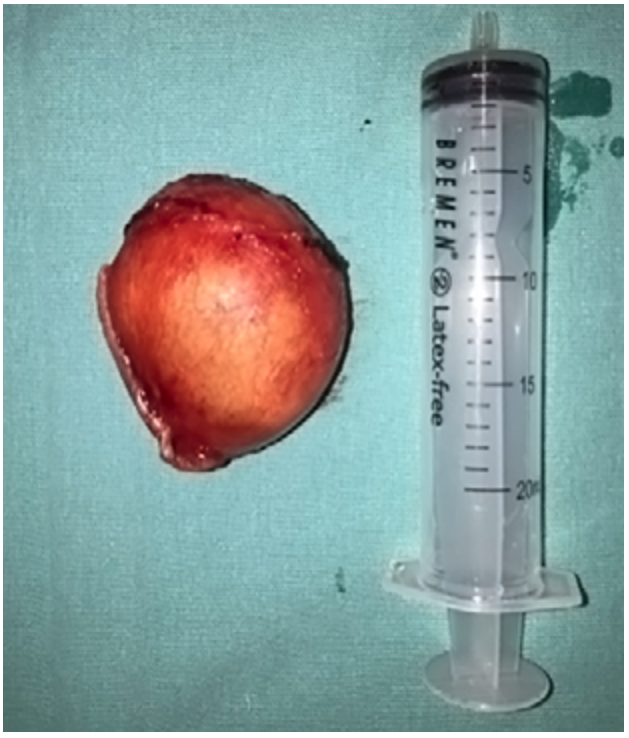

Figure 3: Excised cyst measuring 4.5 x 1.5 cm.

with partially closed technique. Hospital discharge at 24 h. Postoperative controls without evidence of recurrence. Pathological report: cystic formation measuring 4.5 x 1.5 cm compatible with an epidermoid cyst (Fig. 3).

DISCUSSION

Epidermoid cysts are benign, slow-growing lesions that arise from the epidermis. They are generated as a result of the proliferation of epidermal cells within the dermis and are lined by stratified squamous epithelium and filled with keratin.

This type of cysts does not usually have symptoms but they can cause discomfort due to their size or if they become infected. Several factors contribute to its formation, including exposure to ultraviolet light, smoking, HPV, minor trauma, and even surgical procedures such as episiotomy or fine needle biopsies. Perianal abscesses, pilonidal, ductal / glandular cysts, tailgut cysts, benign teratomas, and anal or skin tumors are differential diagnoses. MRI is the study of choice to discriminate the different soft tissue lesions and helps to establish the correct diagnosis. Epidermoid cysts typically present as well-defined lesions, hypointense on T1 and hyperintense on T2. Peripheral enhancement is more evident after contrast administration. The diffusion confirming the diagnosis shows a significant restriction. Once the diagnosis is made, the lesion must be excised with a margin of safety. The entire wall of the cyst must be removed to reduce the risk of recurrence. The prognosis for these lesions is excellent, with a recurrence rate of only 3% and a rare risk of malignant degeneration.

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