Answer to Dermacase *continued from page 31*

2. Dermoid cyst

Dermoid cysts are true hamartomas derived from both ectoderm and mesoderm. There are 3 types: acquired epidermal cysts, which result from traumatic implantation of part of the skin into its deeper layers; congenital teratomas, arising from embryonic epithelium and containing bone, cartilage, teeth, and other structures, which typically develop in the ovaries and testes; and congenital inclusion dermoid cysts, which form along the lines of embryologic fusion[1] and include dermoid cysts of the head and neck.

Dermoid cysts might be seen at birth but often present in childhood. Sudden changes in size make diagnosis more challenging. Approximately 7% of dermoid cysts occur on the head and neck, with the orbit most commonly affected.[2] They also occur in the floor of the mouth, nasal, submental, and substernal areas.[3] Pathologic confirmation is required to establish diagnosis. Histologically, a dermoid cyst must contain 2 germ cell layers. A keratinizing squamous epithelium is typically present, as are adnexal structures such as hair follicles and sebaceous glands. The contents of a dermoid cyst vary and might also include cartilage and teeth.[1-3]

The differential diagnosis includes epidermal inclusion cysts, glioma, meningoencephalocele, and nevus sebaceus.[2,4] An epidermal inclusion cyst is a benign cutaneous skin-coloured or red inflamed papule or nodule, commonly on the face or trunk. Glioma, a neoplasm arising from glial cells, most commonly occurs in the brain. A meningoencephalocele is a protrusion of the meninges or brain tissue as a result of a congenital cranial defect. Nevus sebaceus, a hamartomatous lesion usually noted at birth or in early childhood, usually manifests as a solitary hairless patch on the scalp. Dermoid cysts can be easily differentiated based on their peculiar histologic features. In our case, after a computed tomography scan of the head revealed no evidence of intracranial communication, punch biopsy results revealed the typical histologic features of a dermoid cyst.

A high index of suspicion is required to detect dermoid cysts. A sinus dimple or abnormal hair distribution on a congenital lesion at a typical location should raise suspicion of intracranial extension.[5] Medical imaging helps rule out this possibility and must be performed before surgical intervention. Intracranial extension is rare—it is mostly reported with midline lesions over the scalp and nose.[6] After complete excision of dermoid cysts, recurrence is unusual.

Drs Chedraoui and **Abbas** were Chief Residents in the Department of Dermatology when this article was written and **Dr Salman** is an Associate Professor, all at the American University of Beirut Medical Center in Lebanon.

Competing interests
None declared

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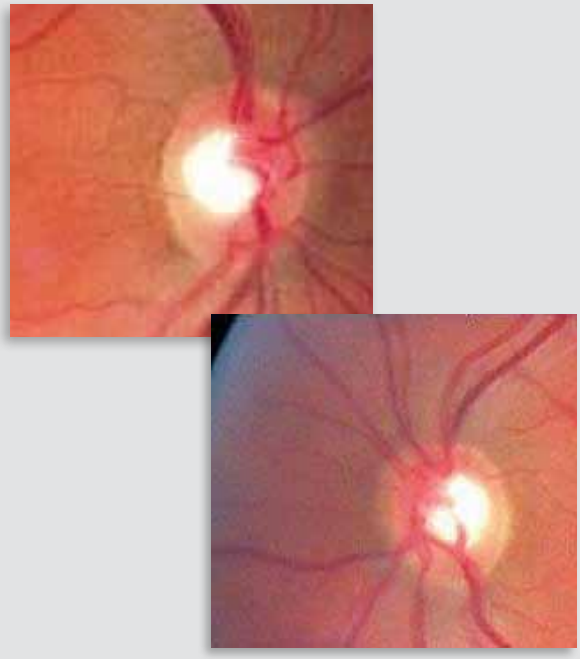
Ophthaproblem



Can you identify this condition?

Jonathan A. Micieli **Michael Surkont**
Shawn L. Cohen MD CM FRCSC DABO

A 58-year-old woman with a family history of glaucoma presents with an intraocular pressure of 30 mm Hg (normal 10 to 21 mm Hg) and a central corneal thickness of 616 µm (normal 540 to 561 µm). Her visual acuity is 20/20, with a normal visual field. Photos of the optic disk reveal the above images.

The most likely diagnosis is

1. Primary open-angle glaucoma
2. Central retinal vein occlusion
3. Ocular hypertension
4. Nonexudative macular degeneration

Answer on page 36