

1 COMMUNICATIONS AND BRIEF REPORTS

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3 **Hourglass Epidermoid Inclusion Cyst: An Unusual**
4 **Clinical Presentation**

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8 *The authors have indicated no significant interest with commercial supporters.*

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14 **A**lthough hourglass epidermoid inclusion cysts
15 have been reported in the cranial region, they
16 have not been reported elsewhere in the body. We
17 report a case of an epidermoid inclusion cyst that
18 was excised completely.

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21 **Case Report**

22 An obese 60-year-old woman presented with a
23 2-year history of a slowly enlarging, painless lump in
24 the hip region. On examination, it was found to be a
25 typical sebaceous cyst, 2.5 cm in diameter, attached
26 to the skin with a punctum at the apex over the
27 greater trochanter laterally. There was no sign of
28 scarring or inflammation.

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30 Under local anesthesia (1% lidocaine with epineph-
31 rine), an elliptical incision including the punctum
32 was made. The dissection was uneventful, with the
33 plane around the cyst well defined and with no ob-
34 vious fibrous tissue. On reaching around the deep
35 surface of the cyst, there appeared to be tethering.
36 Careful dissection and exposure revealed that the
37 cyst continued on, beyond a narrow neck, to another
38 "lobe" that was approximateoy the same size as the
39 superficial portion (Figure 1). The cyst was removed
40 completely. On cut section, the two portions, each
41 2.5 cm in diameter were in communication through a
42 neck 2 mm in diameter (Figure 2).

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Discussion

Epidermoid inclusion cysts do not always need sur-
gical treatment but are commonly excised for cos-
metic reasons and complications. Surgical
approaches are of two categories: traditional wide
excision and minimal excision with punch biopsy.¹
Although minimal excision has been advocated, it is
unclear whether this technique is useful for larger
cysts and prevents recurrence.²

There have been no randomized controlled trials
published that compare the most common surgical
techniques for treatment of sebaceous cysts. Only
one small randomized study involving 60 patients
compared traditional wide excision with punch bi-
opsy.³ Although this study found punch biopsy to be
less time consuming and capable of offering a supe-
rior cosmetic result, it is doubtful that larger cysts
could be removed using this technique.

There have been two reports of hourglass epider-
moid cysts in the cranial cavity, but there is no report
of this anatomical variation in other parts of the
body.^{4,5}

In sebaceous cyst surgery, the cyst may rupture, and
later recurrence is possible. If the assumption is made
that the deep surface of a sebaceous cyst is a smooth

Colour



Figure 1. Gross appearance of the “hourglass” sebaceous cyst.

convexity, blunt dissection of this area could result in rupture and recurrence if the cyst has an hourglass deformity. This abnormality could be difficult to recognize if the field of dissection is bloody, the incision too small, or the lighting inadequate—conditions that often apply, because this procedure is usually regarded as minor and may be performed in less-than-ideal settings and by junior or inexperienced staff.

Colour



Figure 2. Hourglass sebaceous cyst after being cut open.

In this case, there was no scarring, fibrosis, or abnormality of any part of the cyst wall or surrounding tissues, but the wall of a sebaceous cyst varies in thickness. Because this cyst was near the greater trochanter in an obese patient, one could postulate that sustained, repeated pressure from sitting, could produce a small “diverticulum” at the weakest point in the cyst wall. This might then enlarge progressively as the sebum accumulates, producing an hourglass appearance.

If this is true, it may offer a simple anatomical explanation for the common occurrences of rupture at surgery and recurrence thereafter if an hourglass deformity or a much smaller “diverticulum” projects from the otherwise smooth sphere of a sebaceous cyst, resulting in incomplete excision.

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