

Extra Ocular Sebaceous Carcinoma of the Left Gluteal Region – A Rare Entity

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Abstract

Case Report

Sebaceous carcinoma is a rare cutaneous malignancy usually occurring predominantly in ocular region and only occasionally involving extra ocular sites. It is a rare but aggressive malignant neoplasm with poor prognosis. Here we report a case of an extra ocular type of sebaceous carcinoma in left gluteal region in a 67 year old male patient.

Keywords: Sebaceous carcinoma, extra ocular, Gluteal region, Histopathology.

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INTRODUCTION

Sebaceous carcinoma is an uncommon cutaneous tumor first described by Allaire in 1891 accounts for less than 1% of all cutaneous malignancies [1]. Origin of the tumor was from sebaceous glands in the skin and may also arise anywhere in the body where these glands exist [2]. It can be either ocular or extraocular and extra ocular type is very rare [3]. It presents frequently in the periorbital region due to an unusual abundance of sebaceous glands in the ocular region [4]. Sebaceous carcinoma predominantly occurs in the skin of the face, eyelid, scalp and neck [3]. Here we report a Very rare case of an extra ocular sebaceous carcinoma arising from the left gluteal region in a 67 year old male.

CASE REPORT

A 67 year old male presented with a nodular swelling on the left gluteal region since 1 year of duration. He had no history of trauma. The swelling was soft to firm in consistency. The examination showed a large swelling of 7x4x3cm in size situated over left gluteal region. There was no localised or generalise lymphadenopathy. Basic haematological investigations unremarkable. The clinical diagnosis was

made as squamous cell carcinoma. The Patient underwent local excision of the swelling and the excised specimen was sent to department of pathology for histopathological examination.

Macroscopically shows multiple soft tissue bits largest bit skin covered measuring 7x4x4cms. At centre of the lesion ulceration is noted measuring 4x3.5cms. Floor of the ulcer is filled with growth measuring 4x4cms. Smaller bit measuring 3.5x2cms. External surface is grey brown to grey yellow in colour. Cut surface shows multiple grey white lesions noted. Microscopic examination shows tissue lined by keratinized stratified squamous epithelium with focal ulceration. Dermis shows skin adnexae along with infiltrating tumor tissue (Fig-1). Tumor tissue proper shows tubular pattern, comedo pattern, solid nest like pattern and papillary pattern of tumour tissue. Individual tumor cells are round to oval in shape having cells having pleomorphic nuclei increased nucleus and cytoplasm ratio (N: C), prominent eosinophilic nucleoli and moderate amount of eosinophilic to vacuolated cytoplasm (Fig-2). Within the tumor tissue atypical mitotic figures are noted and areas of necrosis also seen in the tumor tissue.

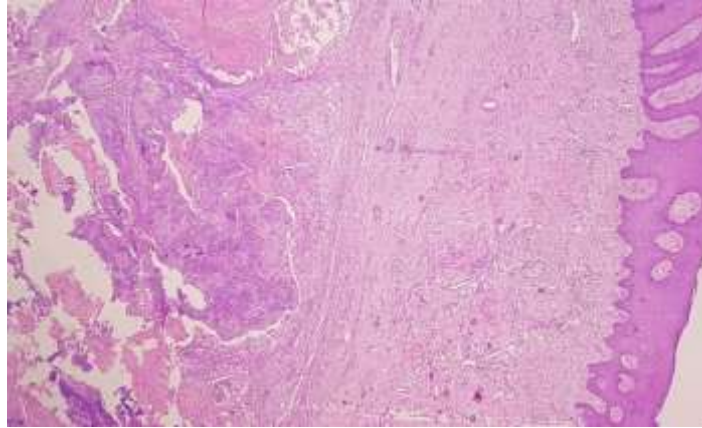


Fig-1: Microscopic examination shows (10X, H&E) epidermis lined by stratified squamous epithelium and dermis shows skin adnexal structures and tumor tissue

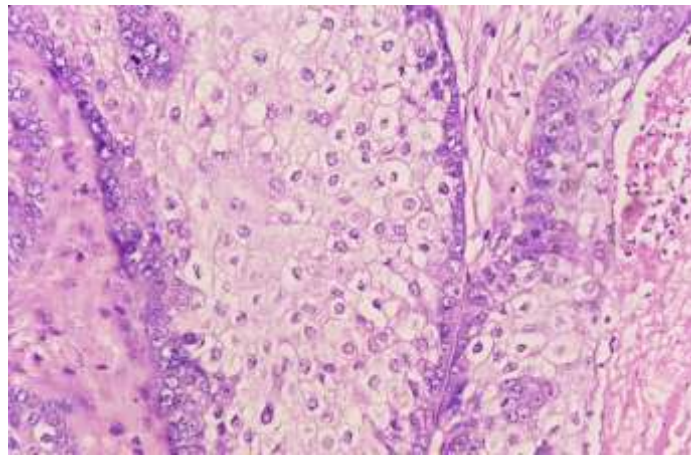


Fig-2: Microscopic examination (40X, H&E) shows tumor cells arranged in lobules, cells having pleomorphic hyperchromatic nucleus, prominent nucleoli, and moderate amount of eosinophilic to vacuolated cytoplasm (Sebaceous differentiation)

DISCUSSION

Sebaceous carcinoma accounts for less than 1% of all cutaneous malignancies and it is a very rare aggressive malignant neoplasm arising from the sebaceous glands [6]. Extraocular sebaceous carcinoma is very rare accounting for 25 % of all cases of sebaceous carcinoma [7]. Common sites for extraocular sebaceous carcinoma are skin of the head and neck followed by the trunk, genitals, salivary gland, and extremities [7]. Clinically, extraocular sebaceous carcinoma presents as an erythematous nodule with focal ulceration. Sebaceous carcinomas are commonly confused with basal cell carcinoma and squamous cell carcinoma with an exophytic ulcerative lesion [5]. It has more difficulties in the diagnosis due to its diverse histological patterns. It can be confused with other cutaneous tumors, like basal cell carcinoma, amelanotic melanoma, and squamous cell carcinoma.

Microscopic examination of sebaceous carcinoma shows tissue lined by stratified squamous epithelium with acanthosis. Dermis shows tumor tissue arranged in solid sheets and lobules. Cells are large round to oval with clear and vacuolated cytoplasm. Adjacent foci showing chronic inflammatory cells and congested blood vessels. Sebaceous cell carcinoma has

more difficulties of diagnosis because it has diverse histological patterns.

Microscopic examination of squamous cell carcinoma shows tissue lined by stratified squamous epithelium with severe dysplasia and underlying dermis showing proliferation of sheets of squamous cells. Squamous cells are round to polygonal with pleomorphic hyperchromatic nucleus, prominent nucleoli, increased N: C ratio and moderate amount of eosinophilic cytoplasm. Most of the cells show individual keratinization. Many keratin pearls and many mitotic figures are noted. Foci showing perineural invasion can also be seen. Nests of tumor cells with clear foamy cytoplasm, vesicular nucleus, and prominent nucleoli absent are in squamous cell carcinoma. IHC - BerEP4 and Androgen is positive for sebaceous carcinoma and is negative for squamous cell carcinoma.

Microscopic examination of basal cell carcinoma shows tissue lined by stratified squamous epithelium with acanthosis and koilocytosis. Adjacent foci showing proliferation of basaloid cells into dermis showing sheets of cells with elongated hyperchromatic nucleus and scant cytoplasm. Peripheral palisading and

peritumoral clefting is seen. Few mitotic figures are seen and myxoid areas are noted. Stroma showing chronic inflammatory cells and congested blood vessels. Basal cell carcinoma exhibit peripheral palisading and clefting from the adjacent stroma. In our case features of peripheral palisading and cleft spaces are not seen. Tumor cells in sebaceous carcinoma are positive for IHC- cytokeratin 7, which is usually absent in basal cell carcinoma.

Microscopic examination of amelanotic melanoma shows tissue lined by stratified squamous epithelium with mild dysplasia. Dermis showing infiltrating tumour tissue. Cells are arranged in sheets, lobules and dispersed pattern. Cells are round with pleomorphic nucleus, prominent eosinophilic nucleoli and moderate to scant cytoplasm. Few mitotic figures are noted. Stroma showing chronic inflammatory cells and congested blood vessels. IHC showing tumor cells are positive for s-100 and HMB-45 and it is negative in sebaceous carcinoma. It can exhibit local aggressive behaviour and metastasize to distant organs and regional lymphnodes [5]. Wide excisions and selective use of radiotherapy is the treatment of choice

CONCLUSION

Extraocular sebaceous carcinoma is a very rare aggressive tumor. Because of its varied clinical presentation and diverse histological pattern, it can be

confused with other malignant skin tumors. Histopathological examination is helpful to confirm the diagnosis.

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