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4. Auricular pseudocyst

Pseudocyst of the auricle is a relatively uncommon condition in which serous fluid accumulates between intracartilaginous spaces of the ear and manifests as a painless, fluctuant, outer-ear swelling. This clinical entity occurs predominantly in men, although it can occur in both sexes, all races, and at any age. Most cases are unilateral, but bilateral cases have been described.

Although the etiology is not clear, these lesions have been associated with minor trauma from a variety of sources, including hard pillows, stereo headphones, and motorcycle helmets. Others have suggested that a minor defect in auricular embryogenesis contributes to pseudocyst formation. This defect causes residual tissue planes to form within the auricular cartilage. Chronic minor trauma, which is believed to create an intracartilaginous cavity, is accepted to be the most probable cause.

Diagnosis

Clinically, an auricular pseudocyst manifests as a benign, noninflammatory, asymptomatic swelling on the lateral or anterior surface of the pinna, usually in the scaphoid or triangular fossa. The swelling typically develops over a period of 4 to 12 weeks.

Pseudocysts of the auricle are usually diagnosed by anamnesis (nonacute painless swelling) and examination (absence of inflammatory signs), although a punch biopsy confirms diagnosis. Histological examination reveals an intracartilaginous cavity lacking an epithelial lining, with thinning cartilage and hyalinizing degeneration along the internal border of the cystic space. The epidermis and dermis overlying the pseudocyst are usually normal; however, a dermal perivascular lymphocytic infiltrate is commonly found. Intracartilaginous fibrosis and granulation tissues are manifestations of later stages of pseudocysts.

Differential diagnoses include subperichondrial hematoma caused by accumulation of blood secondary to trauma, relapsing polychondritis, chondrodermatitis nodularis helicis, cellulitis, and otoseroma.

Treatment

Treatment goals include the preservation of anatomic architecture and prevention of recurrence. Without treatment, permanent deformity of the auricle might occur. Treatment options include needle aspiration; incision and drainage with pressure dressing; needle aspiration with pressure dressing; drainage and pressure dressing; compression suture therapy; intralesional administration of tincture of iodine; intracartilaginous trichloroacetic acid and pressure dressing with button bolsters; curettage and fibrin glue; intramuscular corticosteroid therapy; high-dose oral corticosteroid therapy; and intraleSIONAL corticosteroid therapy. The reason there are various methods of treating auricular pseudocysts described in the literature could be because of the high recurrence rates reported with treatment by aspiration alone.

When pseudocysts do recur they typically do so within several weeks. The mainstay treatment, therefore, is probably drainage (needle aspiration or punch biopsy) followed by any pressure mechanism (Figure 1), owing to its lower recurrence rates. Our patient was treated with a simple 3-mm punch biopsy followed by the application of a bolster for approximately 2 weeks with optimal cosmetic results.

Dr Vano-Galvan is a resident of dermatology at the Ramón y Cajal Hospital in Madrid, Spain.

Competing interests

None declared

References


Figure 1. Proposed pressure mechanism using a button bolster for the treatment of auricle pseudocyst: A) Cellophane-covered button and dressing (materials required); B) Following drainage by needle aspiration or punch biopsy, a cellophane-covered button is placed over the affected area for protection to avoid recurrences; C) Button fixed in place with a bandage until treatment is finished (about 1 to 2 weeks).