

A SOLITARY TRICHOEPITHELIOMA ON UPPER LIP – A CASE REPORT

**Dr. Mahendranath P^{1*}, Dr. Prathiba A², Dr. Vidhya Subramanian²,
Dr. Dinisha Einstien² and Dr. Sucharita Murugesan³**

^{1*}Associate Professor, Department of Pathology, ACS Medical College and Hospital,
Chennai.

²Assistant Professor, Department of Pathology, ACS Medical College and Hospital, Chennai.

³Professor, Department of Pathology, ACS Medical College and Hospital, Chennai.

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*Corresponding Author

Dr. Mahendranath P

Associate Professor,
Department of Pathology,
ACS Medical College and
Hospital, Chennai.

ABSTRACT

Trichoepithelioma is a benign adnexal neoplasm, commonly seen in the scalp, nose, forehead and upper lip. The objective of this paper is to present a case of solitary trichoepithelioma on the upper lip, histological examination and treatment. Because of its close resemblance to basal cell carcinoma, the differential diagnosis should

be considered.

KEYWORDS: Trichoepithelioma, Benign adnexal neoplasm, Basal cell carcinoma.

INTRODUCTION

Trichoepithelioma is a benign adnexal neoplasm, occurring either as multiple or solitary lesion. Multiple trichoepitheliomas are inherited as autosomal dominant traits. ^[1] Solitary trichoepithelioma is not inherited and occurs more commonly than multiple trichoepitheliomas. ^[2] Solitary lesions with relatively little differentiation towards hair structure can be classified as keratotic Basal cell carcinoma. The difficulty of differentiating multiple trichoepitheliomas from Keratotic Basal cell carcinoma on histologic grounds has been pointed out and the need for clinical data has been stressed by various studies.

CASE REPORT

A 55 year old male presented with a slow growing painless swelling on the upper lip for 2 year duration. There was no family history of similar lesions. Local examination revealed a greyish nodular swelling of 1.5x1.5cm in dimension. The swelling was firm, non tender and immobile. No enlarged lymph nodes were palpated in the neck region. The general and systemic examinations were normal. Local excision of the lesion was done and the defect was reconstructed. The surgically resected specimen was sent for histopathological examination. Specimen was processed and paraffin sections stained with Hematoxylin and eosin stains. Microscopic pictures showed multiple horn cysts and tumor cells arranged in islands and nests having peripheral palisading of nuclei and the tumour nests were separated by thick and thin fibrous stroma.

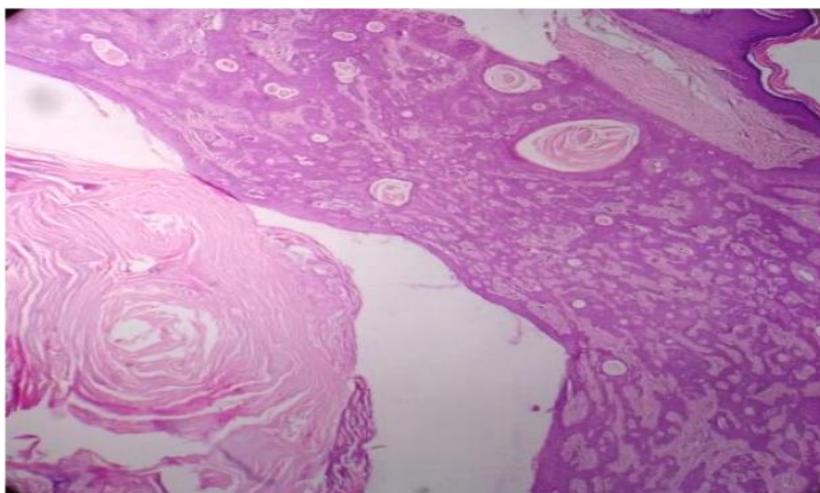


Figure 1: Tumour cells arranged in Nests and showing numerous horn cysts.

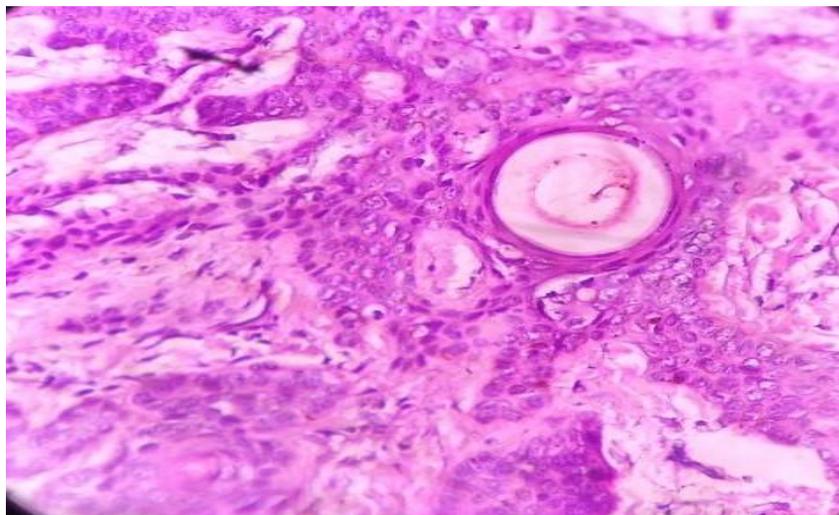


Figure 2: High power view of the tumour nests.

DISCUSSION

Trichoepitheliomas are benign adnexal neoplasms commonly seen in the scalp, forehead, nose and upper lip. They occur as firm elevated flesh coloured nodule and the diameter is rarely more than 2 to 3 cm.^[3] Trichoepithelioma was first described by Brooke as epithelioma adenoides cysticum, in 1892.^[4] As reported in studies published previously, there are three forms of Trichoepithelioma: solitary, multiple and desmoplastic.^[5] Solitary trichoepithelioma often has a high degree of differentiation towards hair structure. Solitary lesions with relatively little differentiation towards hair structure can be classified as keratotic Basal cell carcinoma. If a lesion is to be classified as solitary trichoepithelioma it should contain numerous horn cysts and abortive hair papillae and show only few areas with appearance of Basal cell carcinoma.^[6] Diagnosis may be assisted in a given case, by clinical data, such as the number and distribution of the lesions and presence of hereditary transmission. In addition certain histologic features, as well as immuno histochemical stains can assist in differentiating the two. The presence of well formed horn cysts, Papillary mesenchymal bodies, lack of high grade atypia and mitosis favor the diagnosis of trichoepithelioma.^[7] Histologic features that favour Basal cell carcinoma include the presence of myxoid stroma and stromal reaction (or) clefting around the basaloid islands.^[8] Focal positive CD 34 staining of fibroblastic stroma has been shown in trichoepithelioma, whereas in Basal cell carcinoma, this staining is not present.^[9] Immuno histochemistry for CD 10 may be helpful in differentiating trichoepithelioma from Basal cell carcinoma.^[10] There have been few cases of Basal Cell Carcinoma arising in the setting of multiple trichoepitheliomas.^[11,12,13] The distinction between BCC and trichoepithelioma is of clinical importance, since conventionally a BCC should be excised with a 3 to 4 mm margin of healthy tissue,^[14] whilst trichoepithelioma may only require shave biopsy or minimal resection.^[15]

CONCLUSION

Trichoepitheliomas have close resemblance to Basal cell carcinomas and sometimes it is very difficult to distinguish between the two. In such cases clinical data and immunohistochemistry for CD34 and CD10 may be helpful to arrive at a diagnosis.

CONFLICT OF INTEREST: None declared.

REFERENCES

1. Gaul LE. Heridity of multiple benign cystic epithelioma. Arch Dermatol Syph 1953; 68: 517.
2. Gray HR, Helwig.EB. Epithilioma adenoid cysticum and Solitary trichepithelioma. Arch Dermatol., 1963; 87: 102.
3. Filho GB, Toppa NH, Miranda D, Matos MP, Silva AL. Giant solitary trichoepithelioma. Arch Dermatol., 1984; 120(6): 797-798.
4. Anderson DE, Howell JB. Epithelioma adenoides cysticum: genetic update. Br J Dermatol, 1976; 95(3): 225–232.
5. Ackerman AB, Reddy VB, Soyer HP. Neoplasms with follicular differentiation. 2ndedition, Ardor Scribendi, Ltd., New York, 2001.
6. Zeligman I .Solitary trichoepithelioma Arch Dermatol., 1960; 82: 35.
7. Brooke I D, Fitz Patrick JE, Golitz L E. Papillary mesenchymal bodies: a histologic finding useful in differentiating trichoepitheliomas from Basal cellcarcinoma. J Am Acad Dermatol., 1989; 21(3pt 1): 523-528.
8. Bette Court MS, Prieto VG, Shea CR. Trichoepithelioma: a 19 year clinicopathologic re-evaluation. J cutan pathol., 1999; 26(8): 398-404.
9. Kirchmann TT, Prieto VG , Smoller BR. CD34 staining pattern distinguishes Basal cell carcinoma from trichoepithelioma. Arch Dermatol., 1994; 130(5): 589-592.
10. Pham TT, Selim MA, Burchette JL Jr, et al. CD10 expression in trichoepithelioma and Basal cell carcinoma. J cutan Pathol., 2006; 33(2): 123-128.
11. Pariser RJ. Multiple hereditary trichoepitheliomas and basal cell carcinomas. J cutan Pathol., 1986; 13(2): 111-117.
12. Johnson SC, Bennet RG. Occurrence of basal cell carcinoma among multiple trichoepithelioma. J Am Acad Dermatol., 1993; 28(2 pt 2): 343-345.
13. Wallace ML , Smolle BR. Trichoepithelioma with an adjacent Basal cell carcinoma, transformation or collision? J Am Acad Dermatol., 1997; 37(2pt2): 343-345.
14. Wolf DJ, Zite Ili JA. Surgical margins for basal cell carcinoma. Arch Dermatol., 1987; 123(3): 340-344.
15. Simpson W, Garner A, Collin JR. Benign hair follicle derived tumours in the differential diagnosis of basal cell carcinoma of the eye-lids: a clinicopathological comparison. Br J Ophthalmol., 1989; 73(5): 347-353.