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Letter to Editor Open Access

Squamous Cell Carcinoma Complicated A Trichilemmal Cyst

Ouiame El Jouari*, Sara Elloudi, Rime Dassouly, Ghita Senhaji, Zakia Douhi, Hanane Baybay and Fatima Zahra Mernissi

Department of Dermatology, University Hospital Hassan II, Fez, Morocco

***Corresponding author:** Ouiame El Jouari, Department of Dermatology, University Hospital Hassan II, Fez, Morocco, Tel: 212677879830; E-mail: eljouariouiame88@gmail.com

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Letter to the Editor

Dear editor,

Trichilemmal cyst, also known as pilar cyst, is a dermal epithelial cyst developed at the expense of the hair follicle. It affects Caucasian women with a mean age of 60 years more frequently [1]. They are most often asymptomatic, localized mainly on the scalp. These tumors are often benign but local recurrences are sometimes aggressive. The risk of malignant change of trichilemmal cyst is rare. We describe an uncommon case of squamous cell carcinoma complicated a trichilemmal cyst.

A 70-years old patient with 20 years' history of painless nodular scalp lesions, progressively increasing in number and size. One of these lesions, following a 6 months' traumatism had increased in size and became ulcerated and bleeding. Clinical examination revealed a 7 cm bleeding ulcerated tumor of the vertex. As well as, several nodular lesions, firm in consistency, without any functional signs (Figure 1).

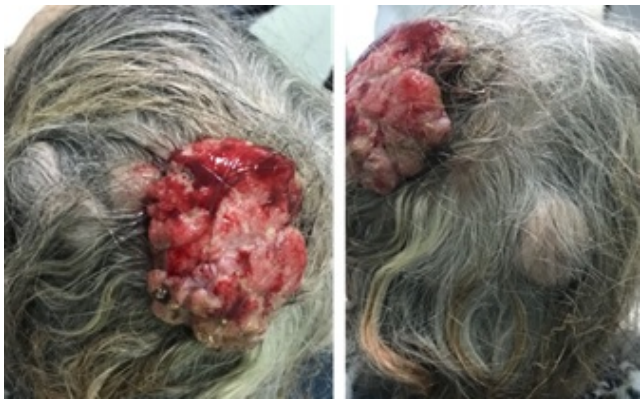

Figure 1: A 7 cm bleeding ulcerated tumor of the vertex.

No lymph nodes were noted. Dermoscopic examination showed yellowish structures, linear vessels and some rosettes (Figure 2). Cutaneous biopsy had objectified squamous cell carcinoma. Lymph node ultrasonography revealed ganglionic formations. No metastasis was identified at the CT scan. The patient was referred to department of plastic surgery for surgical treatment.

Trichilemmal Cysts (TCs) are benign, keratin-filled skin neoplasms that arise from the outer root sheath of the hair follicles [1]. These cysts are rare but morphologically distinctive tumor [2]. They affect 5% to 10% of the population, show a female predominance, and may have an autosomal dominant pattern of inheritance or occur sporadically [3]. TCs most frequently appear in areas with dense hair follicles.

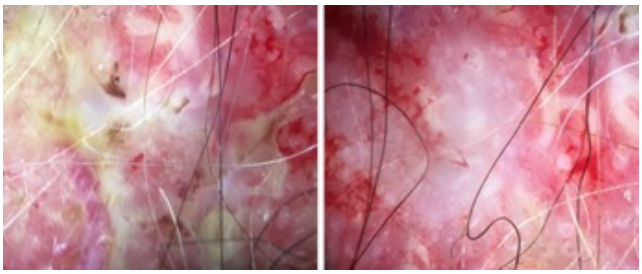

Figure 2: Dermoscopy showing yellowish structures, linear vessels and rosettes.

Hence, the scalp being involved in more than 90% of cases, whereas the face, trunk, groin, and extremities are less frequently affected [1,3]. The main complications of trichilemmal cysts are infection and ulceration. They are often described as benign; however, malignant transformation has also been reported [4]. This transformation most often occurs on a pre-existing trichilemmal cyst for several months or years, owing to subsequent inflammation or trauma, as was the case for our patient. The complete loss of p53 tumor suppressor gene activity is believed to be responsible for transformation [1]. The reported degeneration is to malignant proliferating trichilemmal tumors [3]. To our knowledge, we describe the second case of squamous cell carcinoma on trichilemmal cyst. Clinically, these tumors are painless, well limited, sometimes ulcerated. Macroscopically, they are whitish of variable size, polylobed, solid and of firm consistency. The criteria for malignancy of trichelemmal cysts are poorly defined but some authors consider that the infiltration of the stroma, the presence of metastasis, a high mitotic activity with abnormal mitoses, a marked nuclear pleomorphism and the presence of necrosis are elements in favor of malignancy [4]. Malignant degeneration may result in direct invasion to adjacent tissues and distant metastasis [3]. Management remains empirical and relies on surgical excision with a lateral margin of 1 cm. The microsurgery of Mohs would be a good indication. Radiation therapy and chemotherapy may be offered as adjuvant or palliative therapy [5]. In our patient, given the negative extension assessment, surgical excision was indicated.

The transformation of trichilemmal cyst should be suspected and meticulously diagnosed and treated in all individuals presenting alert symptoms such as chronic ulceration.

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