Egyptian Dermatology Online Journal
Volume 10 Number 1

Recurrent giant apocrine hidrocystoma of the eyelid: A case report

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Egyptian Dermatology Online Journal 10 (1): 10, June 2014

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Abstract

Apocrine hidrocystomas are small, asymptomatic, benign cysts commonly found in face. These tumors when in the region of the eyelids can cause significant functional and cosmetic morbidity despite their benign nature. Various modalities of treatment for such lesions have been enumerated in the literature. Here, we are describing a case of giant solitary recurrent apocrine hidrocystoma which is being managed by en-bloc excision with reconstruction of lower eyelid.

Introduction

Apocrine hidrocystomas are benign cysts that originate from the apocrine secretory glands of Moll. They are commonly located in head and neck region.[1] They can be eccrine or apocrine in origin with varying diameters.Tumours more than 20 mm are called giant apocrine hidrocystomas.[2] To the best of our knowledge only six case reports exist that describe giant hidrocystomas occurring on the face.[1,3,4,5] Laktaoui et al. has reported large apocrine cyst on the eyelid measuring 20mm.[4] We present a case of giant solitary recurrent apocrine hidrocystoma of 30mm in size located over right lower eyelid causing cosmetic and functional morbidity. We emphasize the importance and need for complete excision of such lesions either by complete cyst wall removal or en bloc excision to lower the risk of recurrence.

Case History

A 46 year old male patient presented with swelling over the right lower lid since two years hindering his visual field and causing unsightly lid appearance **(Figure 1)**. There was no history of impaired vision, diplopia, watering of eyes or prior trauma. His past history revealed similar kind of swelling at the same site for which he was operated twice. On examination there is a solitary swelling of 3x2 cm occupying lateral 2/3rd of right lower lid involving skin and conjunctiva, hard in consistency, with no skin changes. Ocular mobility was full. Ophthalmic

examination was otherwise normal. The lesion was excised en-bloc and reconstruction of the lower eyelid with cheek rotation flap was done under general anesthesia. The wound healed well with satisfactory restoration of cosmetic appearance and full restoration of his visual field **(Figure 2)**. Histopathology section revealed multiple cystic spaces of varying sizes with papillary projections. Occasional cysts show columnar secretary cells with decapitation secretion and some double layered epithelium. The features were consistent with apocrine hidrocystoma with no evidence of malignant change **(Figure 3)**. Sutures were removed on tenth post operative day. The patient was followed up to 5 years and there was no recurrence.

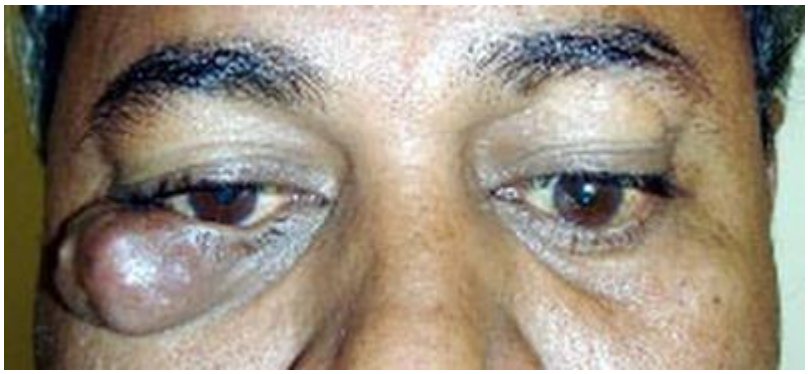

Fig 1: Solitary swelling occupying lateral aspect of right lower eyelid

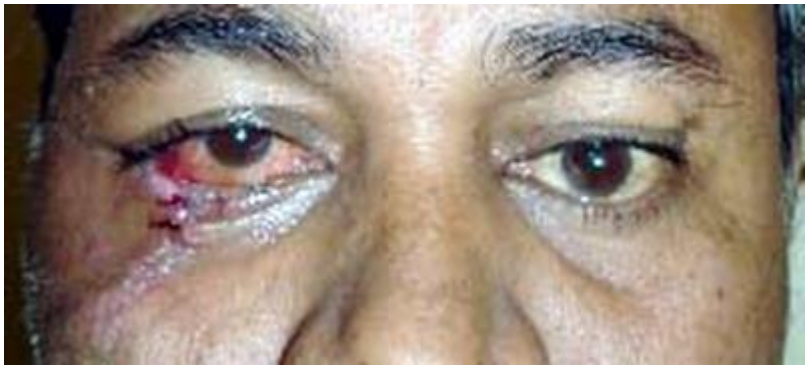

Fig 2: Post operative photograph after en-block excision of the swelling and reconstruction of lower lid

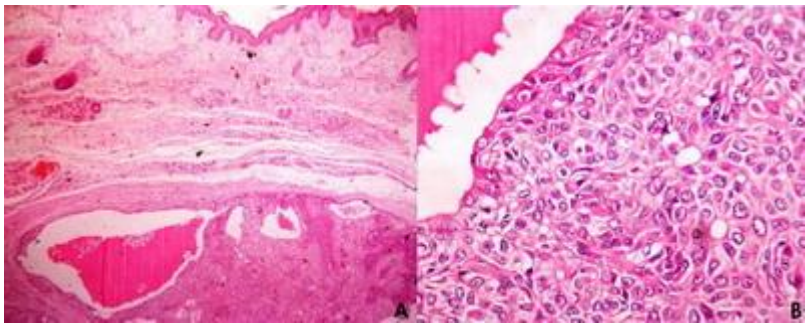

Fig 3: Histopathological section of the mass
a. low power view showing multiple cystic spaces with decapitation secretion in the lumen (H & E,10X)
b. High power view showing cyst lined by epithelial cells. (H & E, 40X)

Discussion

Hidrocystomas, or sudoriferous cysts, are benign adnexal sweat gland tumors. They occur as single or multiple lesions, found especially over the eyelid but other locations like scalp, chest, palms and penis have also been described.[1] Apocrine hidrocystomas are characteristically asymptomatic with a diameter of 3 to 15 mm.[6] According to the literature, out of six cases of giant apocrine hidrocystomas that have been reported over the face, four were involving only the eyelids,[3,5] one involved the internal canthus[4] and one was located in intra orbital[1] region. Ssi-Yan-Kai and Pearson have described a similar case of recurrent giant apocrine hidrocystoma but located in the orbit.[1]

Eccrine and apocrine hidrocystomas may have similar clinical appearances. However, the apocrine type can involve lower eyelid margins and tends to produce oily, foamy secretions whereas eccrine type does not involve eyelid margins and secretions are watery. Histopathologically, apocrine hidrocystomas demonstrate multiple cystic spaces, papillary projections and an outer wall of myoepithelial cells, in contrast to eccrine hidrocystomas which have a single cystic cavity, no papillary projections and is lined by one or two layers of cuboidal epithelial cells.[3]

Clinically they simulate haemangioma, epithelial inclusion cysts, lymphangiomas, molluscum contagiosum and atypical basal cell carcinomas.[5]

Spontaneous resolution is rare and successful management is by excision with complete cyst wall removal.[5] Medical treatment advocated for multiple smaller lesions are laser thermo-ablation, curettage, trichloroaceticacid, chemical ablation, and botulinum toxin whereas surgical treatment involves complete excision of cyst wall in order to avoid recurrence.[3]

In the present case recurrence could be due to lack of complete excision of the cyst or failure to remove the entire capsule. We have opted for en-bloc excision because of its recurrence and size. Surgical en- bloc excision has been described for multiple eyelid apocrine hidrocystomas.[7]

The present case illustrates that giant ocular adnexal apocrine hidrocystoma can cause significant functional and cosmetic disfigurement despite their histologically benign

nature.Apocrine hidrocystomas should be considered in the differential diagnosis of eyelid mass lesions. Surgical en- bloc excision of solitary lesion can be considered in cases of recurrent giant apocrine hidrocystoma to reduce recurrence. In spite of our extensive literature search in pubmed, we were unable to find similar case in Indian literature so, the present case has been reported for its rarity and size.

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