SEBACEOUS NEOPLASMS

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Sebaceous neoplasms

- Sebaceous adenoma (Benign)
- Sebaceous carcinoma (Malignant)
SEBACEOUS ADENOMA

**Benign** tumours composed of incompletely differentiated sebaceous cells of varying degrees of maturity
- **Papule** usually < 1 cm dia
- Mostly on head or neck
- Occasionally yellowish/brownish
- **Sebaceoma** – nodular variant, located deeper in dermis
• Similar clinically with sebaceous hyperplasia
• However solitary and larger
Sebaceous hyperplasia

Multiple sebaceous lobules composed of mature sebocytes frequently radiating from dilated hair follicles
Sebaceous adenoma

- Lacks a central follicle
- Connect directly to epidermis
- Well-circumscribed, multilobular tumour of predominantly mature, lipid-filled sebocytes with a rim of basaloid, germinative seboblasts at the periphery
Sebaceoma

• Located deeper in dermis

• Predominance of germinative sebocytes over mature, lipidized sebocytes

• May show mitoses but lacks cytological atypia
Treatment

• If microscopic diagnosis definite – no further treatment

• Often difficult to establish the circumscription of lesions in superficial/ partial biopsies

• Complete excision appropriate to exclude possibility of BCC with sebaceous differentiation or sebaceous carcinoma
SEBACEOUS CARCINOMA

- **Malignant** tumour with cells showing differentiation toward sebaceous epithelium

- **Rare**, <1% of all skin malignancies

- Occurs in middle-aged and elderly
- Solitary, firm, erythematous/ pearly nodules or plaques
- May be ulcerated/ crusted
- Occasionally display yellowish colouration
- Head and neck region - commonest sites, particularly periocular area
- 40% involve eyelids
- Usually very slow growing
- Can metastasize to locoregional lymph nodes and distant sites
• Asymmetry and lack of circumscription

• Neoplastic cells (basaloid, basosquamous, and epidermoid) with various degrees of sebaceous differentiation arranged in lobules (nodular pattern) or sheets of cells (infiltrative pattern)

• Nuclear pleomorphism, prominent nucleoli, mitotic figures, areas of necrosis
Immunohistochemistry

- In nearly all cases
  - Epithelial membrane antigen (EMA) +ve
  - Adipophilin (ADP) +ve
  - Androgen receptor (AR) +ve

- Helps to differentiate from SCC & BCC
Treatment

• Wide local excision

• Mohs micrographic surgery

• Radiation therapy - in patients unable or not willing to undergo surgery
Prognosis & follow-up

- Local recurrence - 9-36% patients

- Older age, poorly differentiated tumors, distant metastasis - unfavorable prognostic factors

- Late relapses have been reported 5-11 years after excision - extended follow-up necessary
Muir Torre syndrome

- Rare *autosomal dominant* condition

- Association of at least one *sebaceous tumor* (sebaceous adenoma or sebaceous carcinoma or sebaceous keratoacanthoma) and at least one *visceral malignancy* (colorectal, endometrial, ovarian, and urothelial cancers)

- Considered a phenotypic variant of hereditary nonpolyposis colorectal carcinoma syndrome (Lynch syndrome)
• Skin tumours predominantly occur outside head and neck area

• Skin tumours can precede, occur concurrently, or follow the diagnosis of internal malignancy

• Caused by germline mutations in DNA mismatch repair (MMR) genes (MLH1, MSH2, MSH6 or PMS2)
Diagnosis

• Screen all sebaceous neoplasms for DNA mismatch repair protein defects (MLH1, MSH2, MSH6 or PMS2) by immunohistochemistry

• If abnormal – perform germline mutational analysis
Management

Patients diagnosed with Muir-Torre syndrome and first-degree relatives should undergo preventive cancer screening programme

- Annual skin examination

- For colorectal cancers (colonoscopy) starting at age of 20-25 years

- For stomach (endoscopy) and urogenital cancers (urinalysis, endometrial biopsy, pelvic ultrasound) starting at age of 30-35 years
References


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THANK YOU