Sir,

Epidermal inclusion cysts (EICs) are the common keratin-containing benign cysts lined by the epidermis. They arise from sequestered epidermal cells in the dermis, either congenitally or from traumatic implantation. Post-traumatic EICs are rare and are found mainly on the fingers, toes, palms, and soles, the frequently traumatized sites of the body. Breast is an uncommon site for post-traumatic EIC, and only few cases have been reported to develop following the penetrating injuries in adult patients. Here, we report a case of EIC arising from nipple in a child following blunt trauma.

A 15-month-old girl presented with a painless, white, soft tissue growth from the right nipple for the past 2 months. To begin with, the lesion was lentil sized and continued to enlarge gradually until her presentation. The gradual increase in the size was the only concern of the mother. She did not report any discomfort, itching, or discharge from the growth. There was no history of similar complaints in the left breast. Mother did not give history of any kind of trauma to the breast prior to the onset of the growth. However, on detailed questioning, the mother informed that she used to squeeze the breast of child during the neonatal period to express the witch’s milk.

General physical examination was unremarkable. Cutaneous examination revealed a single well-circumscribed, pearly white, dome-shaped lesion measuring about 0.8 x 0.8 cm arising from the right nipple. The surface of the lesion appeared smooth with no umbilication [Figure 1]. On palpation, the lesion was soft, cystic, and non-tender. There was no underlying mass in the breast tissue. The contour of the areola was maintained. The left breast was completely normal. An EIC or giant milium was suspected on the basis of clinical findings. Cyst was excised under local anesthesia with complete cosmetic recovery and the specimen was sent for histopathological examination. Sectioning revealed a cystic structure containing soft foul-smelling cheesy material. Microscopic examination showed a cyst lined by stratified squamous epithelium with lamellated keratinous material in the lumen with no adnexal structure [Figures 2 and 3]. A final diagnosis of EIC was made on the basis of relatively large size (8 mm) and soft consistency of the lesion containing cheesy material with corroborative histopathological finding.

EICs are the benign keratinous cysts. They present as a smooth, soft to firm, flesh-colored, freely movable, dome-shaped dermal or subcutaneous lesion. Cysts near the surface, as in ear lobe or scrotum, appear yellowish or white. They vary in size from a few millimeters to 5 cm. Histologically, they are indistinguishable from milia, being lined by stratified squamous epithelium several layers thick with a granular cell layer and contain concentric lamellae of keratin. However, EIC do have several clinical features that differ slightly from milium. Milia are superficial, firm, pearly white, dome-shaped lesions, rarely more than 1 to 2 mm in diameter. On incision and evacuation, milium reveals typical round keratinous content, while EIC shows soft cheesy keratinous material. Thus, relatively large size, soft consistency, foul smelling cheesy keratinous contents on sectioning, and gradual continued slow...
Letters to the Editor

Figure 1: Well-defined, pearly white, dome-shaped cystic lesion arising from the right nipple

Figure 2: Histological section shows the cyst containing keratinous material arranged in laminated layers (black arrow) and is lined by stratified squamous epithelium (H and E, ×100)

Figure 3: Higher magnification showing that the cyst wall is composed of several layers of stratified squamous epithelium including the granular layer (H and E, ×250)

Although a few cases of post-traumatic EIC of the breast have been described in the literature, all of them are reported in adult patients following penetrating injuries such as reduction mammoplasty, needle aspiration biopsy, etc. To the best of our knowledge, ours is the first case of EIC arising from the nipple following the blunt trauma in a child. It is also to emphasize that both EIC and giant milium should be considered in the differential diagnosis on coming across a painless white lesion on the areola in a child.

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REFERENCES


Sir,

A 19-year-old female presented to our outpatient department with an asymptomatic, right-sided facial atrophy and alopecia involving frontal region of scalp and right eyebrow since four years [Figure 1]. Skin over the involved areas was smooth in texture, non-dyspigmented, and could be easily pinched up on palpation. In addition to this, right eye showed retraction of upper-lid margin with loss of cilia and same-sided ear pinna showed atrophy of the skin and cartilage [Figure 2]. She had a history of being operated for a congenital heart disease, i.e., Shone's complex (subaortic stenosis and coarctation of aorta and additional finding of patent ductus arteriosus, as evidenced by the transthoracic echocardiographic report of 2006) diagnosed almost 6 years back [Figure 3a and b]. Chest examination revealed sternotomy scar and cardiovascular system examination was normal. Dental examination was normal. Complete hemogram, urine analysis, antinuclear antibody were within normal limits. X-ray chest showed bilateral cervical ribs, right rib being more prominent than left and old sternal sutures. Orthopantogram X-ray, X-ray of skull, CT scan of brain, Electroencephalogram, Electrocardiogram, and Transthoracic echocardiography were normal. A punch biopsy from scalp was taken and a light microscopic evaluation of the hematoxylin and eosin (H and E)-stained histopathological slide showed atrophied epidermis, thick collagen bundles surrounding eccrine glands, and mild mononuclear cell infiltrate in reticular dermis. There was considerable loss of hair follicles and atrophy of appendages.

Our clinical and histopathological findings made us keep both Parry-Romberg syndrome and linear localized scleroderma (LSc) “en coup de sabre” as the dermatological differential diagnoses, since both these conditions tend to overlap.

Parry-Romberg Syndrome is a rare disorder characterized by progressive hemifacial atrophy of

Figure 1: Right-sided facial atrophy and alopecia involving frontal area of scalp and eyebrow. This image also shows atrophied ear pinna

Figure 2: Right eye upper lid margin is retracted with partial loss of cilia

Figure 3: Transthoracic echocardiography image showing Shone's complex, (a) Subaortic membrane (b) Coarctation of aorta
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