

CASE REPORT

DERMOID CYST OF EXTERNAL NOSE: A CASE REPORT

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ABSTRACT: INTRODUCTION: Dermoid cysts or Dermoid sinus tracts are congenital inclusion cysts or sinuses lined by stratified squamous epithelium with normal dermal appendages. They occur due to sequestration of skin along the lines of embryonal clefts or fissures. They may arise from vestigial epithelial lined structures. There is a gradual accumulation of epithelial debris sebaceous and sweat secretions and hairs. Commonly dermoid cyst occurs in face, neck and scalp.^[1] They can also occur in the soft palate, the tongue, the nasopharynx and the paranasal sinuses. Before the replacement of the nasofrontal fontanel by the nasal process of the frontal bone the dura and the skin are in contact without intervention of any bony structure. If any part of the ectoderm fails to separate from the dura and is carried to the prenasal space a dermoid cyst will be formed usually behind the nasal or frontal bone.^[2,3] If it retains its connection with the skin, a sinus will result. Commonly the sinus will discharge cheesy offensive material or glow abnormal hairs. Both cysts and sinuses may have a connection with an intracranial component through an abnormal foramen cecum in the anterior cranial fossa.

KEYWORDS: Genital ulcer, Lepromatous Leprosy, Immune zones, STI, Genital Examination.

CASE REPORT: A 35 years old male person presented with a small soft tissue growth arising from the left margin of nasal columella. The growth was presented from early childhood stage. Gradually it grew in size till he attained five years of age. From then its size remained almost static.

EXAMINATION: Size of growth was about ½ cm in length. It was firm in consistency and firmly attached to underlying structure. There was no pain, tenderness, bleeding on manipulation. Also there was no secretion from the growth, no transillumination, no expansion of growth with crying, valsalva manoeuvre or no compression of ipsilateral jugular vein. Only problem of the patient was bad looks.

TREATMENT: The mass was excised completely from its base under local anaesthesia and systemic analgesia. Brisk bleeding from the site of attachment was checked by chemical cauterization with Trichlor Acetic Acid. Wound was left open after applying an antibiotic-antiseptic cream. Healing took place in a normal course. More than two years have elapsed and there is no report of recurrence.^[4,5,6,7,8]

DISCUSSION: Nasal Dermoid Cyst is usually diagnosed within the first three years of life. It presents in the midline dorsum of the nose anywhere from the glabella down to the nasal tip or columella—the most common site being the lower third of the nasal bridge as a cystic mass non-tender painless swelling over the dorsum or the sides of the nose, which is freely moveable beneath the skin but is firmly attached to the deeper structure. Otherwise a sinus tract or tracts with fistula may be noted at the site of dimpling which is usually in the midline and may present protruding hairs.^[9,10]

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Microscopic picture: shows a fibrous walled cyst lined with stratified squamous epithelium and containing hair follicles, sweat glands, sebaceous glands or a keratinous sebaceous like material or any combination of these. If the cyst becomes infected pain and swelling develop with subsequent opening of the sinus tract and purulent drainage.

The infection may result in localized bone destruction due to osteomyelitis but more often the bony lesion is due to pressure necrosis from the cyst itself.

The optimal treatment for congenital dermoid cyst is complete excision. Most cases are matters of simple excision while an intracranial extension requires craniotomy. Depending on the case any of the procedure like incision and drainage, cauterization, marsupialization, amputation, curettage and the use of sclerosing agent may be required.

DIFFERENTIAL DIAGNOSIS: D/D fall into three groups of developmental errors—those of neurogenic origin—the gliomas, neurofibromas and encephaloceles, those of ectodermic origin—the pilonidal sinus and those of mesodermic origin—the hemangiomas. Other possibilities include the sebaceous cyst, lipomas, inclusion and implantation cysts, furuncles or localized abscess, meningoceles, aberrant ethmoid cells and obstruction of nasolacrimal system.

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Fig. 1: Arrow showing dermoid cyst



Fig. 2: Tissue specimen - Dermoid



Fig. 3: After treatment

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