Answer to Dermacase *continued from page 667*

3. Steatocystoma multiplex

Steatocystoma multiplex (SM) is a rare, benign, sporadic or familial disorder. Although most cases of SM in the literature are of the sporadic variety, a few cases of patients with an autosomal dominant mutation in keratin 17 have been reported.[1] Steatocystoma multiplex might present concomitantly with pachyonychia congenita type 2 (which is characterized by hypertrophic nail dystrophy, focal keratoderma, multiple pilosebaceous cysts, and myriad conditions associated with ectodermal dysplasia) or eruptive vellus hair cysts.[1] No sex or ethnic predilection has been identified in SM.[2]

In its classical presentation, the lesions of SM appear during adolescence or in early adulthood.[2] Although the average age of onset is 26 years, a 78-year-old man with late-onset facial SM was reported in literature.[3]

Our patient had an extensive family history of SM, of varying severity. His father, uncle, and male sibling had similar scrotal subcutaneous cysts. There was no personal or familial history of nail disorders.

Diagnosis

Steatocystoma multiplex is characterized by multiple, localized or widespread, asymptomatic or inflammatory dermal cysts involving the pilosebaceous units.[4] Lesions can appear anywhere on the body, but SM is more commonly involved with those areas of the skin with a high density of developed pilosebaceous units, such as the axilla, groin, neck, and proximal extremities. There are several variants of SM, including localized, generalized, facial,[3] acral,[5,6] and suppurative types.[7]

Histopathologic examination reveals well-encapsulated cysts, with the cyst walls folded with several layers of epithelial cells and a thick eosinophilic cuticle without a granular layer. The cavities of the cysts might be filled with vellus hairs and hair follicles.[6]

Treatment

Most SM lesions are asymptomatic. There is no preferred treatment or curative method mentioned in the literature. Lesions can be widespread and only the suppurative variant of SM requires antibiotic therapy.[7] Tetracycline derivates with their anti-inflammatory effects have been reported to be efficient in this variant, while oral isotretinoin therapy has been administrated for suppurative lesions with limited success.[8] To remove lesions, cryotherapy can be administered, although there is a risk of residual scarring. Facial lesions can be aspirated with an 18-gauge needle to minimize scar formation, but recurrence is frequent. Carbon dioxide laser ablation is likely the preferred method for removing widespread and numerous lesions with no anesthesia, as the technique boasts a low percentage of recurrence and a good cosmetic outcome.[9] However, surgical excision still remains the most commonly applied method of treatment of SM.

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Competing interests
None declared

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