CASE REPORT

ADULT WOMAN WITH INTRA-ORAL EPIDERMOID CYST

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Epidermoid cyst is a rare, slow growing lesion of head and neck region. Its rarest site of presentation is intra-oral. It presents later in life, while taking its time to grow to a significant size, causing other complaints as dyspnoea and dysphagia. We present here a case report of epidermoid cyst at a very rare and unexpected site of presentation. Patient presented in ENT OPD with complaints of large intra-oral midline swelling and associated complaints of dyspnoea and dysphagia. Patient was admitted and operated upon with intra-oral approach, producing good results. It should be kept in mind as one of the differential diagnoses when dealing with long standing intra-oral swellings.

Keywords: Epidermoid Cyst, Mouth Floor, Congenital, Histology

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INTRODUCTION

Epidermoid cyst in intra-oral presentation is a rare condition. Its presentation in 2nd and 3rd decade of life is frequent. It may also be found with its histologically neighbouring types of dermoid and teratoma. They are congenital lesions but their presentation late in life shows slow growth pattern. Typical case pattern is a painless midline swelling with a long standing history and no other associated symptoms. They are easily diagnosed on ultrasonography and CT-Scan but final diagnosis still lies upon histopathology.

CASE SUMMARY

Our patient, a 21-year-old woman presented with a midline swelling in neck and oral cavity for past 5 years. She presented with her complaint of dysphagia for the past 6–7 months. There were no other complaints of generalised weight loss or pain in the swelling. The swelling increased in size very slowly over past 5 years. Swelling neither moved on swallowing nor came out on protrusion of tongue. Examination of swelling revealed a 5×6 Cm lump in the midline floor of mouth. It was fluctuant, well demarcated, and bimanually palpable. Patient was subjected to all preoperative evaluation and investigations required for General Anaesthesia. Patient had been visiting other clinics before presenting to us so she already had her MRI-Scan done with and without contrast. (Figure-1, 2)

Our preoperative differential diagnosis was between dermoid and epidermoid cyst. She was operated for the swelling by intraoral approach. The whole cyst was removed with capsule intact and space closed by primary closure. In postoperative period patient was subjected to mouth wash and antibiotic cover. Her stay in the hospital was weeklong with serial follow-up visits of 1 week for 1 month, then at 3 months, 6 months, and 1 year after discharge. There was no recurrence observed during the follow-up.

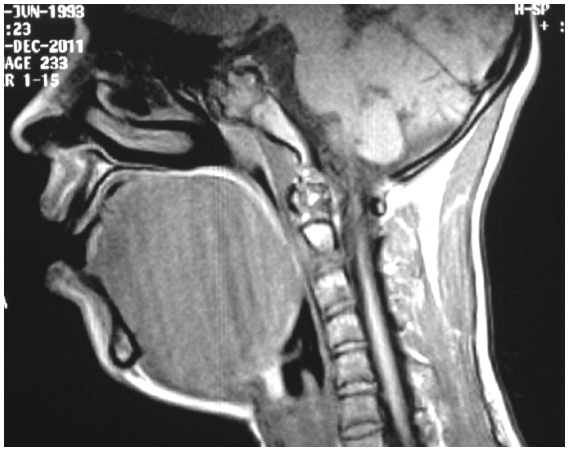

Figure-1: MRI (T1-weighted) showing intraoral mass

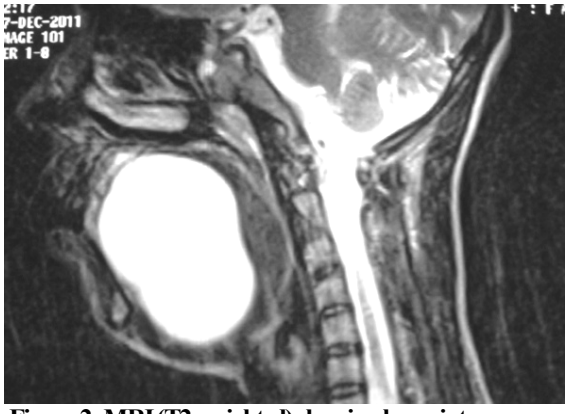

Figure-2: MRI (T2-weighted) showing hyperintense mass

DISCUSSION

Dermoid cyst in human body encompasses in itself a group of different defects histologically differentiated from each other. It occurs due to failure of fusion of ectoderm from underlying tissue with patches of ectoderm still enclosed inside the underlying tissue, eventually transforming into cyst over years. It consists of 3 histological types depending upon which portion of ectodermal tissue gets entrapped. Their types are

dermoid cyst (consisting dermis with all skin appendages), epidermoides cyst (containing only epidermis with keratinizing squamous epithelium), and teratomas. These cysts are really rare to be found in oral cavity with reported incidence of 1.6% out of their presence all over the body.[1,2] Other major locations of these cysts in the body include ovarian and sacral regions (80%) with head and neck sharing only 7%.[2] They are congenital in origin but mostly present very late in life (mostly 2nd and 3rd decades).[3,4] It can be explained by their slow rate of growth. Most of the patient present when the swelling is significantly large enough to hinder important functions like articulation and speech, deglutition, swallowing and chewing. They may also present with serious complains like dyspnoea and dysphonia as it pushes the tongue upwards and backwards pressing upon airway opening.[4] Later clinical presentation with few patients presenting with cosmetic concern is due to the fact that it causes minimal external cosmetic disfigurement.

It is very easy to suspect it clinically as in given time it grows to large enough size which avoids being missed on presentation for the first time. Any history of growth of less than 3 weeks indicates a self-limiting infectious process.[5] Diagnosis lies at FNAC preoperatively. CT scan is other non-invasive test of choice as it is fluid filled cyst but its better use lies for pre-operative planning of operative technique.

Extra- and intra-oral approach for surgery both can be used for excision of cyst with extra oral technique being easier of two but intra oral technique having an advantage of better cosmesis. One thing which must be taken care of regardless of the technique being used is to take the whole cyst out as a whole to avoid spillage of its contents. Its contents do not pose any serious complications but are irritant to the surrounding tissue and may present postoperatively with inflammation and delayed healing of the wound.[6] Malignant transformation of epidermoid cyst has been reported in up to 5% cases in one study.[7]

CONCLUSION

Epidermoid cyst, or any dermoid cyst for that matter, is a rare condition in head and neck especially intra-oral presentation. They are easily picked on presentation with easy diagnosis and treatment options.

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