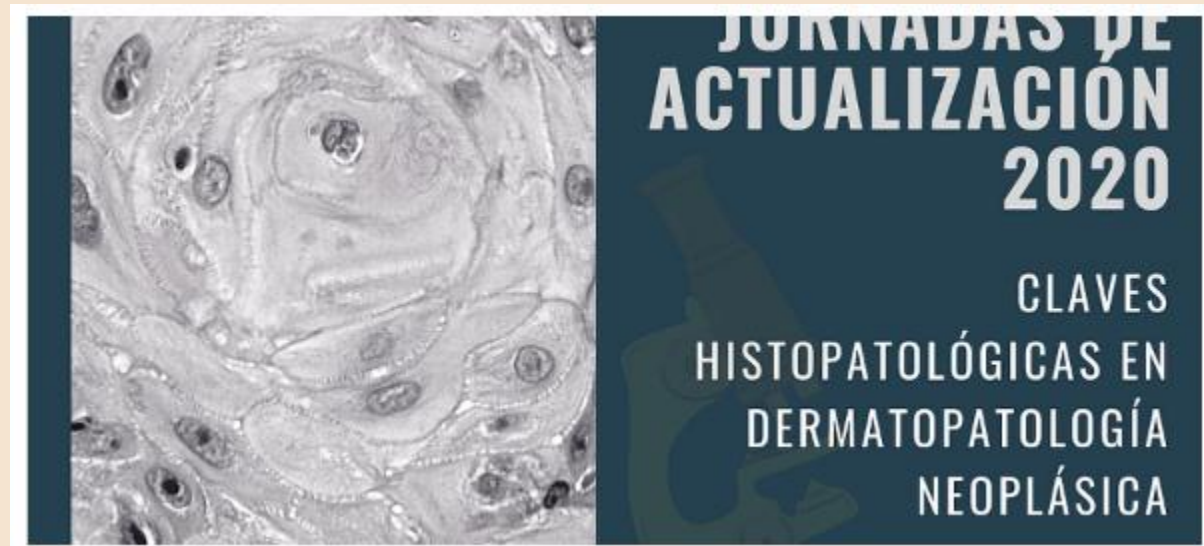


Quistes de Los Anexos Cutáneos

CUERDA PIEL

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Agradecimientos

Dra. Johana Pontón

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Dr. Pablo Landívar (Departamento de Imágenes)

Departamento de Dermatología

Hospital Luis Vernaza



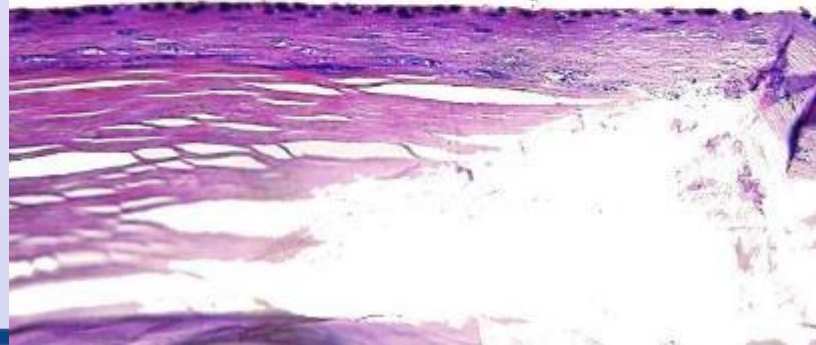
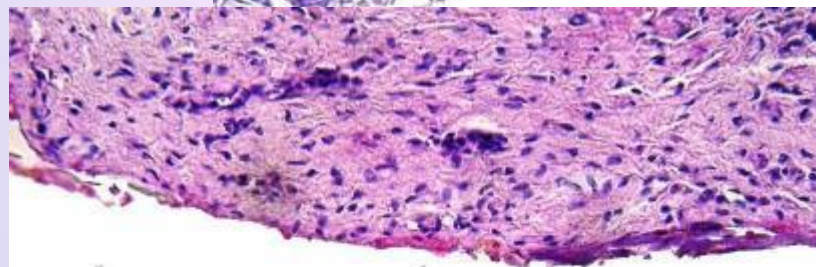
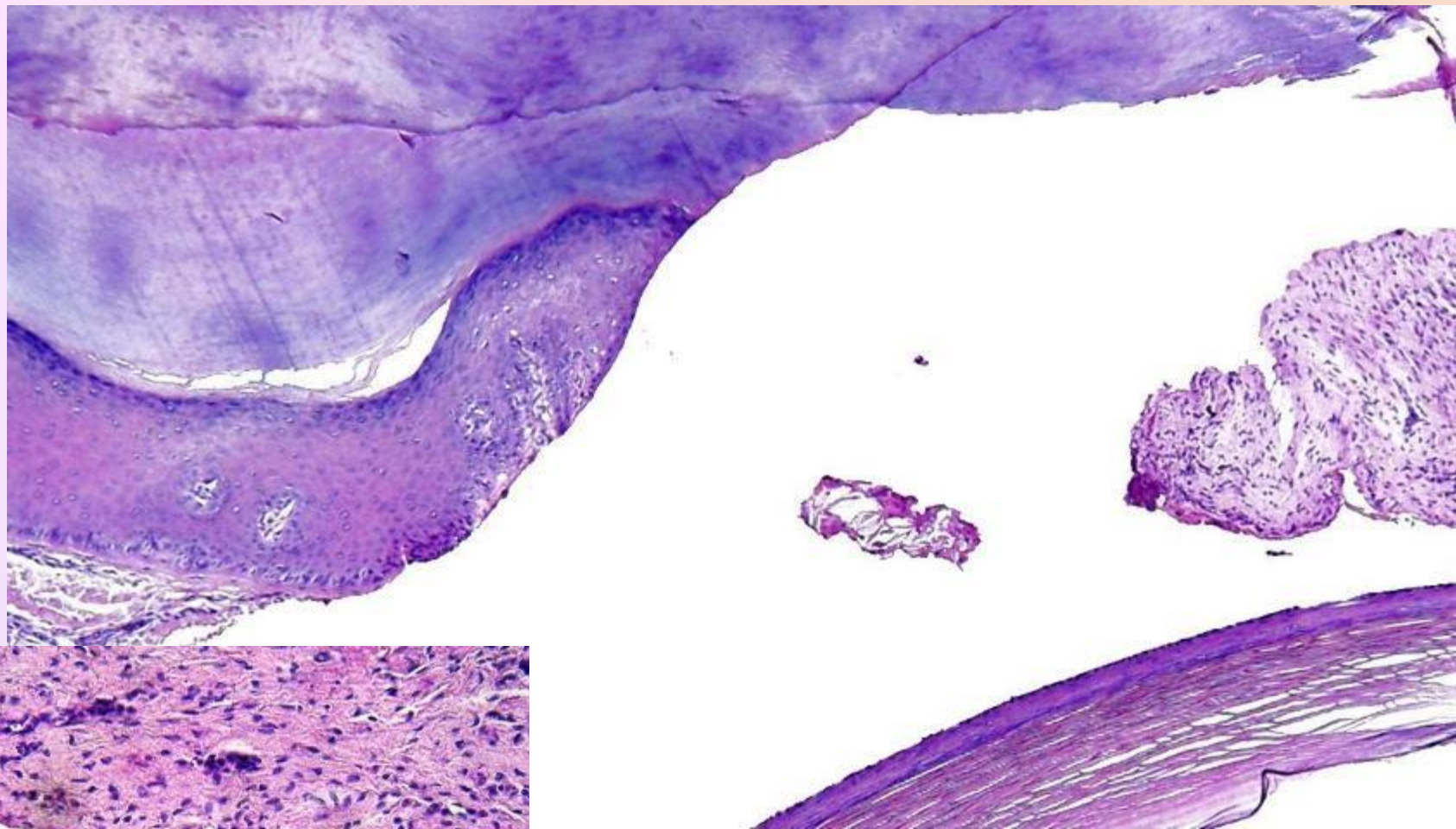
CASO 1

Paciente de 26 años de edad, sexo femenino. Desde hace 1 año presenta posterior a trauma tumor en piel volar de articulación metatarso falángica de pie izquierdo



¿Diagnóstico?

- a. Callosidad
- b. Verruga
- c. Quiste de Inclusión





Palmoplantar epidermoid cysts: two cases and brief review of the literature

Jorge Arandes-Marcocci MD, Gemma Melé-Ninot MD, Mònica Quintana-Codina MD, Maribel Iglesias-Sancho MD, Montse Salleras Redonnet MD PhD.

Affiliations: Department of Dermatology, Hospital Universitari Sagrat Cor, Barcelona, Spain

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Figure 2: Histological examination shows a cystic wall filled with eosinophilic keratin, lined by a stratified squamous epithelium and granular layer. H&E, 10 \times .

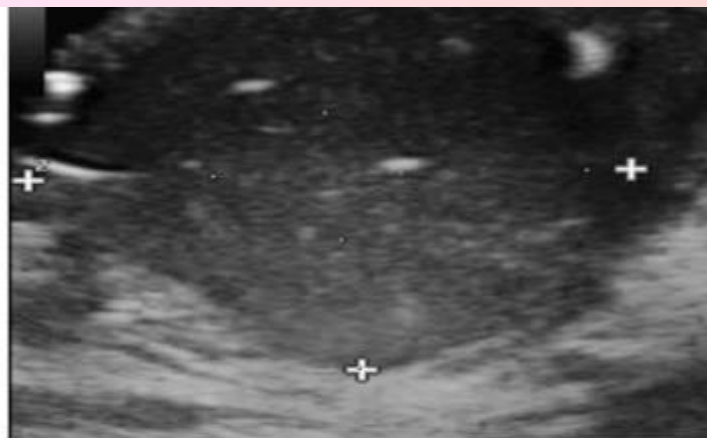


Figure 3: Ultrasonography shows a 15 \times 16mm well-circumscribed, heterogeneous, oval lesion located in the dermis and subcutaneous tissue.



Figure 1. A) Well-defined, skin-coloured and indurated 20 \times 15mm nodule on her left sole. B) Solitary tender 30 \times 30mm nodule, with inflammatory signs on the right thenar eminence.

Quistes Epidermoides Palmo/Plantares

- Implantación de fragmentos epidérmicos secundario a trauma
- Conductos ecrinos
- HPV 60

Human papillomavirus-associated plantar epidermoid cyst related to epidermoid metaplasia of the eccrine duct epithelium: a combined histological, immunohistochemical, DNA–DNA *in situ* hybridization and three-dimensional reconstruction analysis

K. Egawa, N. Egawa* and Y. Honda†

Departments of Dermatology and †Surgical Pathology, Kumamoto University School of Medicine, 1-1-1 Honjo, Kumamoto 860-0811, Japan

*Division of Cancer Cell Research, Institute of Medical Science, University of Tokyo, Minato-ku, Tokyo 108-8639, Japan

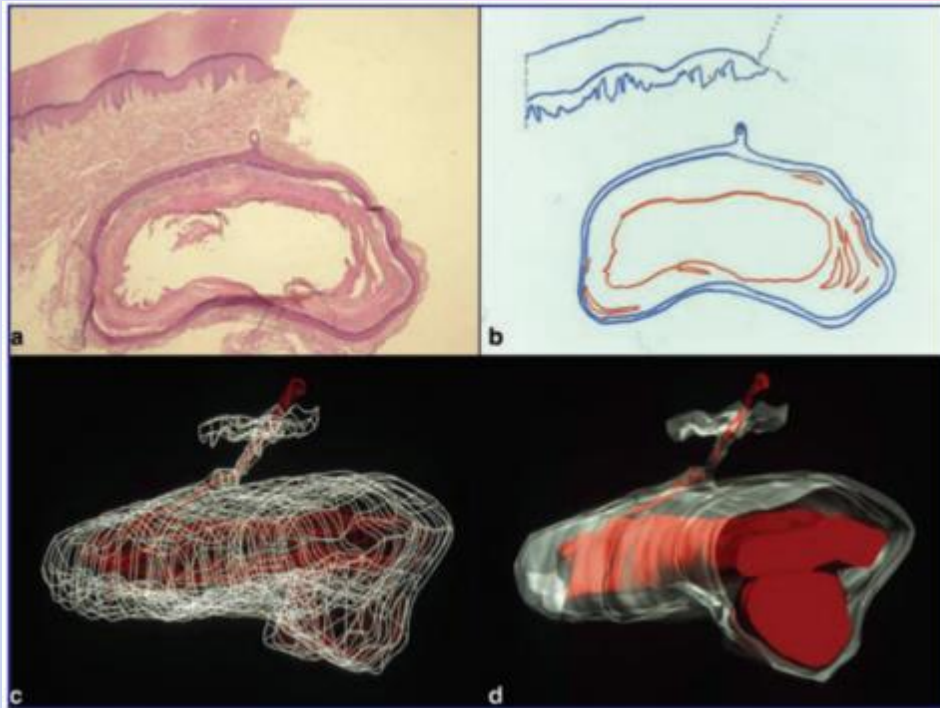


Fig 4. Computer-based, three-dimensional reconstruction (3DR) analysis of a human papillomavirus 60-associated plantar epidermoid cyst. (a) Histological section (the same as Figure 3, no.190). (b) Tracing of the outline of the histological ductal structures expressing carcinoembryonic antigen (red) and of the cyst wall and overlying epidermis (blue). (c) A wire-frame of the epidermoid cyst generated by computer using a montage of tracings obtained from all the serial sections. (d) 3DR analysis visualizing the fine structure of the epidermoid cyst connecting with the eccrine dermal duct.

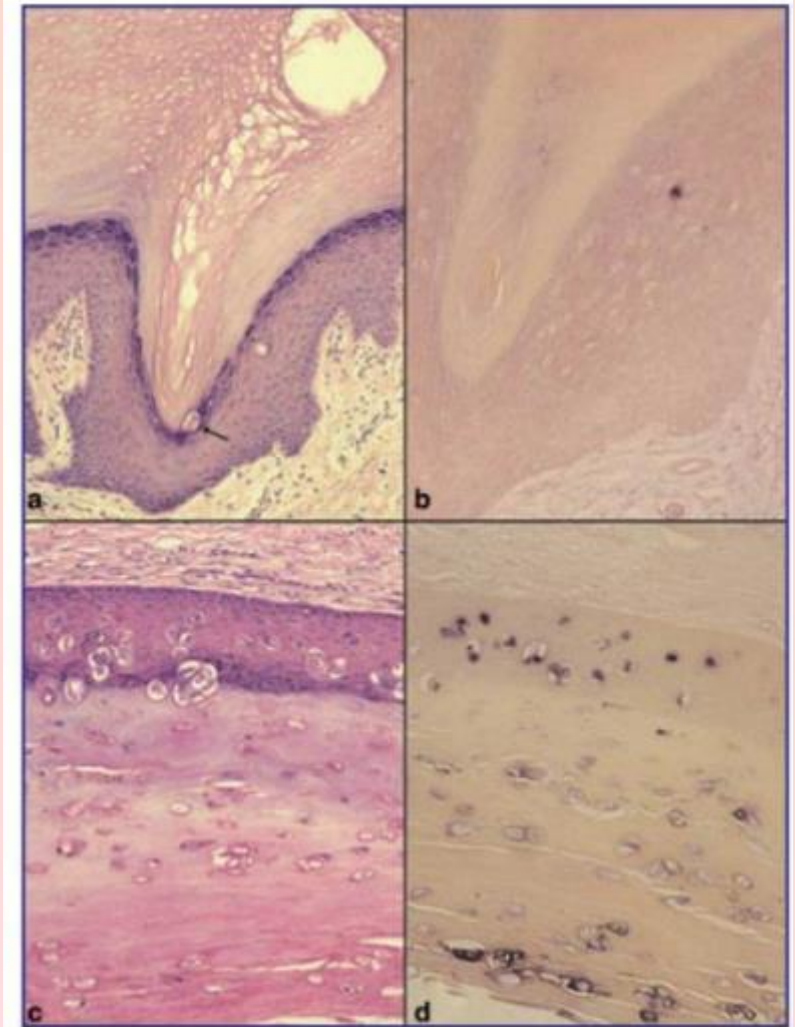


Fig 5. Histological localization of human papillomavirus (HPV) 60 DNA sequences. A high-power view of the same section (a,c; haematoxylin and eosin) and a serial section (b,d; DNA–DNA *in situ* hybridization) of Figure 3, no. 230. Homogeneous intracytoplasmic inclusion bodies (a,c) and HPV 60 DNA sequences (b,d) are seen in the acrosyringeal epithelium (a,b) as well as in the cyst wall (c,d).

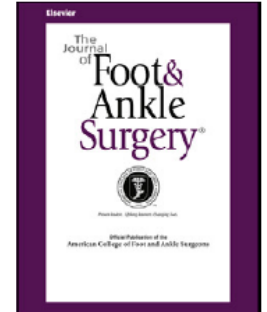


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Case Reports and Series

A Rare Presentation of a Giant Epidermoid Inclusion Cyst Mimicking Malignancy

Tarin Paparella, DPM ¹, Lawrence Fallat, DPM, FACFAS ²

¹Postgraduate Year 3 Resident, Podiatric Surgery Residency Program, Beaumont Hospital Wayne, Wayne, MI

²Director, Podiatric Surgery Residency Program, Beaumont Hospital Wayne, Wayne, MI



Fig. 1. Clinical appearance of ulcerated soft tissue mass on the plantar-medial left hallux.



Fig. 2. Close-up view of the ulcerated soft tissue mass on the plantar-medial left hallux.



Fig. 6. View of the soft tissue defect after mass excision down to the level of bone.

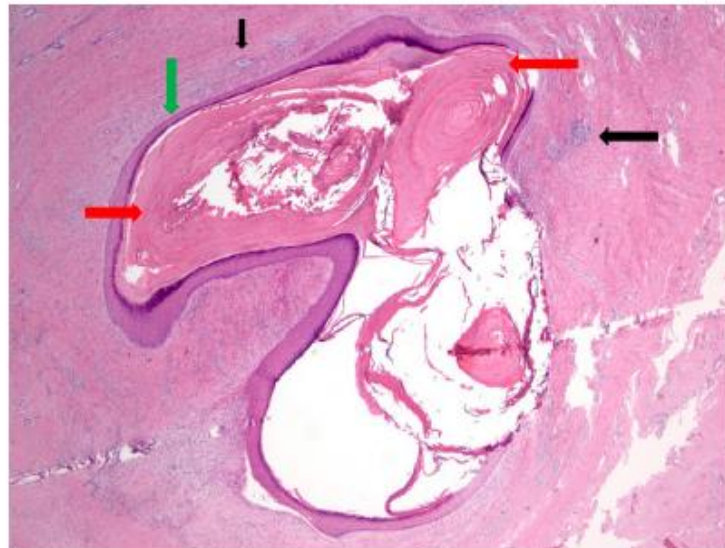


Fig. 11. Pathologic image of the epidermal inclusion cyst with hematoxylin and eosin stain high power (magnification $\times 400$). Red arrow indicates keratin collections; green arrow, squamous epithelium lining; and black arrows, foreign body giant cells.



Fig. 7. Gross appearance of the soft tissue mass measuring 4.6 cm \times 4.8 cm \times 1.3 cm.

Giant Plantar Epidermoid Cyst with Invasion of the Interosseous Muscles

Antonio Córdoba-Fernandez, DPM, PhD*
Adrián Lobo-Martín, DP*
Carlos Escudero-Severín, MD†
Victoria Eugenia Córdoba-Jiménez, BS‡

Epidermoid cysts of the sole of the foot are rare lesions that must be differentiated from other, more common subcutaneous pathologic abnormalities located on the sole. Cases of epidermoid cysts that extend to the interosseous musculature are rarer still. We report the case of a giant epidermal cyst in a 64-year-old individual that extended to the intrinsic musculature of the third space of the right foot and that was diagnosed after fine-needle aspiration biopsy and subsequent cytologic study. Differential diagnosis of these lesions should be made with the support of additional imaging tests, and diagnostic confirmation should always be obtained after surgical removal and subsequent histopathologic study. (J Am Podiatr Med Assoc 107(4): 329-332, 2017)

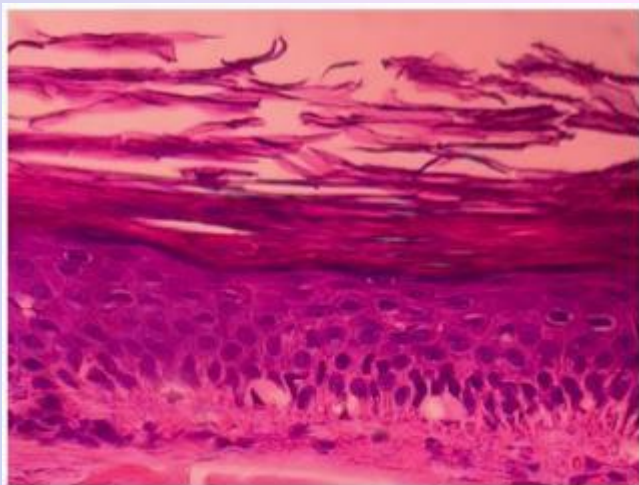


Figure 9. The cyst has well-differentiated squamous epithelium forming the wall and is filled with abundant laminated keratin (H&E, x200).



Figure 1. Clinical appearance of the lesion.



Figure 2. Axial T1-weighted magnetic resonance image shows a cystic lesion extending from the sole to the dorsum of the foot by displacing the interosseous muscles.

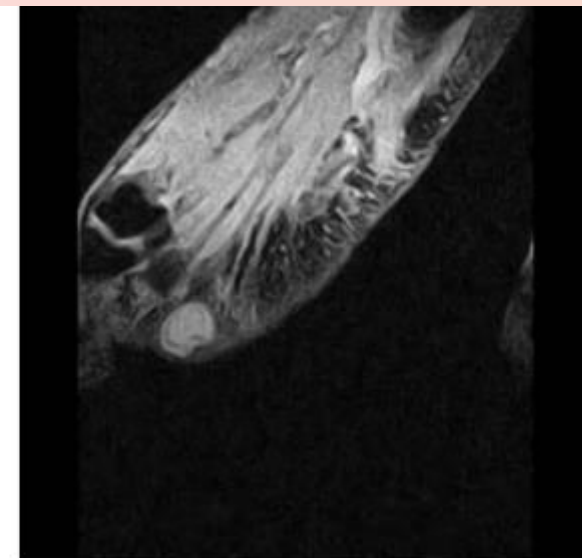


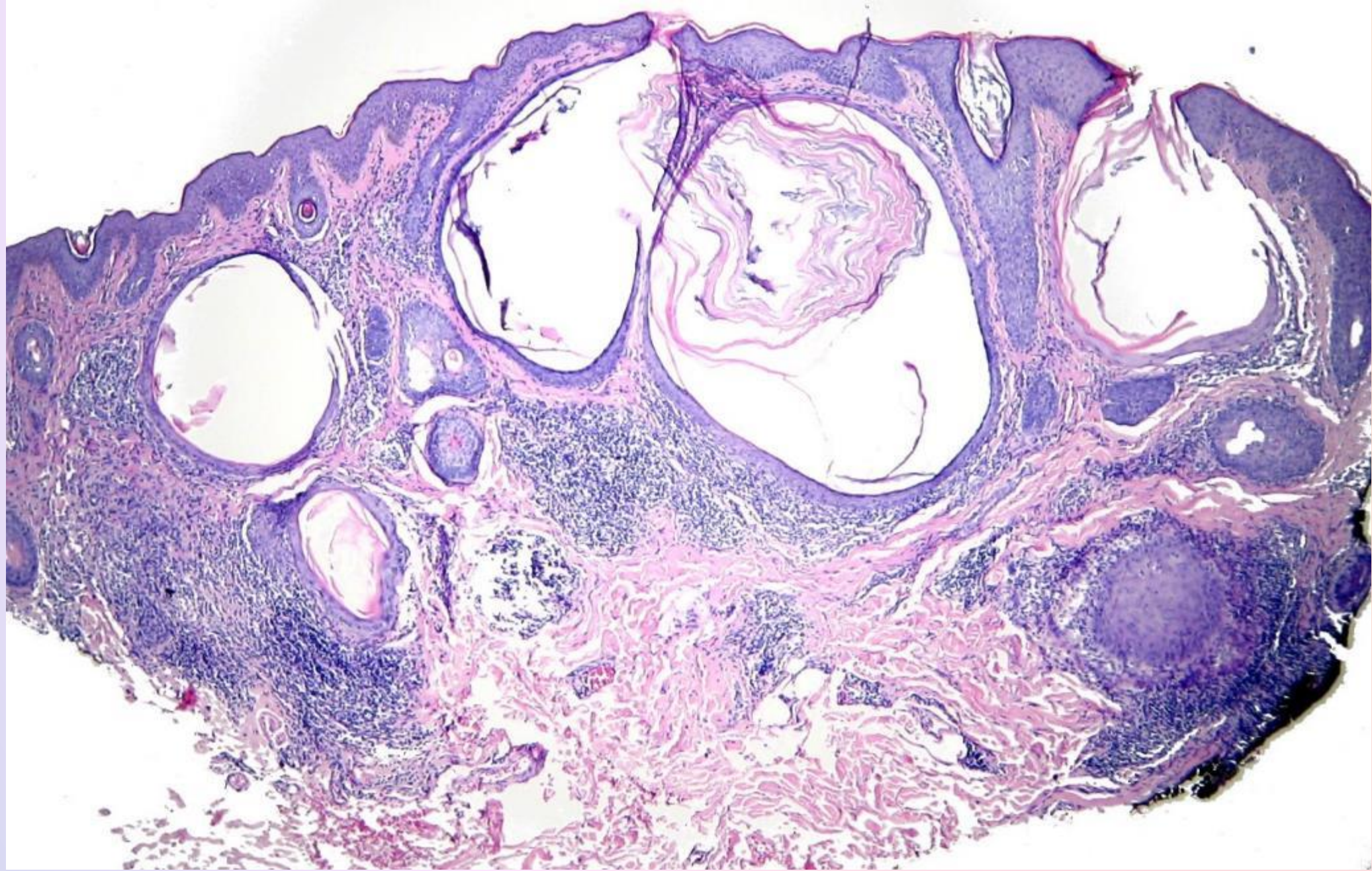
Figure 4. Coronal T2-weighted magnetic resonance image.



CASO 2

- Paciente femenino, 30 años, sin antecedentes de importancia, quien presenta desde hace 6 meses, placas bilaterales retroauriculares. No existen antecedentes de trauma ni de roce mecánico. No existen antecedentes de otra localización ni antecedentes familiares de importancia.







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Caso clínico

Milio en placa retroauricular

Retroauricular milia en *plaque*

Enrique Uraga^{a,*}, M.^a Cecilia Briones^b, Annette Morán^b, M.^a Verónica Uraga^b,
Andrea Lubkov^b y Enrique Loayza^a

^aDepartamento de Dermatología y Dermatopatología, Hospital Luis Vernaza, Guayaquil, Ecuador

^bCentro Privado de Piel Dr. Enrique Uraga Peña, Guayaquil, Ecuador

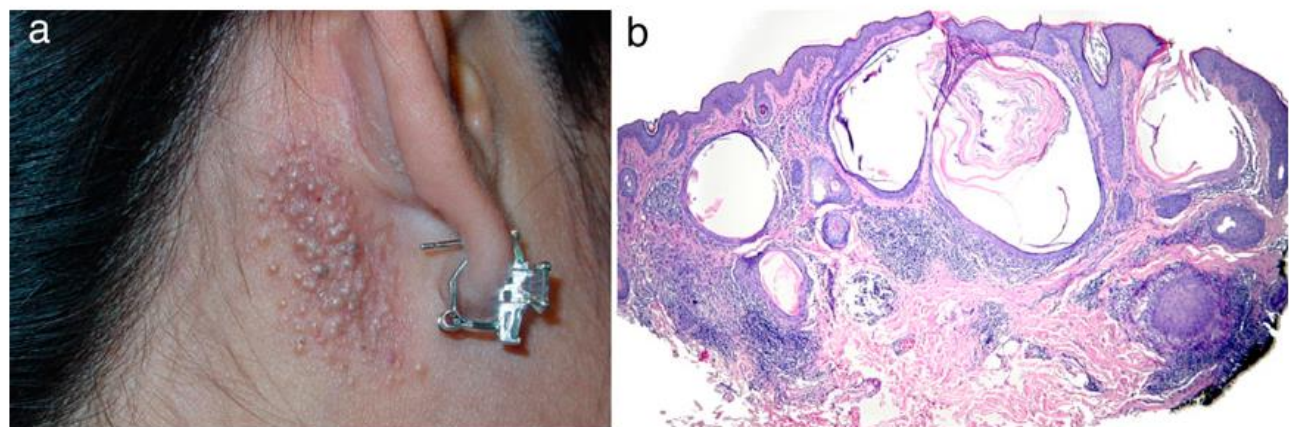


Figura 1 – (a) Placas retroauriculares izquierda y derecha (b) Histopatología que muestra múltiples cavidades quísticas con queratina laminillar, algunas comunicándose con la superficie.

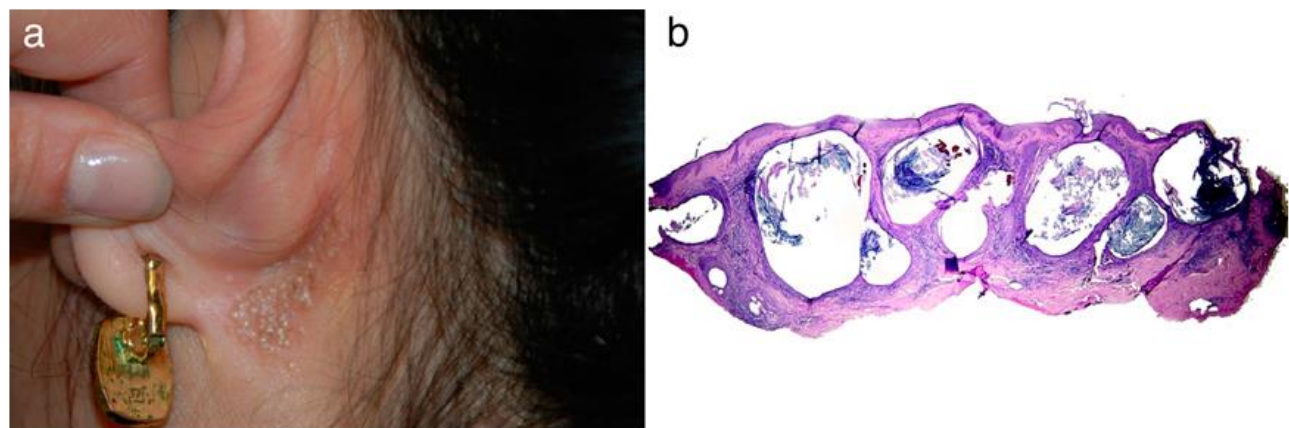


Figura 2 – (a) Placa retroauricular izquierda compuesta por quistes de milia y comedones sobre una base discretamente eritematosa. (b) Histopatología de la lesión demuestra la presencia de múltiples quistes en el espesor de la dermis.

Tabla 2 – Casos reportados en revistas ibero-latinoamericanas. Un total de 19 casos a los que añadimos dos nuevos pacientes

| Autor | País | Edad | Sexo | Localización |
|-------------------------------------|-----------|------|------|--|
| Agner et al. ³ | Brasil | 32 | M | Retroauricular |
| Consigli et al. ²⁹ | Argentina | 65 | F | Bilateral Retroauricular |
| | | 67 | F | Palpebral |
| García et al. ³⁰ | Argentina | 57 | F | Retroauricular |
| Carbia et al. ³¹ | Argentina | 67 | F | Bilateral retroauricular,palpebral |
| Griffa et al. ³² | Argentina | 63 | F | Bilateral retroauricular, frente, nuca, cuello |
| | | 38 | F | Mejilla |
| De Anda et al. ³³ | Uruguay | 47 | M | Bilateral retroauricular |
| | | 45 | M | Bilateral retroauricular |
| Alonso et al. ¹³ | España | 63 | F | Bilateral palpebral |
| Martínez-Moran et al. ¹² | España | 75 | F | Preauricular |
| Pereiro et al. ²¹ | España | 9 | F | Mano |
| Monteagudo et al. ¹¹ | España | 50 | F | Bilateral preauricular |
| Mayo et al. ³⁴ | España | 60 | F | Retroauricular |
| Galan et al. ²⁶ | España | 54 | F | Bilateral retroauricular |
| | | 36 | M | Bilateral retroauricular |
| Baniandres et al. ⁷ | España | 72 | F | Bilateral retroauricular, palpebral |
| González-Lopez ⁹ | España | 54 | F | Bilateral retroauricular |
| Martín-Ezquerro ³⁵ | España | 58 | F | Extremidades |
| Uraga et al. (Reporte actual) | Ecuador | 30 | F | Bilateral retroauricular |
| | | 51 | F | Retroauricular |

Utilidad de la dermatoscopia en el diagnóstico de milia desarrollada sobre tatuaje previo.

Dr. Enrique Uraga*, Dr. Enrique Loayza** Dra. María Cecilia Briones***, Dra. Verónica Uraga***, Dra. Annette Morán****

*Director del Departamento de Dermatología Hospital Luis Vernaza. Guayaquil. Ecuador.

** Dermatopatólogo del Departamento de Dermatología Hospital Luis Vernaza. Guayaquil. Ecuador.

*** Médicos del Centro Privado de Piel "Dr. Enrique Uraga Peña"

**** Residente 2 del posgrado de Dermatología UCSG.



Figura 1.- Tatuaaje en forma de ángel



Figura 2.- Imagen anterior con mayor aumento, mostrando numerosos puntos blanquecinos sobre el tatuaje .

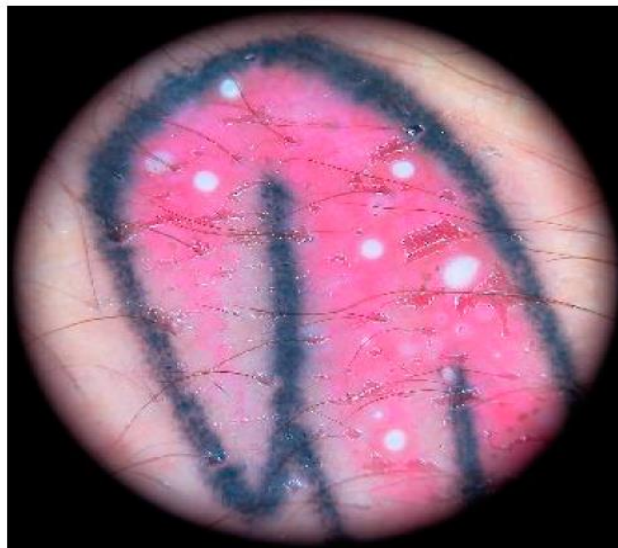
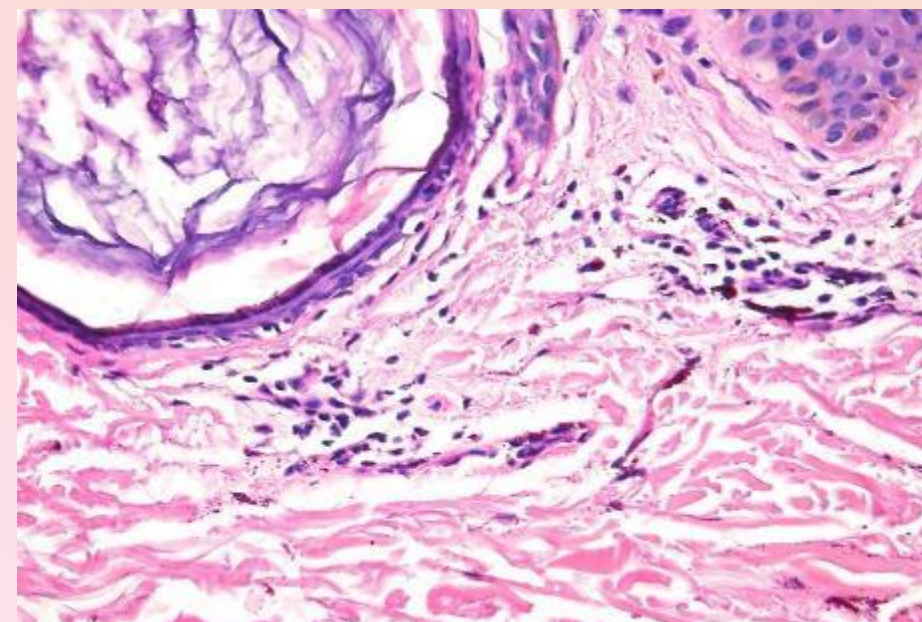
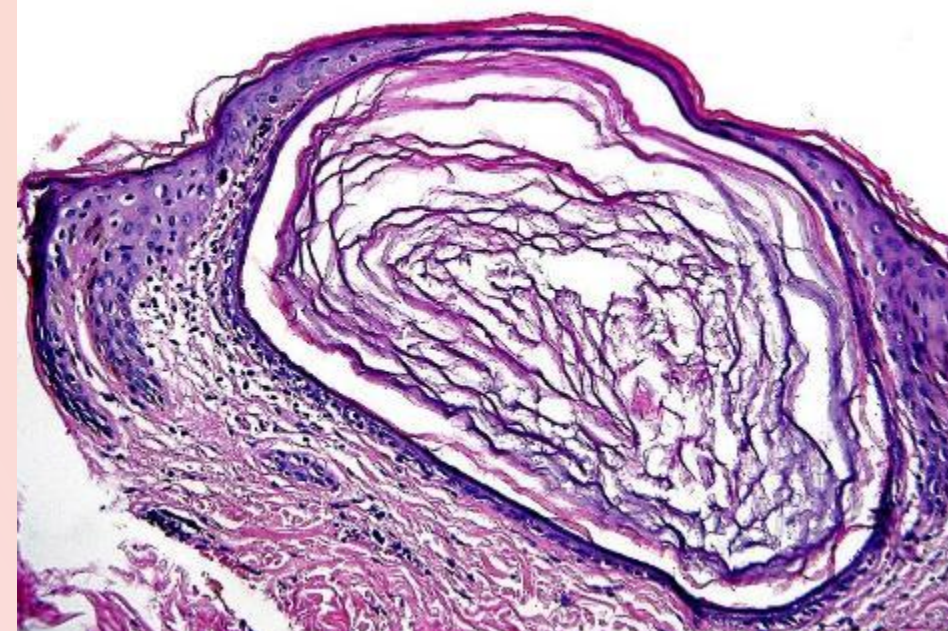


Figura 3.- Formaciones blancas redondeadas u ovaes sobre el área de pigmento rojo del tatuaje.



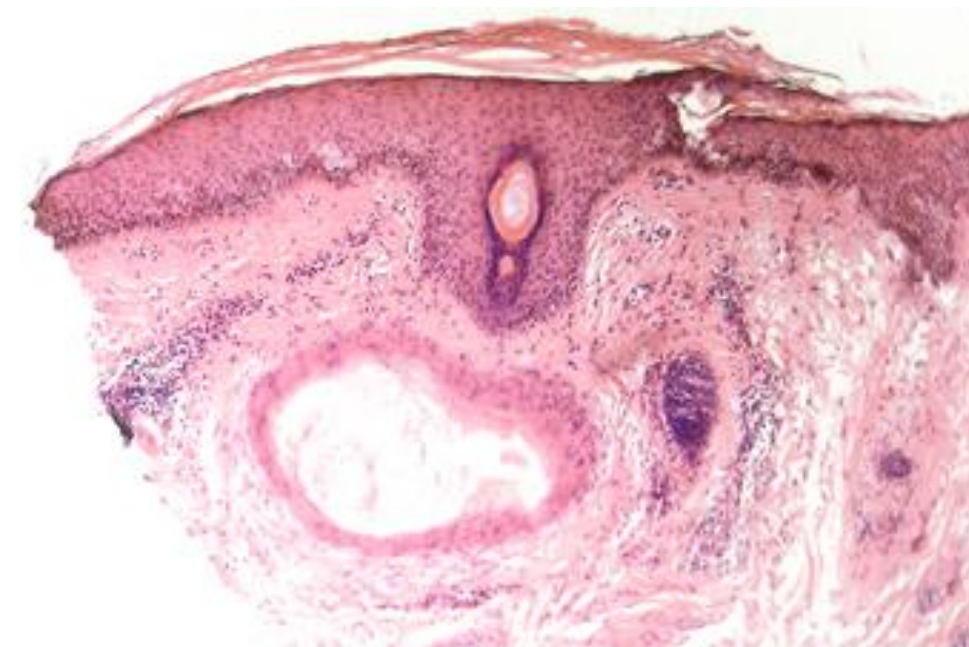
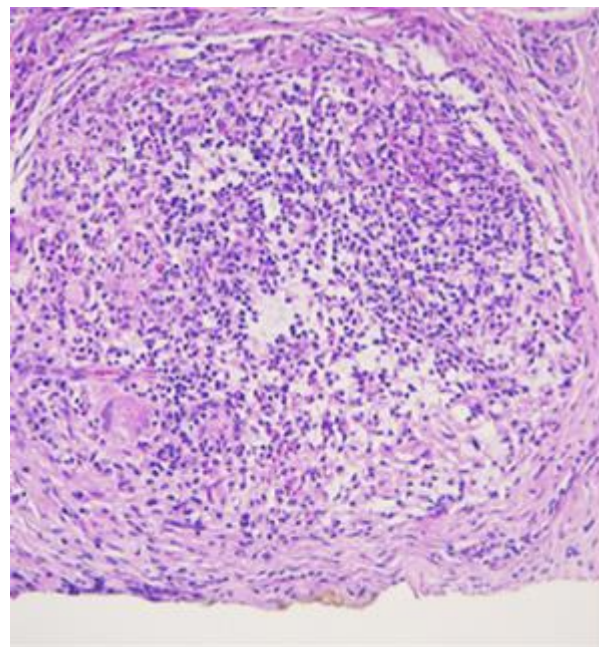
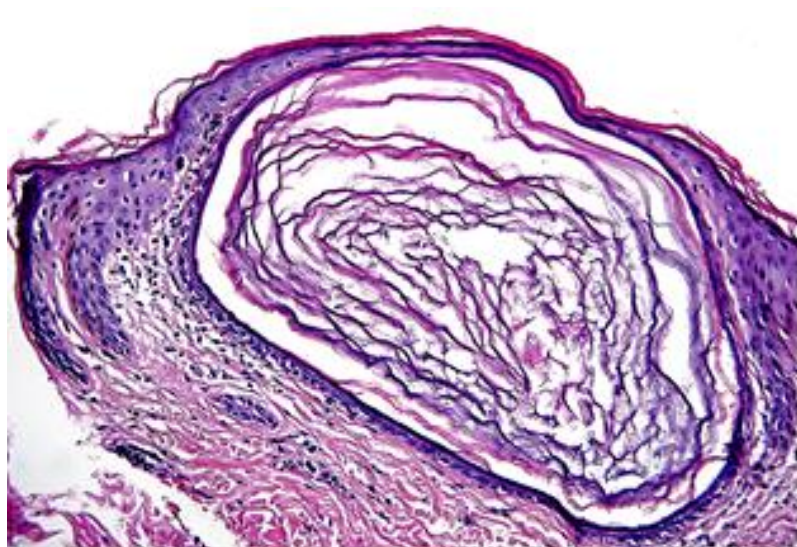
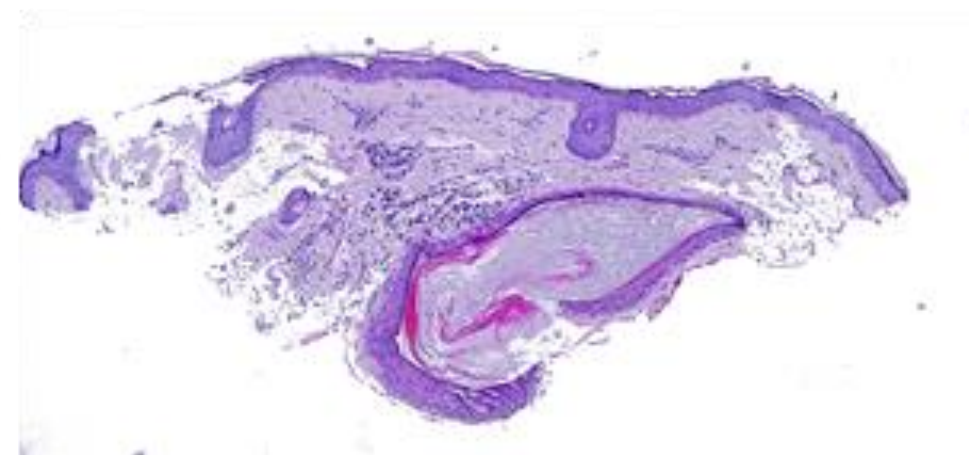
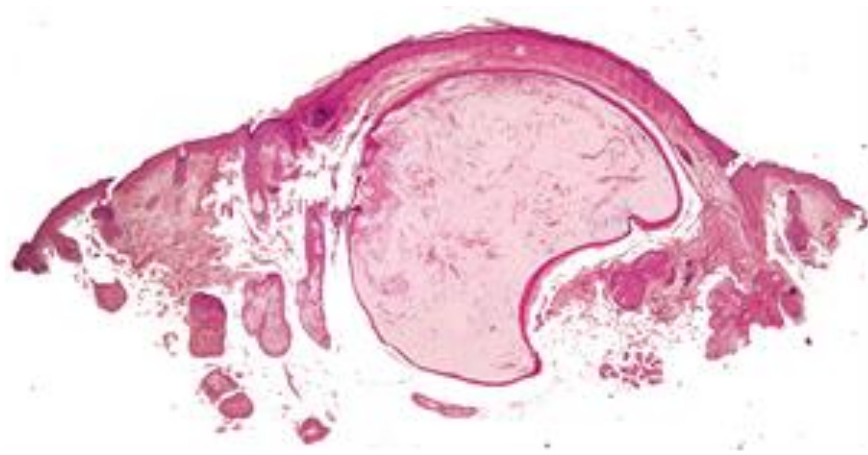
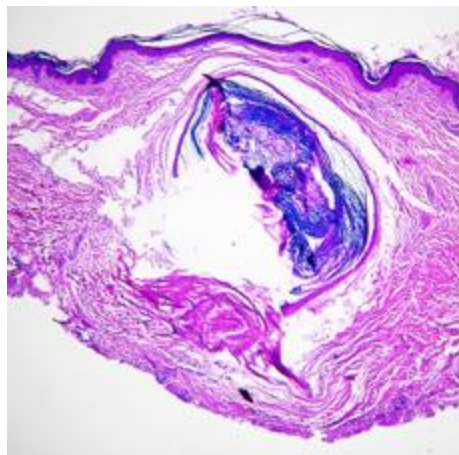
Figura 4.- Lesiones similares sobre pigmento azul, tomando en esta ubicación un tono celeste.



| Milia Primaria | Milia Secundaria |
|---|------------------------|
| Congénita | Enfermedades asociadas |
| Milia benigna primaria de niños y adultos | Medicación asociada |
| Milia en placa | Trauma asociado |
| Milia agrupada nodular | |
| Milia eruptiva múltiple | |
| Nevo despigmentoso con milia | |
| Genodermatosis asociadas | |

Tabla 1.- Milia : Clasificación según Berck y Bayliss.

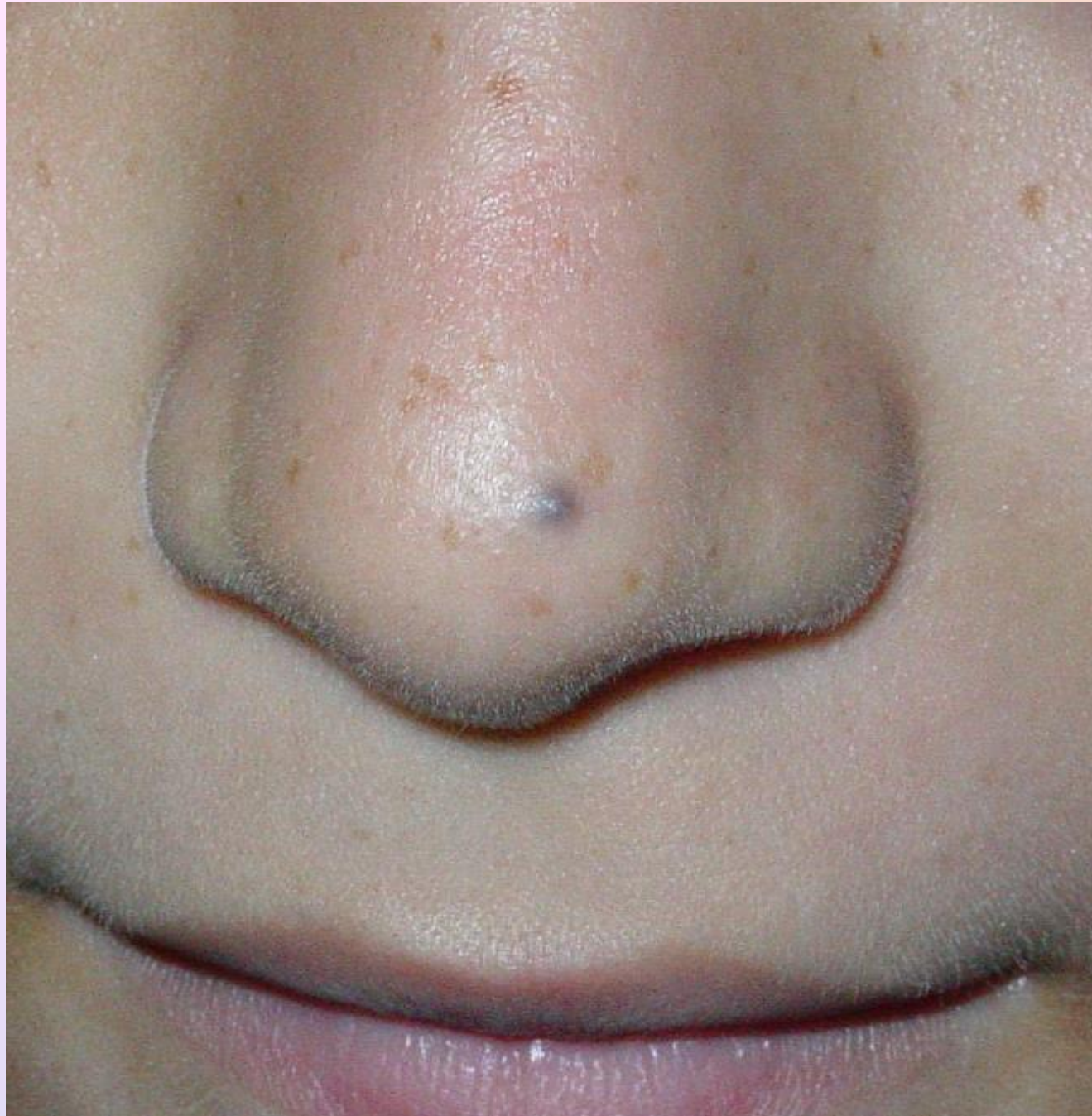


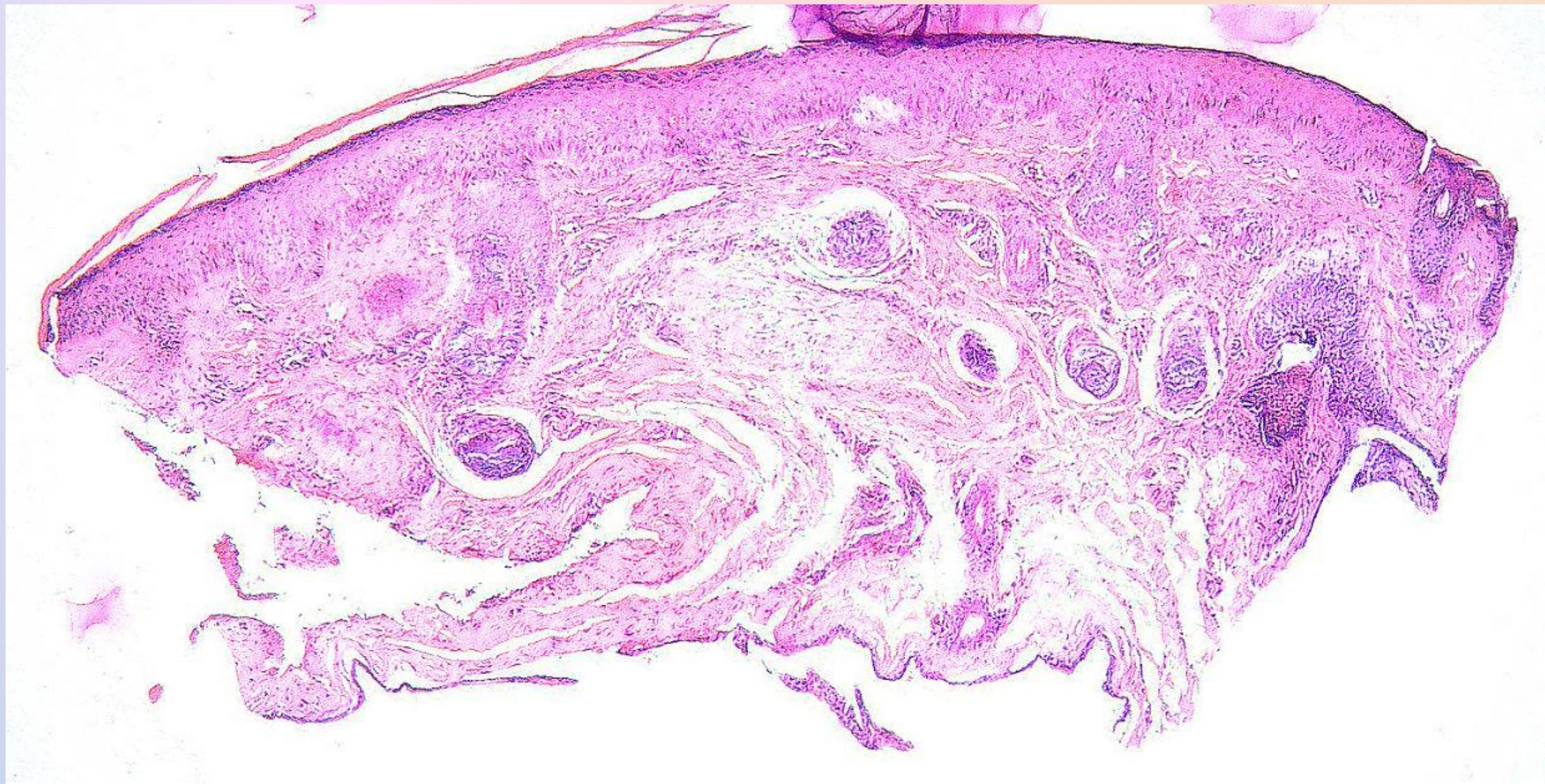


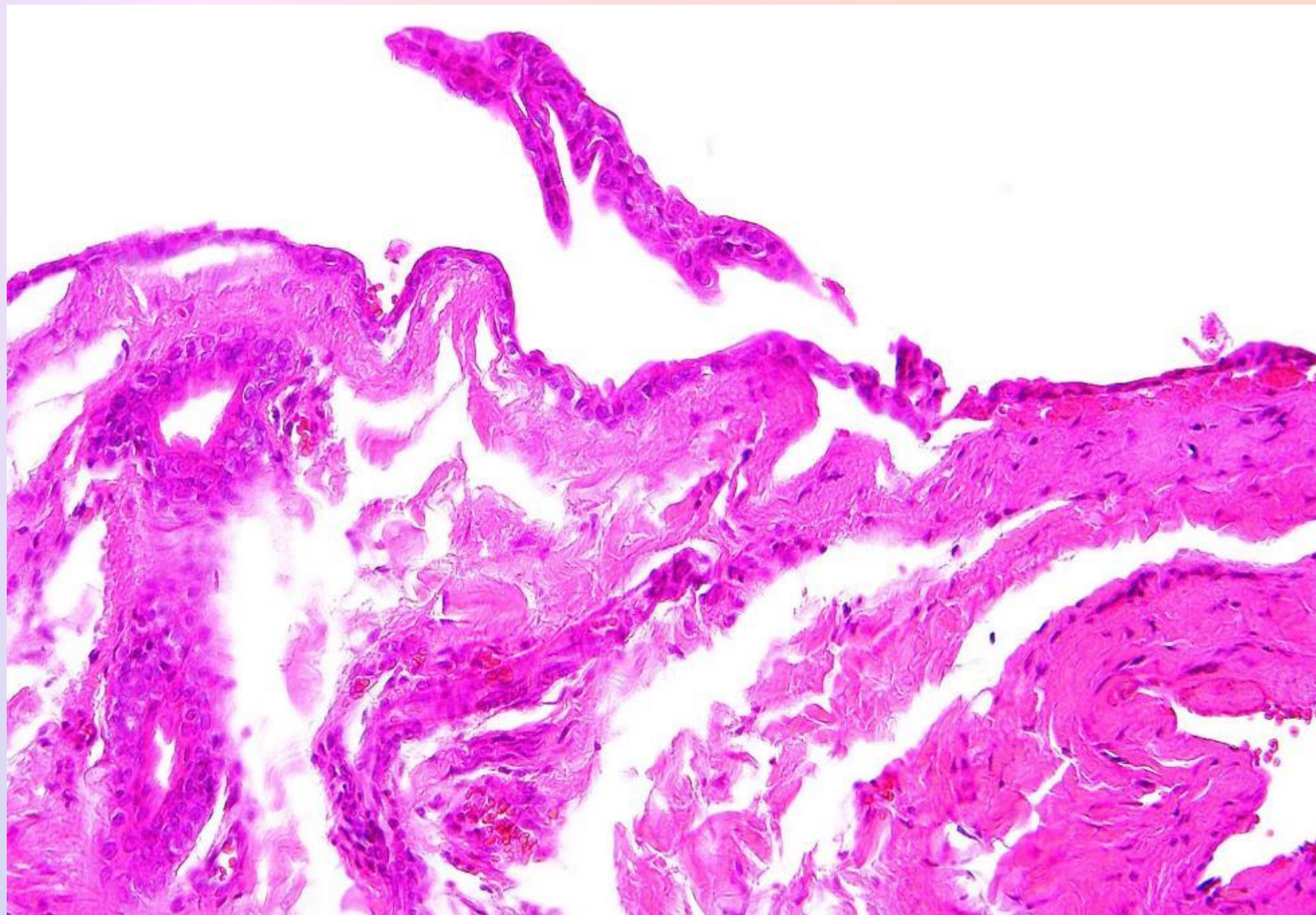
CASO 3

i

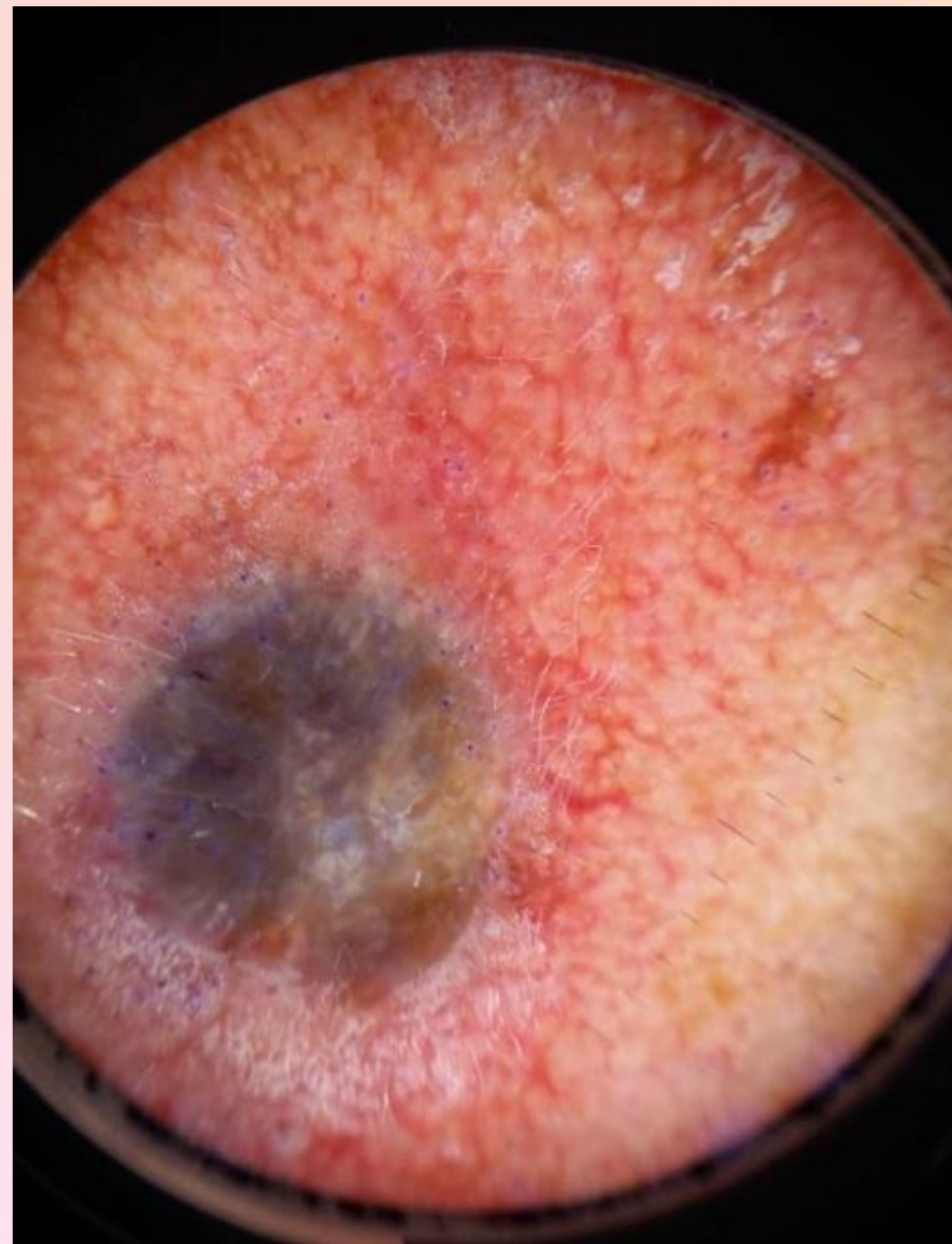
- Paciente 7 años femenino
- Pápula violácea de 3 meses de evolución localizada en nariz







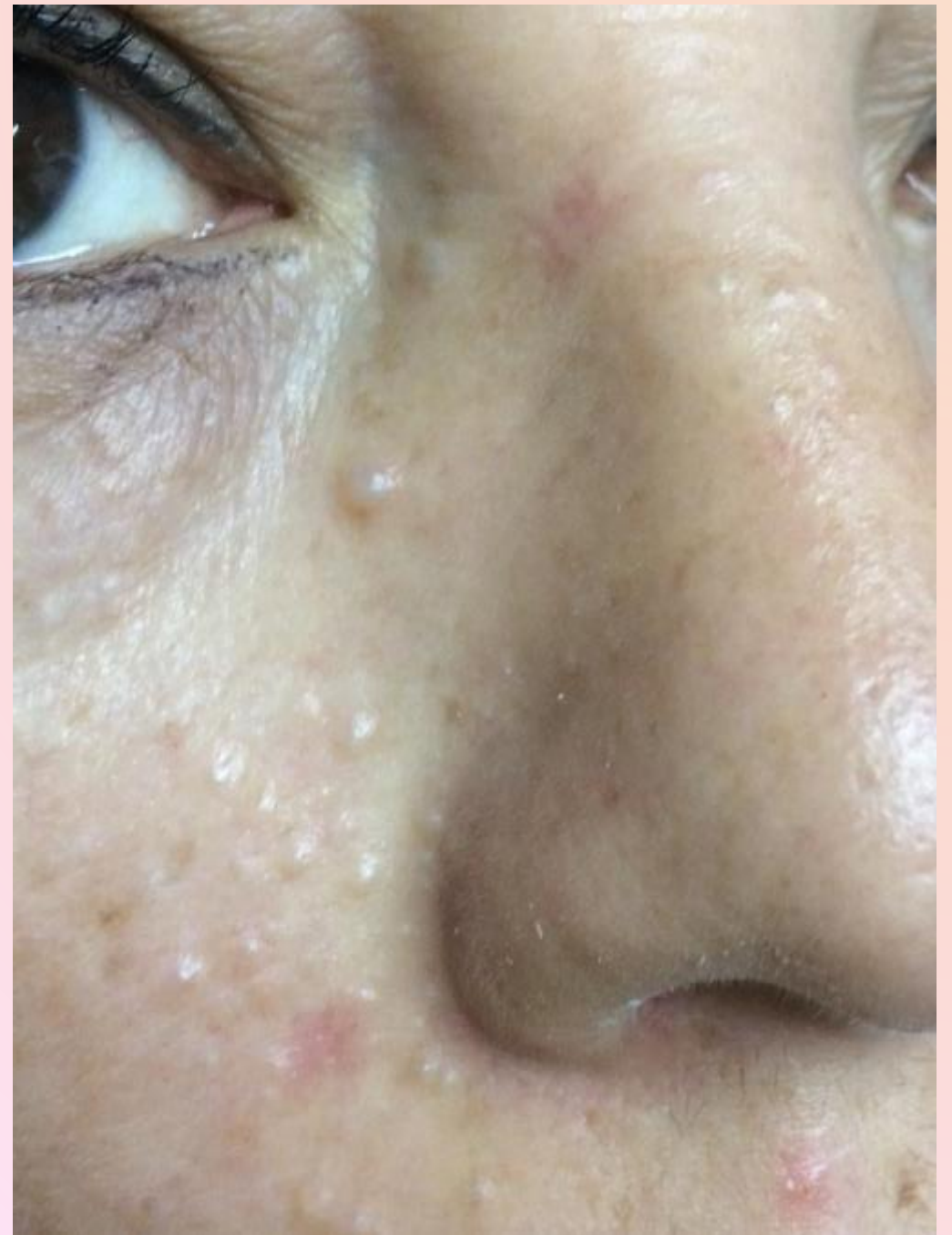


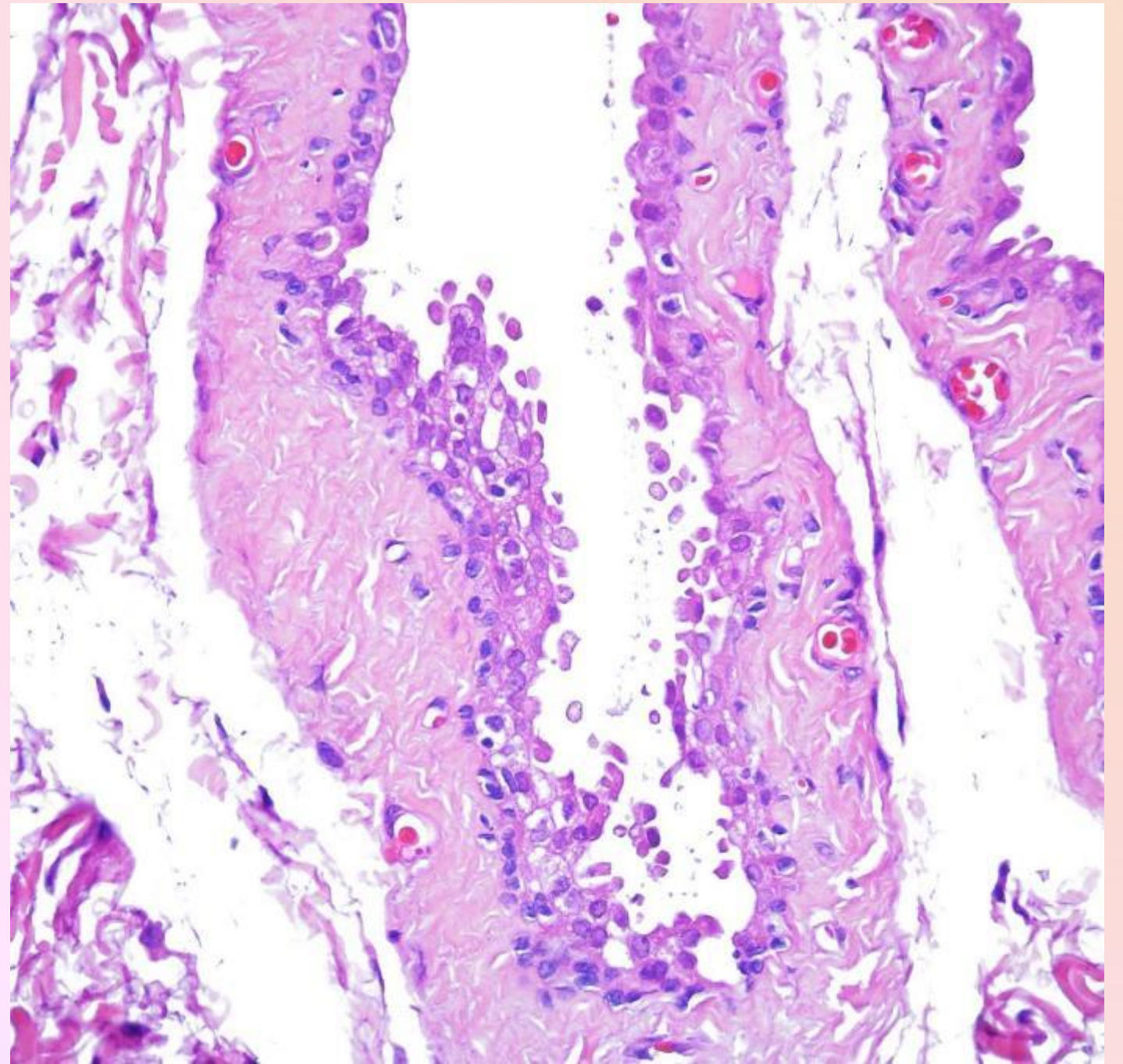
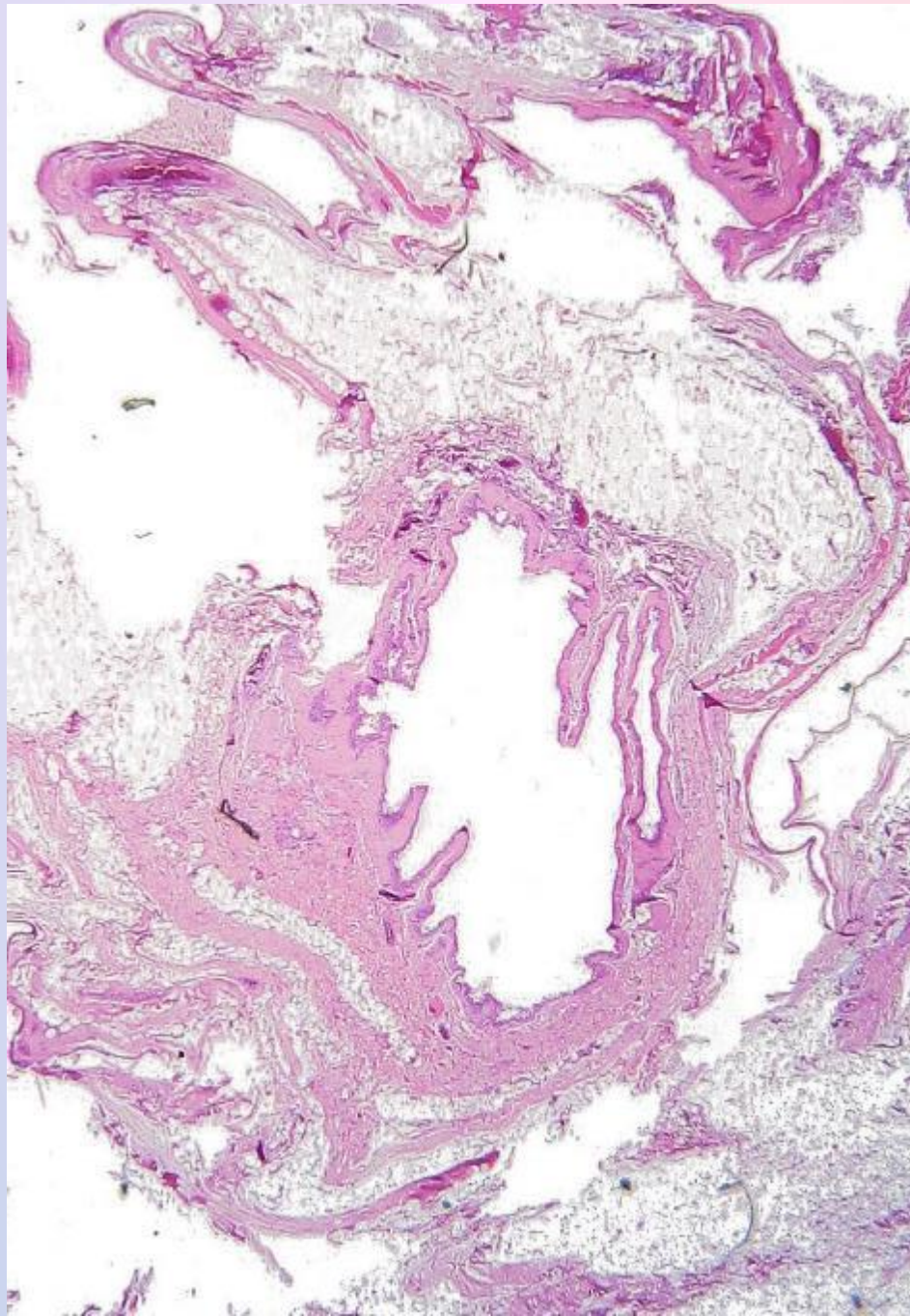


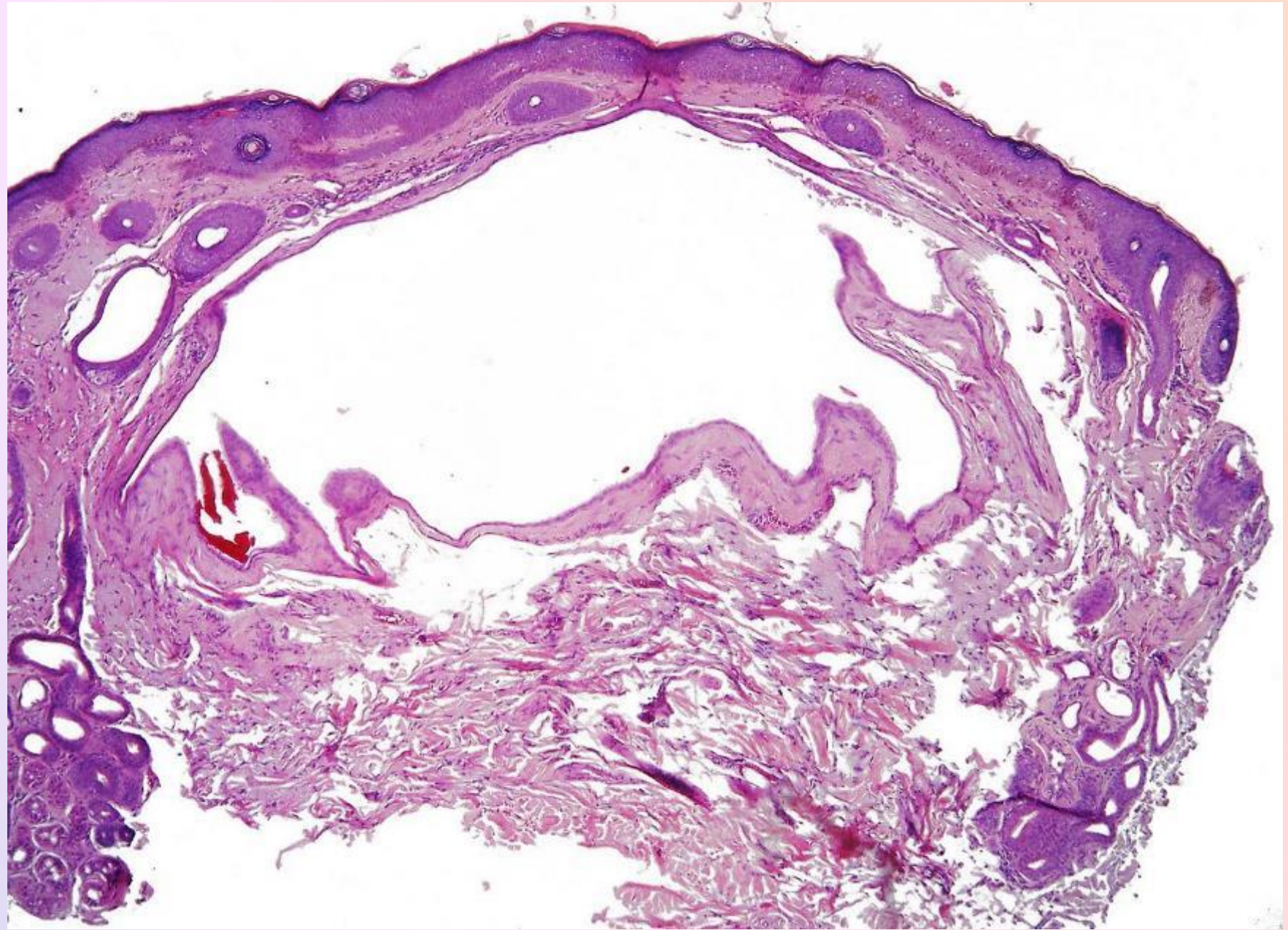








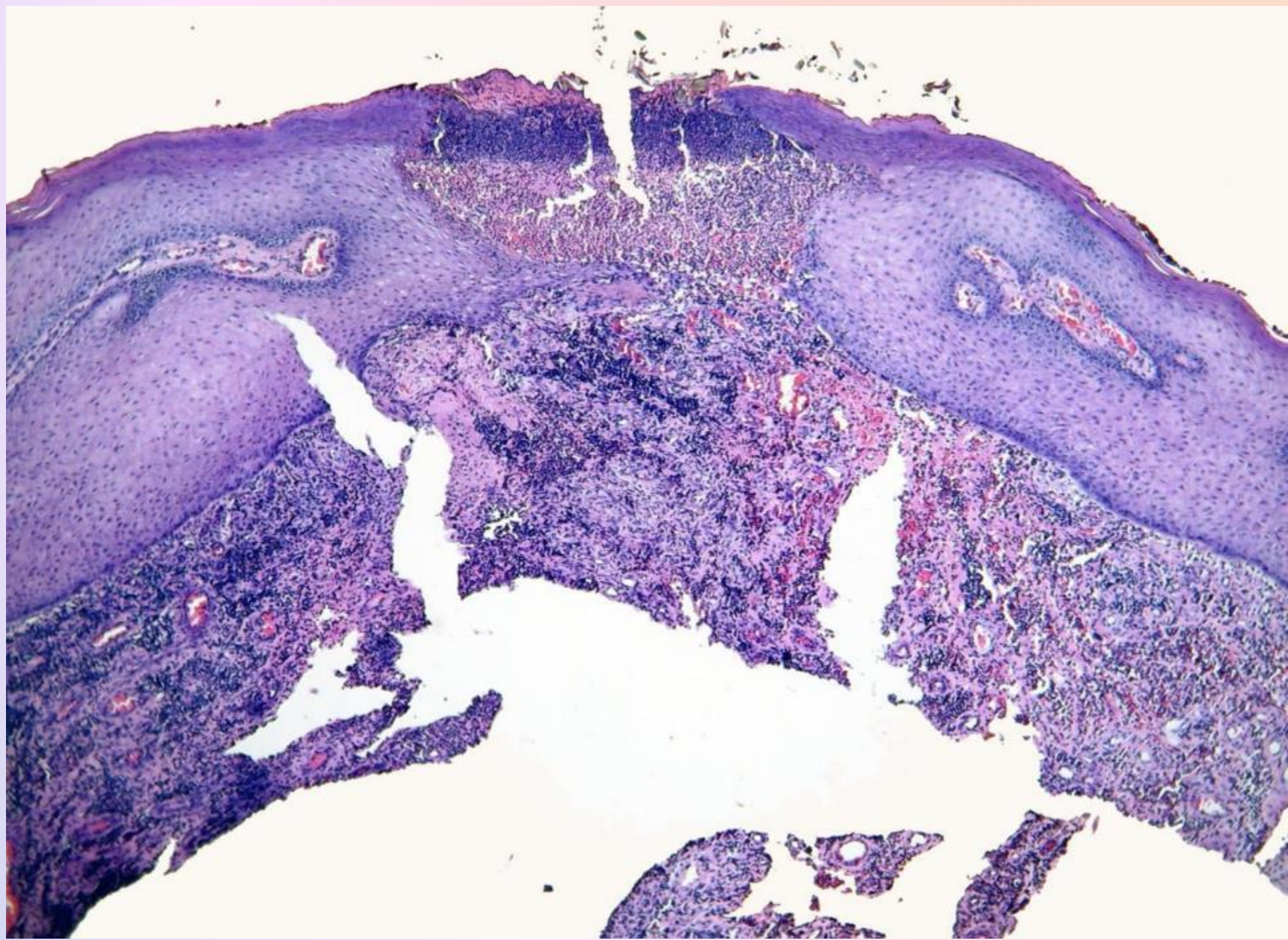




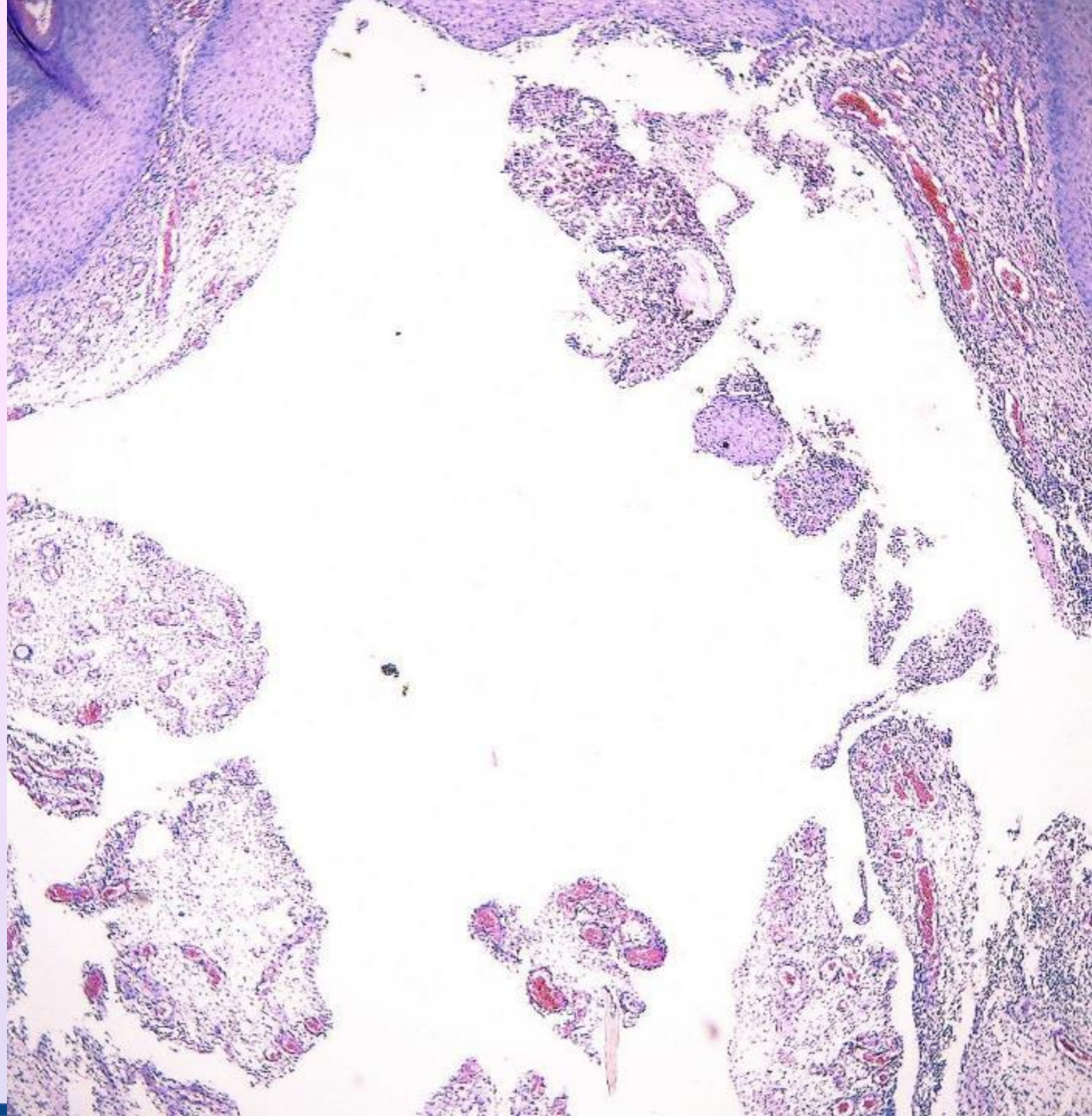
CASO 4

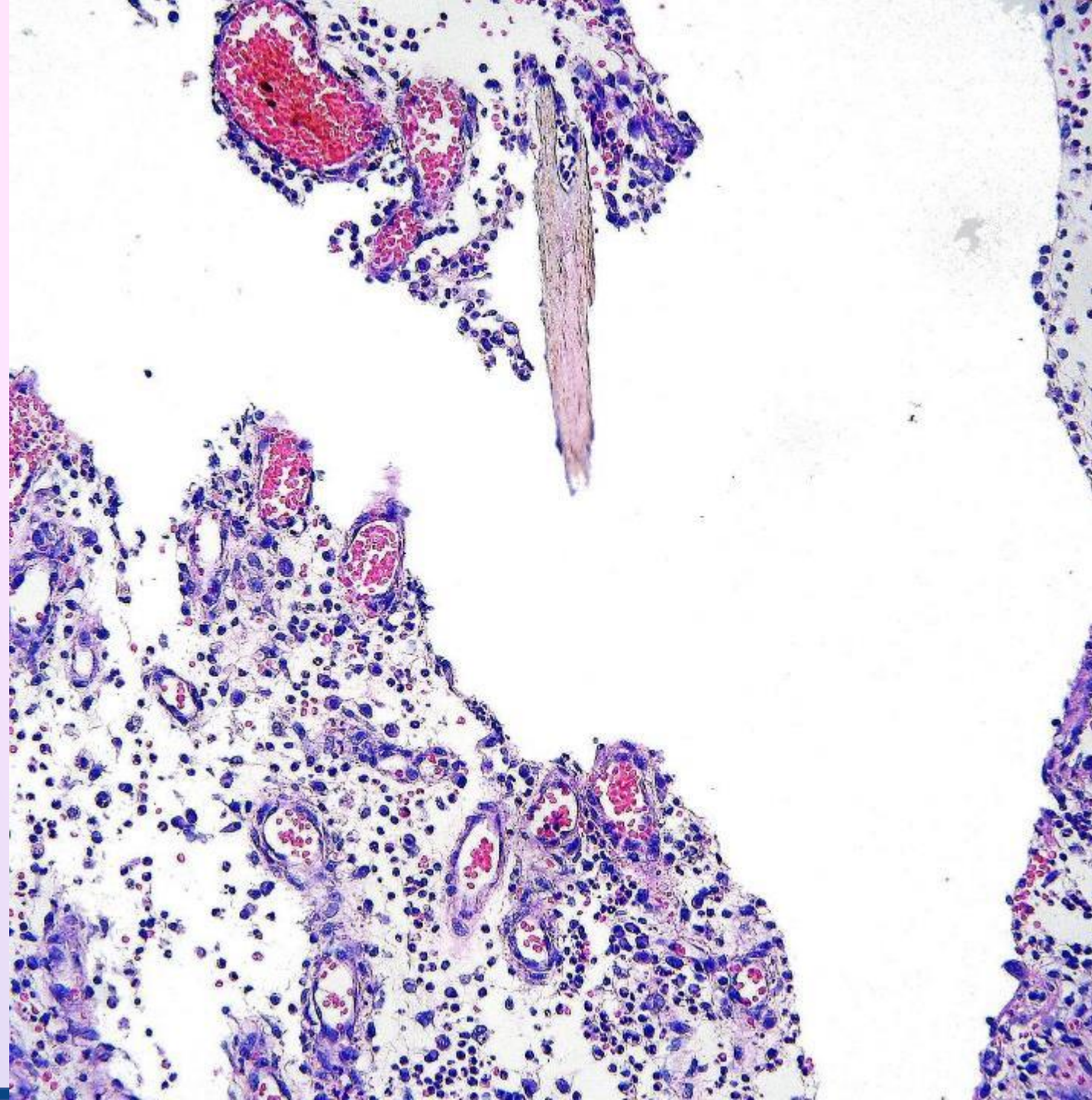
Paciente de 23 años de sexo masculino, presenta
pápula-nódulo en glúteo no doloroso de un año de
evolución





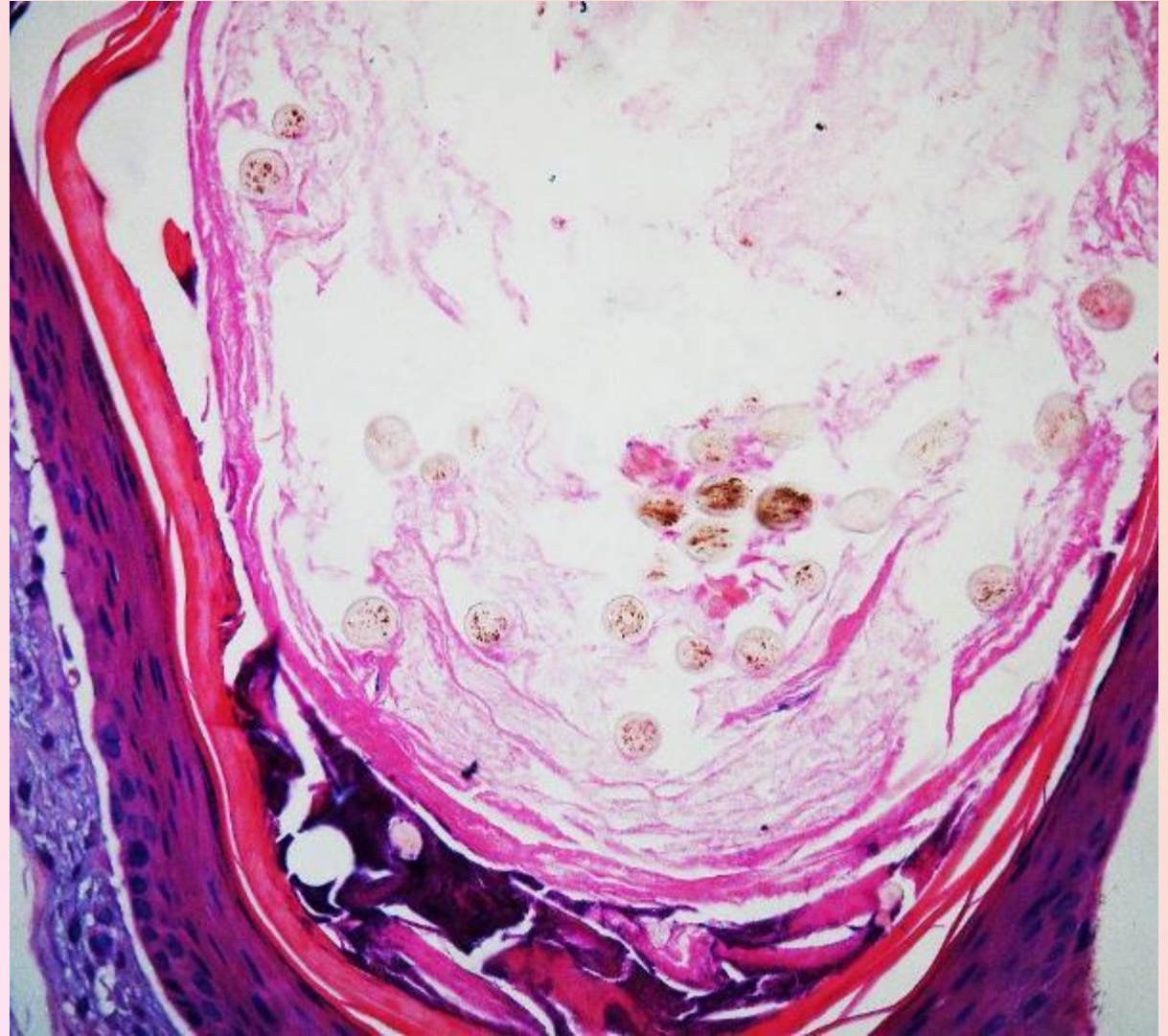
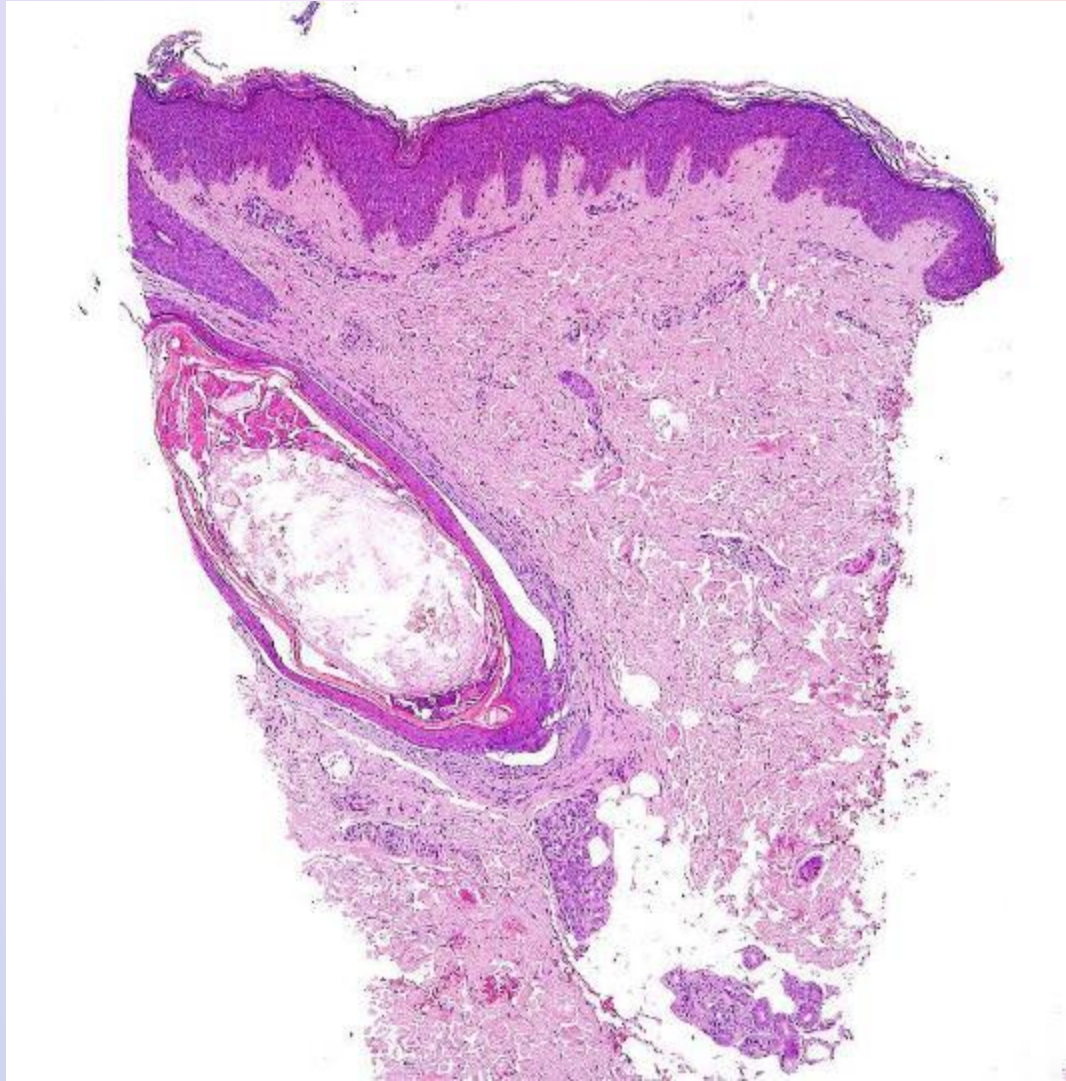




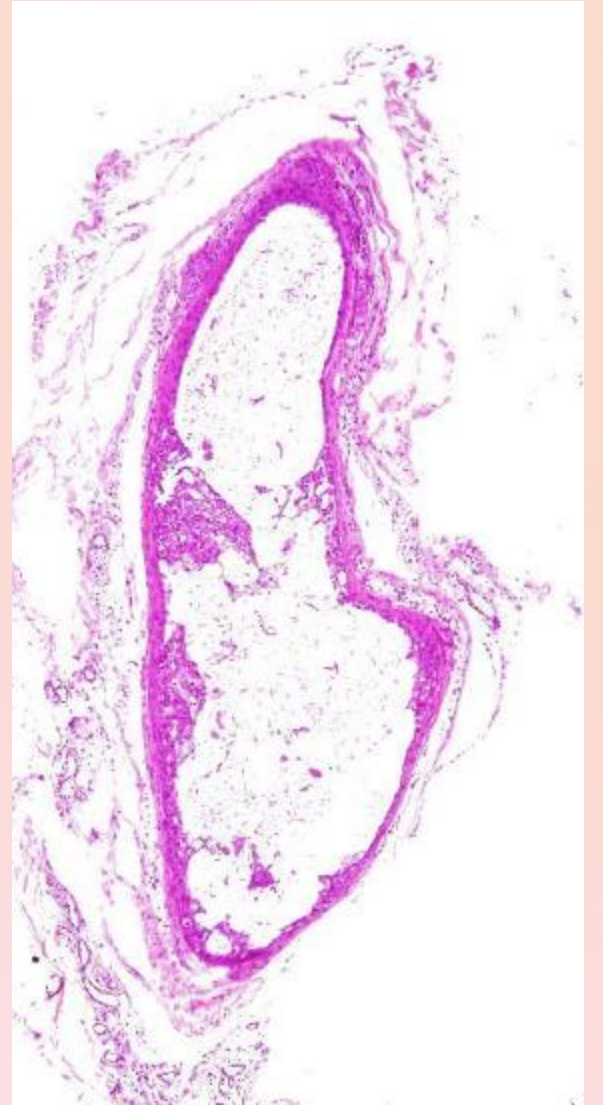
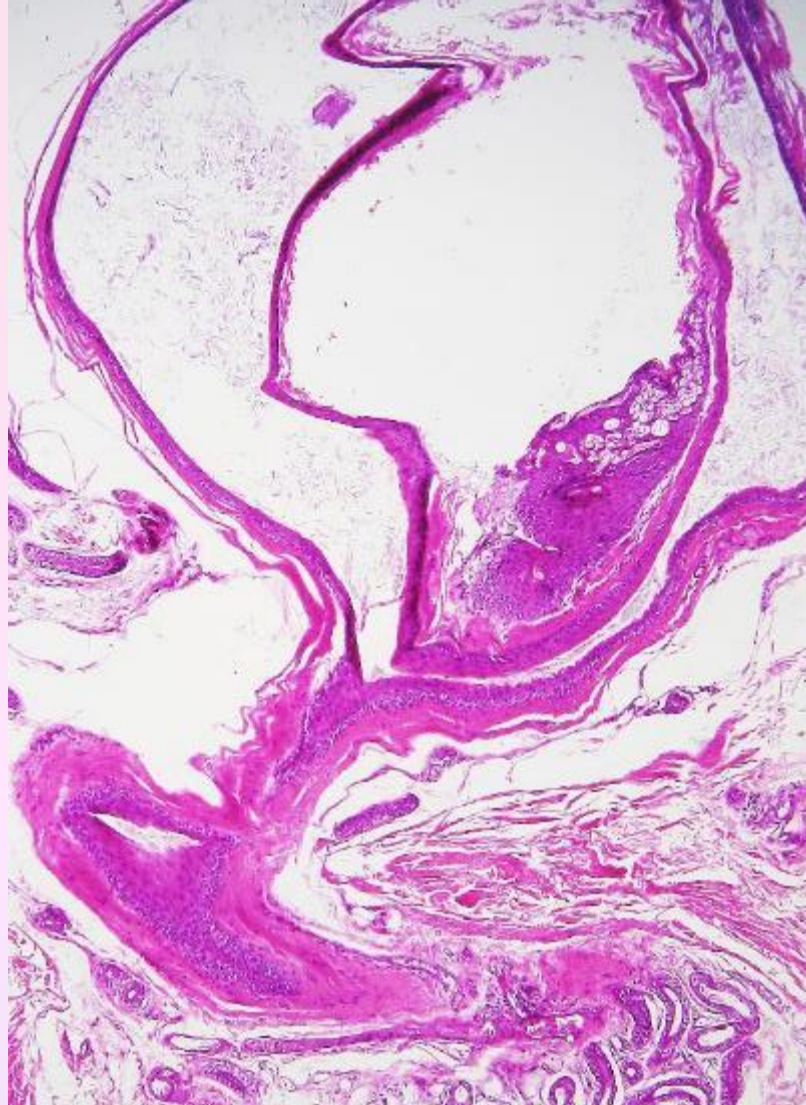
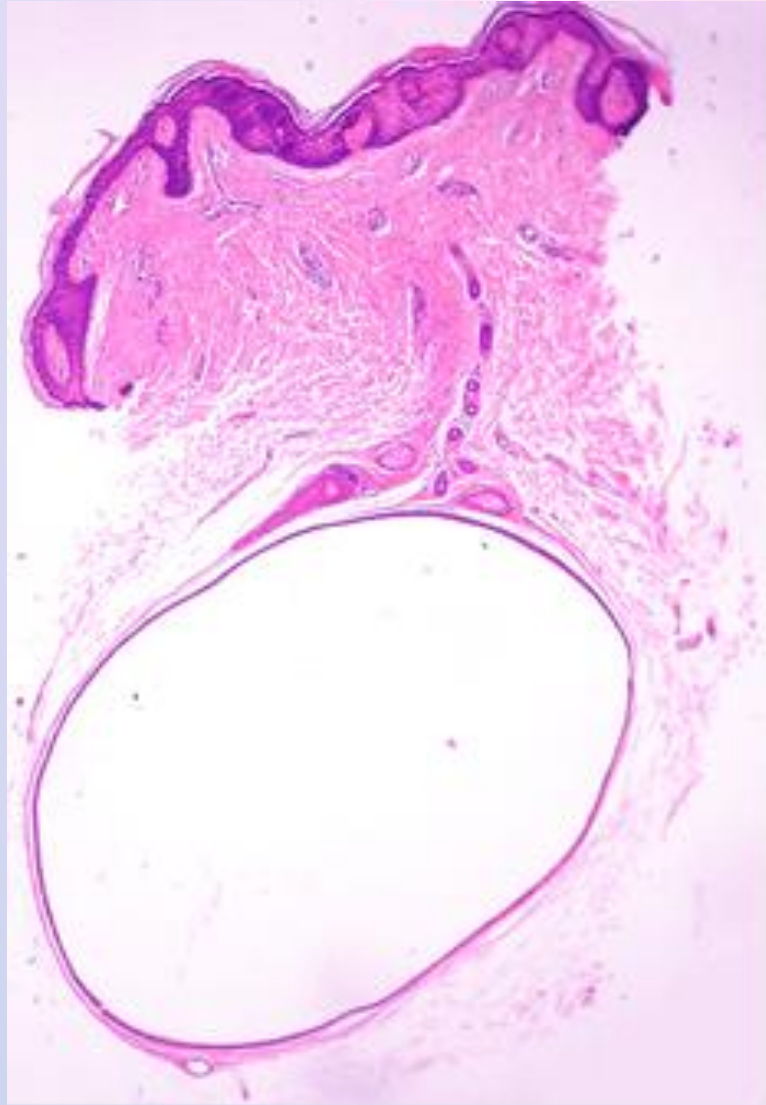


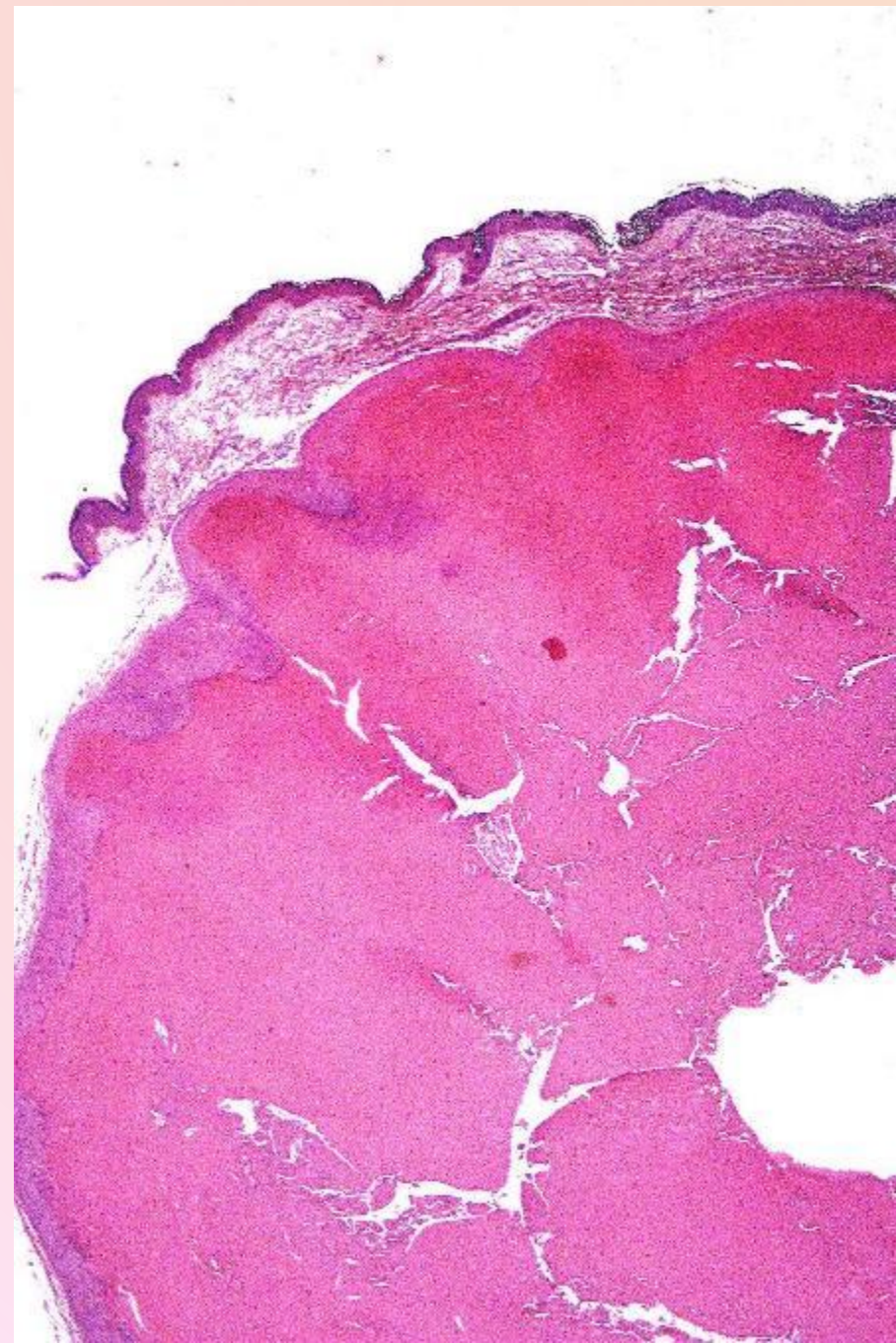
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