RARE CASE OF MALIGNANT PROLIFERATING TRICHILEMMAL TUMOUR

Poorna Shetti1, Swapna Athawale2, Nikhil Talathi3, Hemant Lekawale4

12nd Year Postgraduate Resident, Department of General Surgery, SKNMC and GH, Pune, Maharashtra, India.
2Assistant Professor, Department of Plastic Surgery, SKNMC and GH, Pune, Maharashtra, India.
3Assistant Professor (Neuro Surgeon), Department of Neurosurgery, SKNMC and GH, Pune, Maharashtra, India.
4Professor (Onco Surgeon), Department of Onco Surgery, SKNMC and GH, Pune, Maharashtra, India.


PRESENTATION OF CASE

- A 45 years old female patient came with c/o non-healing ulcer over left occipital region since a year.
- She gave history of being operated thrice for nodular growth over occipital region, which recurred after two surgeries and after the third surgery she developed an ulcer.
- The three surgeries took place in 2015- Satara, May 2016- Phaltan and in Dec 2016- Phaltan.
- CT brain was done during all these surgeries, which revealed no intracranial abnormality or involvement of cranial vault.
- HPE done after surgery in May 2016 was s/o Epidermoid tumour/ infected sebaceous cyst in the subgaleal region.

Detailed Description of Ulcer

- Local Examination- An 8 x 11 x 1 cm ulcer was seen in left occipital region which was irregular in shape, covered with granulation tissue and slough.
- The ulcer edge was sloping and ulcer bed bled on touch.
- A single firm mobile non-tender cervical lymph node (Level 2) was palpable 3 x 2 x 1 cm on the left side.

DIFFERENTIAL DIAGNOSES

- Cutaneous squamous cell carcinoma.
- Sebaceous carcinoma.
- Clear cell hidradenocarcinoma.
- Cutaneous metastasis of RCC.
- Cylindroma.
- Dermoid cyst.
- Epidermal inclusion cyst.[1]

CLINICAL DIAGNOSIS

Patient underwent routine lab investigations, four quadrant biopsy of occipital lesion and MRI brain after being admitted in our hospital in Dec 2017.

- HPE of biopsy was s/o malignant proliferating trichilemmal tumour.
- MRI brain- ill-defined heterogeneously enhancing lesion in left occipital region invading underlying bone and dura.
DISCUSSION OF MANAGEMENT
Preoperative workup was done and patient was prepared for surgery and decision was taken to operate the patient by oncosurgeon, neurosurgeon and plastic surgeon.
- Firstly, oncosurgeon did WLE of occipital lesion with 2cm margin and left level 2, 3, 4, 5 neck lymph node dissection.
- Then neurosurgeon removed the involved underlying bone of approx. 6 x 5 cm and dura 2 x 1 cm.
- Then plastic surgeon harvested tensor fascia lata graft and pedicled trapezius flap 15 x 10 x 1 cm.
- The dural defect was covered with tensor fascia lata graft.
- The occipital defect was covered with trapezius flap with transverse cervicalis artery pedicle after creating a tunnel below the skin and rotating it.
- The defect which developed on the donor site of trapezius flap was covered with STSG from right thigh.
- Vascularity of trapezius flap was checked.
- Three drains were kept in the neck region, trapezius flap region and occipital region above dura.
- 4 specimens were sent for HPE-neck dissection, WLE tumour, occipital bone, dura.
- Patient was given antibiotics for 7 days and check dressing of skin graft was done on POD 5 - 100% graft take was there.
- All three drains were removed on POD 10.
- Patient complained of headache and fever on POD 15, USG revealed loculated collection of approx. 8 x 1.6 cm- IV antibiotics and acetazolamide tablets were given for the same for 5 days as advised by neurosurgeon.
- Follow-up- Patient was followed up every month. Patient had no e/o recurrence.
- Suture site was well.
- Patient had not started radiotherapy.
- Patient was counselled for radiotherapy and sent to higher centre for the same.

PATHOLOGICAL DISCUSSION
Histopathologically, WLE specimen s/o- Malignant proliferating trichilemmal tumour- all margins free of tumour.
- 3 out of 19 neck lymph nodes dissected showed tumour deposits.
- Bone and dura showed tumour deposits.
It is a chemo-resistant tumour.

It is affecting the scalp of elderly women.\[6\] It is a large, solitary, multilobulated lesion that may arise within a trichilemmal cyst (Pilar cyst). It yields lobulated and variably exophytic masses that occasionally ulcerate.\[7\]

Malignant transformation occurs occasionally, which can be manifested by sudden rapid growth. Histologically, malignant PTTs show severe nuclear atypia, marked cellular pleomorphism with atypical mitoses, dyskeratotic cells and infiltrating margins.\[8,9\]

Malignant transformation in such a tumour was introduced by Saida et al.,\[10\] who suggested three stages in the oncological development- adenomatous stage, epitheliomatous stage and carcinomatous stage.

There are two growth patterns seen in malignant proliferating trichilemmal tumour-circumscribed nodular and diffuse spindle cell type.

It is usually confused with squamous tumour-circumscribed carcinoma. It is more common in females and in older individuals 50-75 years old.

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REFERENCES