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Spinal Epidermoid in a Child: A Case Report

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Description

Spinal epidermoids are rare, and encompass less than 1% of the lesions seen in the spine. They are seen frequently in association with dysraphism, sinuses and other congenital anomaly of the spine. Aquired epidermoids are seen in conjuncture with repeated lumbar punctures and trauma. The presence of an epidermoid without any of the above mentioned associated lesions or trauma is very rare. We present a case of a de novo epidermoid of the dorsal spine without dysraphism, trauma or syndromic association which was successfully identified and removed surgically with no deficits for the patient. We present a review of relevant literature along with this case report.

A One year old female child presented to the outpatient clinic with a brownish discoloured skin patch on the back with a slight swelling observed since birth. The child had no deficits and was healthy, feeding and playing well. On consultation with a General Practitioner (GP) in West Bengal (where the parents hailed from), they were told about possible underlying spine deformities that could exist. Hence they came to us for treatment. On examination, no other neurocutaneous markers were seen. There were no deficits, or deformities perceptible. No evidence of dysraphism existed. On Imaging of the child's neuroaxis using a Magnetic Resonance Imaging (MRI), an intradural extramedullary lesion was detected at the level of D10 posterior to the cord. The histopathological examination of the specimen revealed it to be an epidermoid cyst. Histologically, epidermoid and dermoid cysts are lined by stratified squamous epithelium supported by an outer layer of collagenous tissue, progressive desquamation of keratin from epithelial lining toward the interior of the cyst which produces soft white material. Differentiation between the two forms is based on the presence of skin adnexa and adipose tissue presence in the wall of dermoid cyst, which is absent in the epidermoid. As this differentiation is clearly made Immuno-histochemistry (IHC) confirmation was deemed unnecessary by the pathologist. Cyst wall lined by atrophic stratified squamous epithelium, lumen filled with lamellated keratin material. No skin appendages are seen. (H&E 20X) The child continues to be on regular follow up every 6 months and has made a complete recovery devoid of deficiets or other complications associated with such maladies.

Among the spinal epidermoids the thoracic region is the commonest site of occurrence, followed by the sacral and cervical regions. Epidermoids may extend into the spinal canal or laterally through

The neural foramina. They may extend ventrally as well, breaching the anterior or posterior vertebral body. Urinary dysfunction with or without back pain may be the presenting symptom. Others may present with cutaneous manifestations of spinal dysraphism or meningitis, as was in our case.MRI is the imaging methodology of decision for the finding of Spinal Epidermoids. The tumor is traditionally a nonenhancing injury of "cerebrospinal liquid force" that is isointense on T1-weighted successions and hyperintense on T2-weighted arrangements. Inconsistency in the force qualities happen because of differing lipid also, protein parts. Irregularities in vertebral bodies or back components might be apparent in long-standing sores. DW imaging shows limited dispersion, for example, in ECs somewhere else, and might be of advantage while assessing a cystic sacral sore. Spinal epidermoids are uncommon and progress along a favorable course. As in most of CNS tumors, manifestations auxiliary to pressure impacts show regularly. The presence of factors such as dysraphim, syndromic predeliction and trauma must be taken into account, when considering such a diagnosis. Imaging remains extremely important to the diagnosis and follow up of patients. Surgical excision remains the best and perhaps only satisfactory treatment modality. Complete excision is curative and offers the prospect of a disease free life devoid of deficiets if done well.

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