

Cutaneous sebaceous gland carcinoma in the postauricular region

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Abstract

Carcinomas of the sebaceous glands of the skin are uncommon. These tumours metastasize frequently. A case of cutaneous sebaceous carcinoma localized in the postauricular region is presented with its exceptional large size and very poor prognosis.

Introduction

Sebaceous glands are prominent adnexal components of the skin found closely with hair follicles to form the pilosebaceous apparatus. They are alveolar and holocrine in type and the sebum thus formed is discharged via a short duct.

Cutaneous sebaceous neoplasms can be divided into three separate categories *viz.* sebaceous adenoma, basal cell carcinoma with sebaceous differentiation and cutaneous carcinoma (Raizada and Khan, 1986).

Carcinomas of the sebaceous glands are very rare. They generally occur in the head and neck region where these glands are concentrated. Ocular adnexae are the most frequent site of occurrence where it has a poorer prognosis than cutaneous sebaceous carcinoma located elsewhere (Hood *et al.*, 1986).

Case report

A 65-year-old man was referred to our department with a 7 × 7 cm ulcerated, mobile, non-tender mass localized in the right postauricular region present for the past two months (Fig. 1). An incisional biopsy was performed. Histopathological examination revealed a sebaceous gland carcinoma (Fig. 2). The photomicrographs show the characteristic fea-



FIG. 1

Ulcerated mass of sebaceous gland carcinoma in the right postauricular region.

tures of a sebaceous gland tumour (Figs. 3 & 4). Any lingering doubt about the primary nature of the postauricular tumour would have been dispelled by a post mortem examination lacking in this case. A total body investigation was carried out to determine the stage of the disease. Para-aortic lymph node and multifocal liver metastasis and free fluid (ascites) in the peritoneum were demonstrated by ultrasonography and computed tomography.

The mass was excised totally for palliation and the defect covered with a split-thickness skin graft. A chemotherapy programme composed of Mitomycin (10 mg), Vepesid (100 mg) and Cisplatinium (80 mg) was started. Liver functions were affected and the ascites increased dramatically. Tumour recurrence in the excision site and metastasis producing a fixed cervical lymph node occurred on the second post-operative month. The patient died five months after the onset of the disease.

Discussion

The pilosebaceous unit including sebaceous and apocrine glands, develops *in utero* over the entire skin surface except the palms and soles. The sebaceous glands specialized for lipid synthesis are widely distributed over the body but concentrated in the scalp, face, upper back and chest. Each hair follicle is associated with sebaceous glands. Some sebaceous glands without associated hairs open directly onto the surface and are known as sebaceous follicles. On the eyelids they are known as Meibomian glands.

The sebaceous gland depends upon, and is extremely receptive to, androgenic hormones. Androgens increase the sebaceous gland size, secretion of sebum and the mitotic rate of the sebaceous gland (Evans *et al.*, 1979). The development of squamous or basal cell cancer in pre-existing chronic radiodermatitis is well recognized. Four cases of cutaneous carcinoma of the face after superficial radiotherapy have been reported since 1958 (Hood *et al.*, 1986). Patients with a history of radiation and such skin changes in areas normally having a large population of sebaceous glands may be at risk for this malignancy and should be monitored accordingly. Such lesions warrant wide excision with removal of as much of the irradiated tissue as possible (King *et al.*, 1979; Hood *et al.*, 1986).

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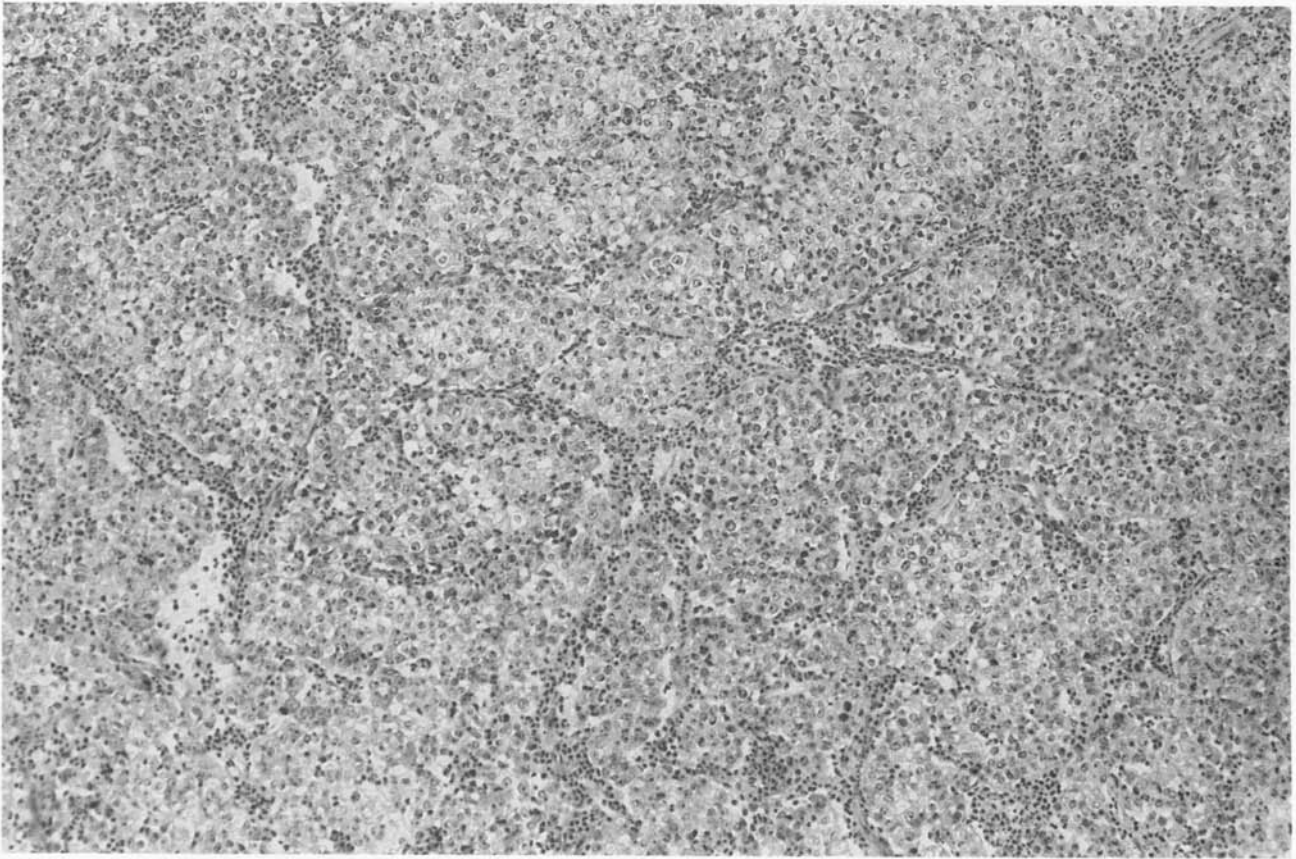


FIG. 2

Survey picture to show the lobular structure of the tumour. Note the basaloid cells forming a peripheral layer around the differentiated sebaceous cells. (Haematoxylin-eosin $\times 157$)

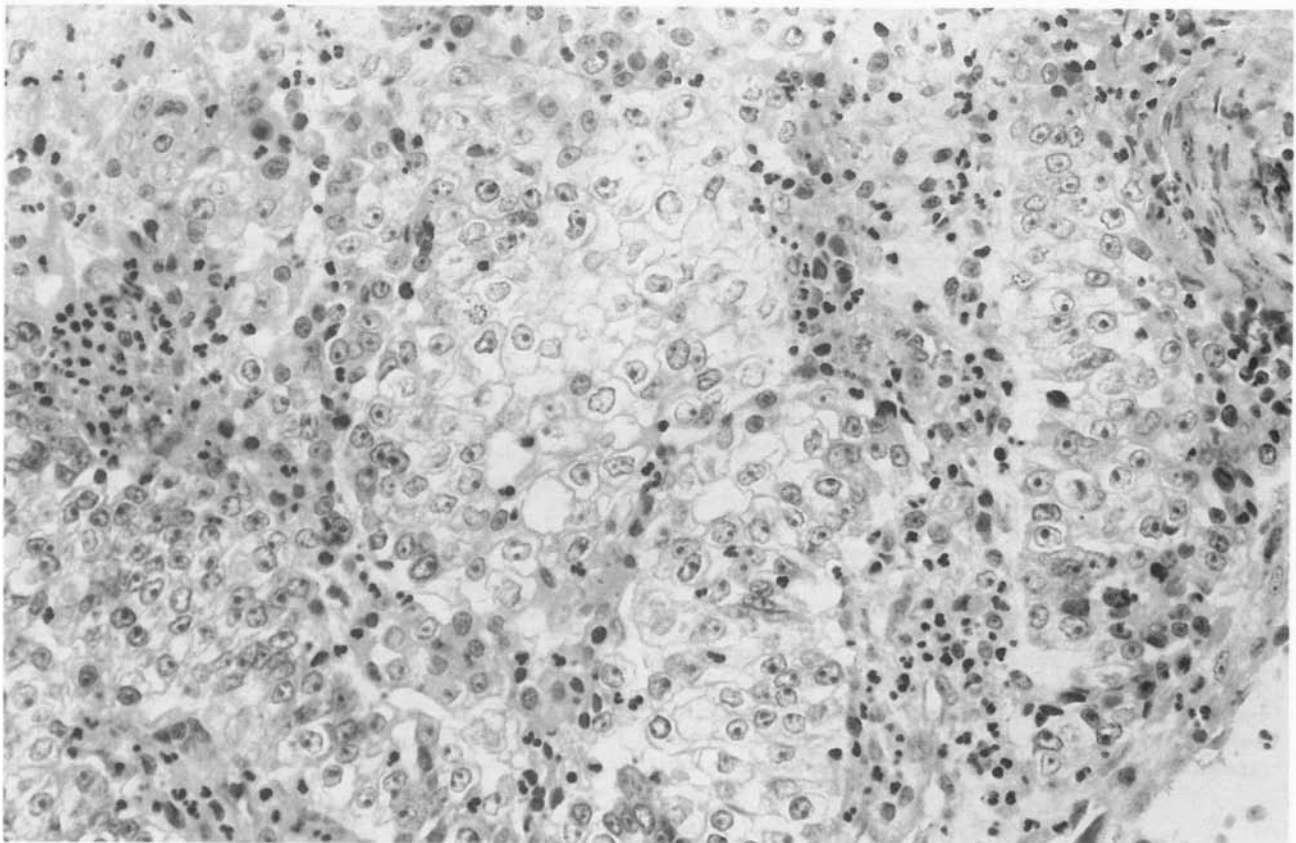


FIG. 3

High power illustration of the clear sebaceous cells forming the central parts of the lobules seen in Fig. 2. Note the outer layers formed by cuboidal to columnar cells, shown in detail in Fig. 4. (Both H&E $\times 400$)

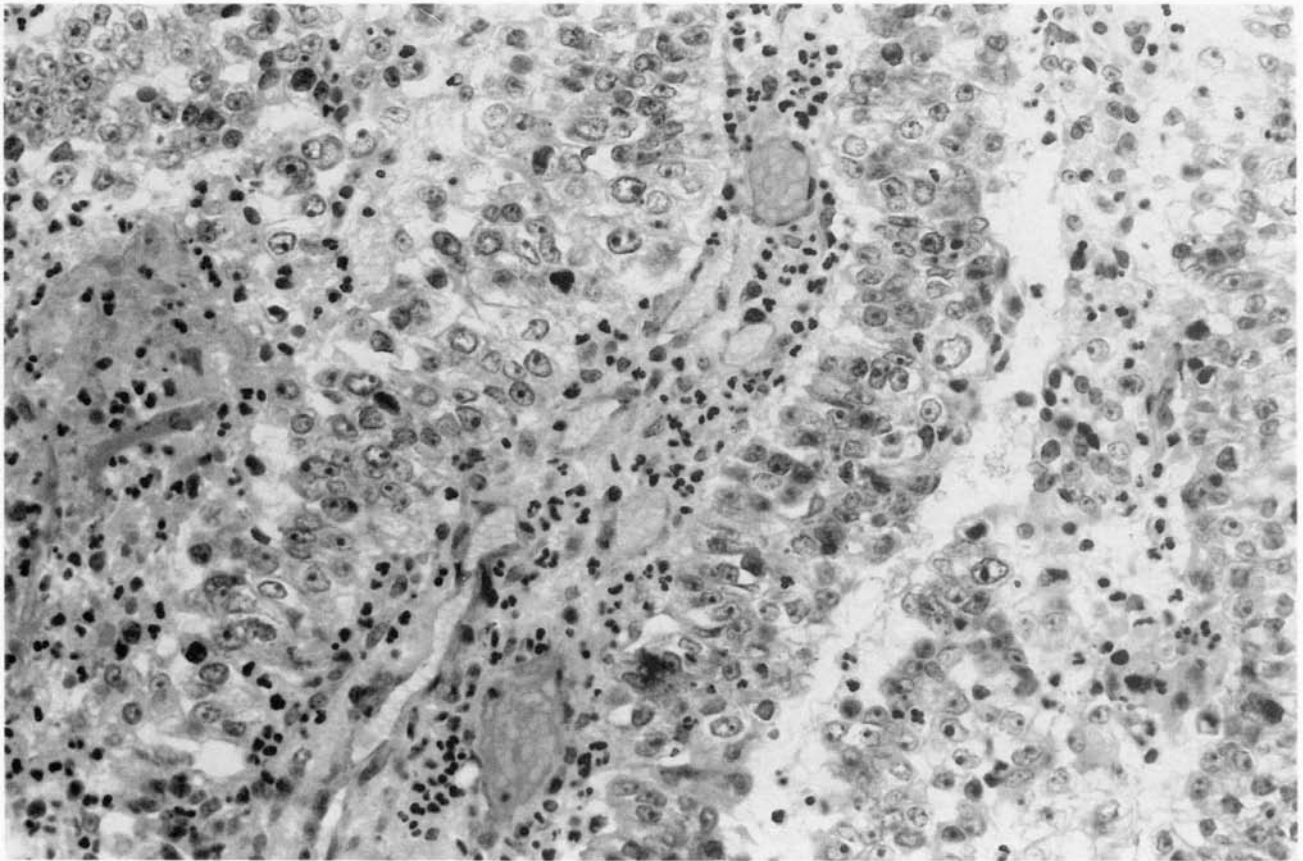


FIG. 4

Photography by Janet McKenzie, Clinical Photographer at Northwick Park Hospital, Harrow, acknowledged with many thanks.

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