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CASE REPORT

A Rare Case of Midline Dermoid Cyst of the Upper Lip: Case Report

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***ABSTRACT*:**
Dermoid cysts usually occur in patients at their second or third decade of life. Clinically, the lesion presents as a slow-growing asymptomatic mass, usually located in the midline. Because they are almost always asymptomatic, dermoid cysts are usually diagnosed only after they have reached a considerable size. A 55 year old male patient reported to the department of oral and maxillofacial surgery with a complaint of a conspicuous swelling in upper lip mucosa since 3 months. Circumferential incision was made, layer wise dissection done, and lesion was excised.
Key words: Dermoid cyst, excision, midline, upper lip.

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INTRODUCTION:

Dermoid cysts are cystic malformations lined with squamous epithelium; they constitute 1.6% to 6.9% of all cysts in the head and neck area. Histologically, they can be further classified as epidermoid (lined with simple squamous epithelium), dermoid (when skin adnexa are found in the cyst wall) or teratoid (when other tissues, such as muscle, cartilage and bone are present).[1]

These cysts occur most often in patients in their second or third decade of life. Clinically, the lesion presents as a slow-growing asymptomatic mass, usually located in the midline. Because they are almost always asymptomatic, dermoid cysts are usually diagnosed only after they have reached a considerable size. Recommended treatment is surgical excision via intraoral or extra oral access, depending on the lesion's size and location

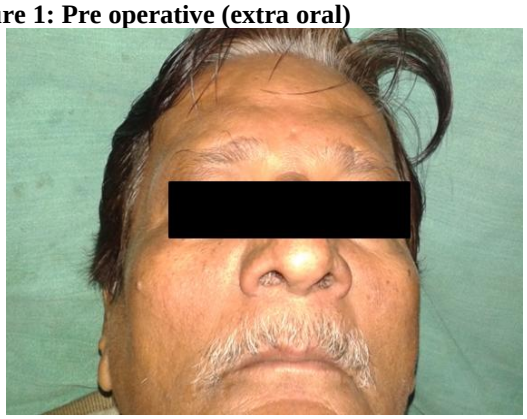
CASE REPORT:

A 55 year old male reported in dept of oral and maxillofacial surgery with a complaint of a conspicuous swelling in upper lip mucosa since 3 months (Figure 1). According to patient he was alright 3 months back when he first observed a tiny swelling in the concerned region, it gradually increased in size. Patient has no history of trauma or swelling in the same or other region of face previously.

Patient had no history of any kind of systemic disease like hypertension, thyroid, diabetes, malignancy or any neuronal disorder. Patient had no history of tobacco chewing or any sort of smoking or alcohol consumption. Patient was edentulous and was wearing the existing denture since last 8 years and did not have any complaint

regarding its fitting of its borders irritating the mucosa or vestibule.

Figure 1: Pre operative (extra oral)



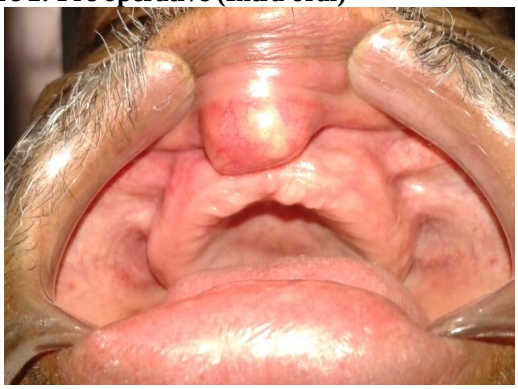
Examination:

On Extra oral Examination:

1) No significant elevation of upper lip or change in skin.
2) no sinus tract opening or discharge and no ulceration.
3) No signs of any regional involvement or extension into surrounding structures and no nerve involvement.
4) On palpation it was non tender, firm, no raised temperature and was well circumscribed.

On Intra Oral Examination: (Figure 2)
1) Swelling of 10 X 4 mm was present at upper lip mucosa with anterior border 3mm away from anterior mucosa boundary of upper lip, and posterior extension approximately 3 mm away from labial frenulum.
2) No discharge, or any signs of ulceration, on palpation swelling was firm, non fluctuant, fixed with intact mucosa. No signs of sinus involvement or any associated anomalies.

Figure 2: Pre operative (Intra oral)

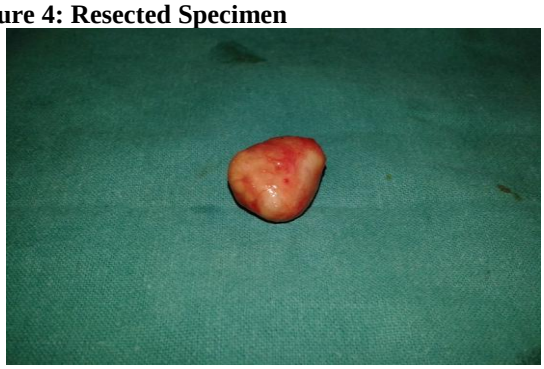


Treatment:
Provisional diagnosis of Irritation Fibroma was made and patient was planned for excision (Figure 3) of lesion under local anesthesia.

Figure 3: Intra operative

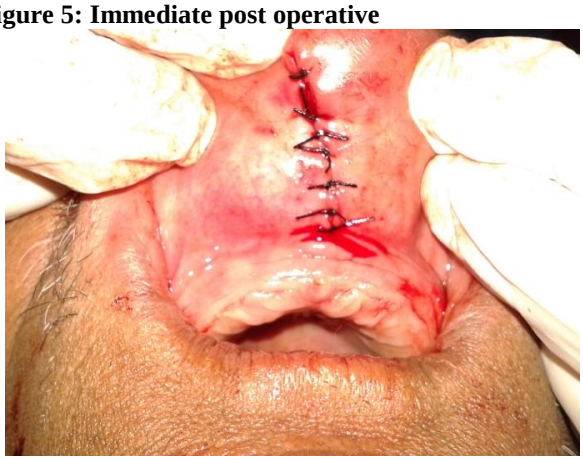
Lesion was locally infiltrated with 2 % lignocaine with adrenalin. Circumferential incision was made, layer wise dissection done and lesion was excised (Figure 4) and sent for histopathological examination.

Figure 4: Resected Specimen



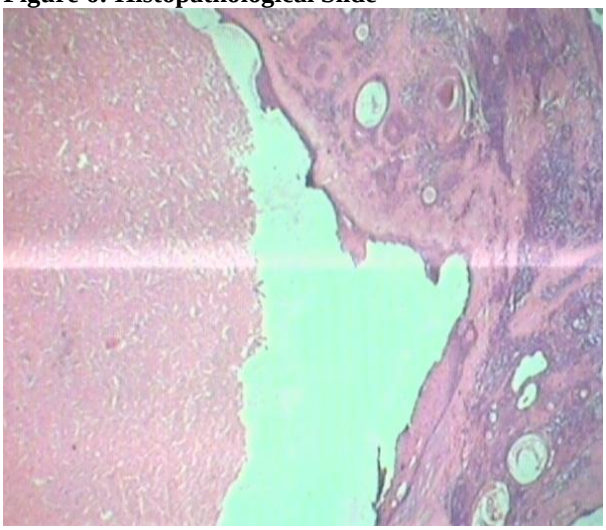
Layer wise closure was done (Figure 5). Patient was prescribed oral antibiotics and recalled after 1 week for review.

Figure 5: Immediate post operative



Histopathological report:
Slide obtained with H and E revealed the presence of cystic epithelium covering the lumen which is extensively filled with keratin. The lining is showing papillary proliferation in the cystic wall (Figure 6).

Figure 6: Histopathological Slide



The stroma showing the cystic lining has the presence of appendages like hair follicles and sebaceous tissue with mild chronic inflammatory infiltrate is noted in it. Its overall features suggestive of "dermoid cyst".

DISCUSSION:
The presentation of a midline dermoid cyst should prompt the physician to investigate not only for sinus extension but also for associated congenital anomilies.[2] Data regarding the incidence and correlation of midline dermoids with other anomalies are rare, with no clear association with a specific syndrome. A case study of 36 patients with dermoids by Deyonelle et al., however, found that 3 of the 36 patients had cysts presenting in conjunction with anomalies such as bilateral aural atresia, bilateral pinna abnormalities, or nasal cavity agenesia.[3]

Treatment of dermoid cysts requires complete surgical excision of the cyst and sinus tract. Any remaining dermoid neuroectodermal, or epithelial tissue after surgery represents incomplete resection. McCaffrey et al. concluded that of 21 patients with dermoid cysts, 15 with complete excision as determined at the time of surgery had a recurrence rate of 7 % comparatively, three cases of irrigation and debridement as well as three cases of incomplete resection resulted in a 100% recurrence rate.[4] Although dermoid cysts are benign lesion, incomplete resection increases surgical complication of recurrence, infection, decreased cosmesis, and possible malignant transformation.[5]

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