

Disclosures

February 5, 2018

The following planners and faculty had no financial relationships with commercial interests to disclose:

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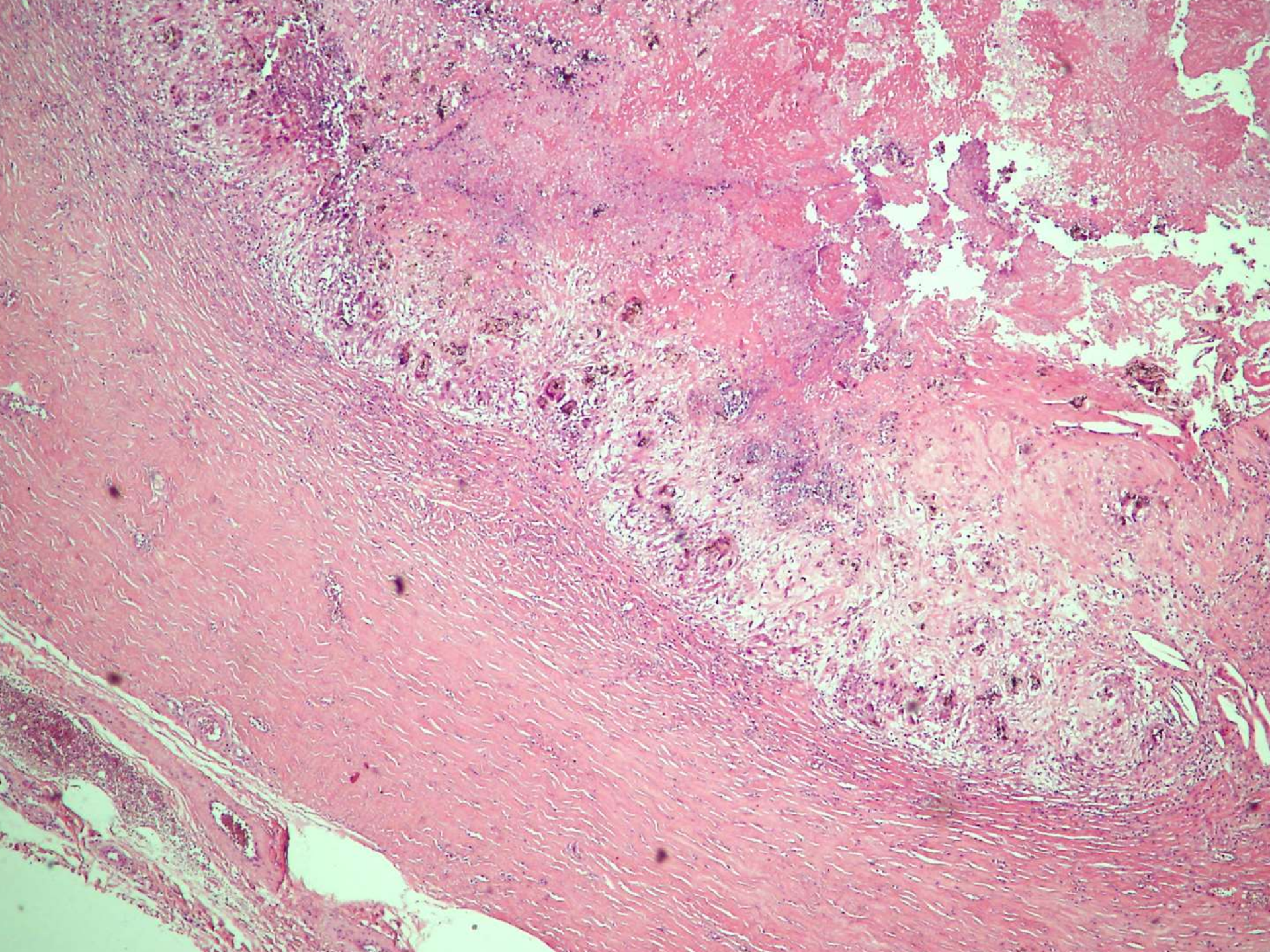
Ankur Sangoi, MD

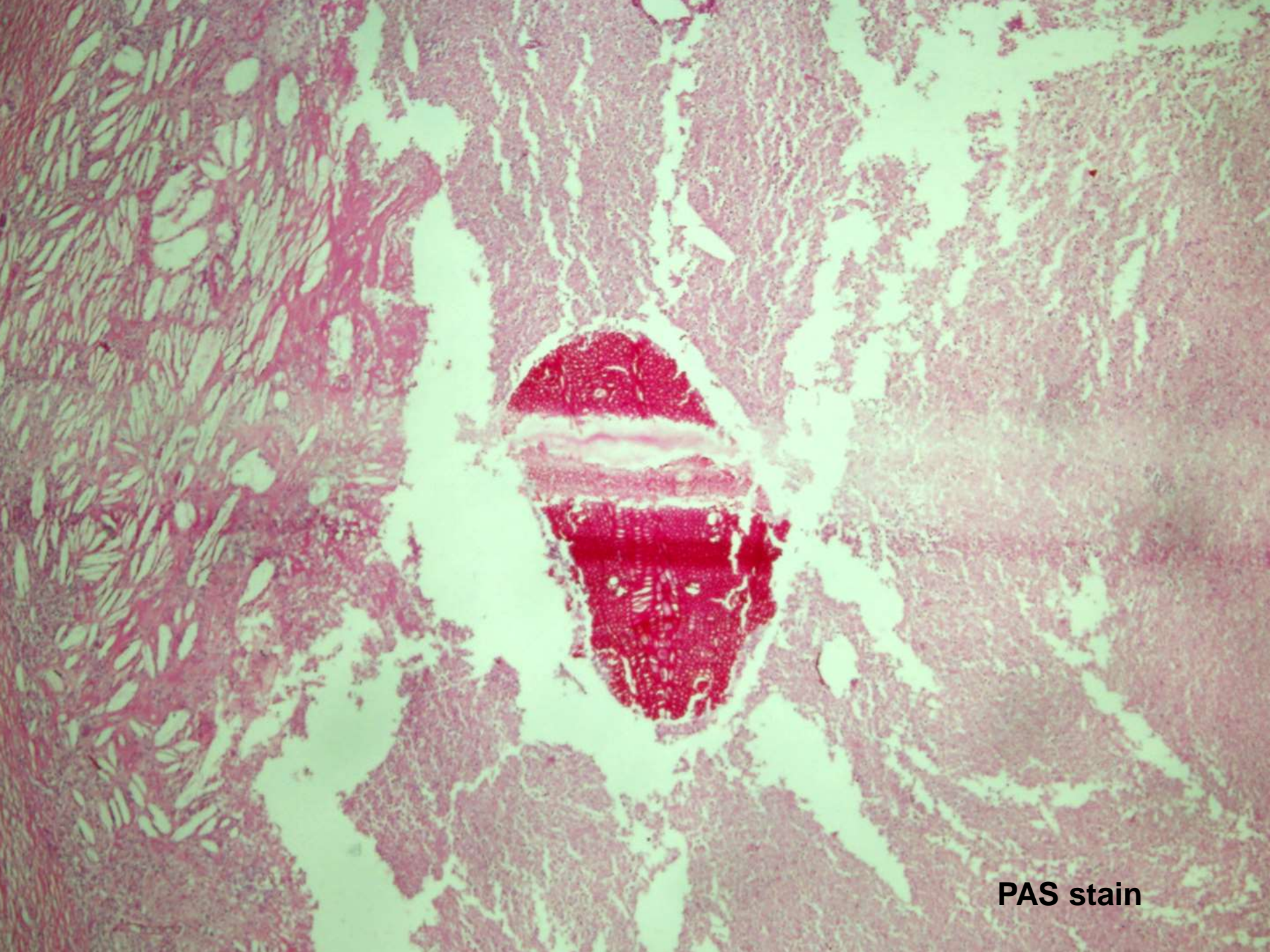
Megan Troxell, MD, PhD

SB 6241

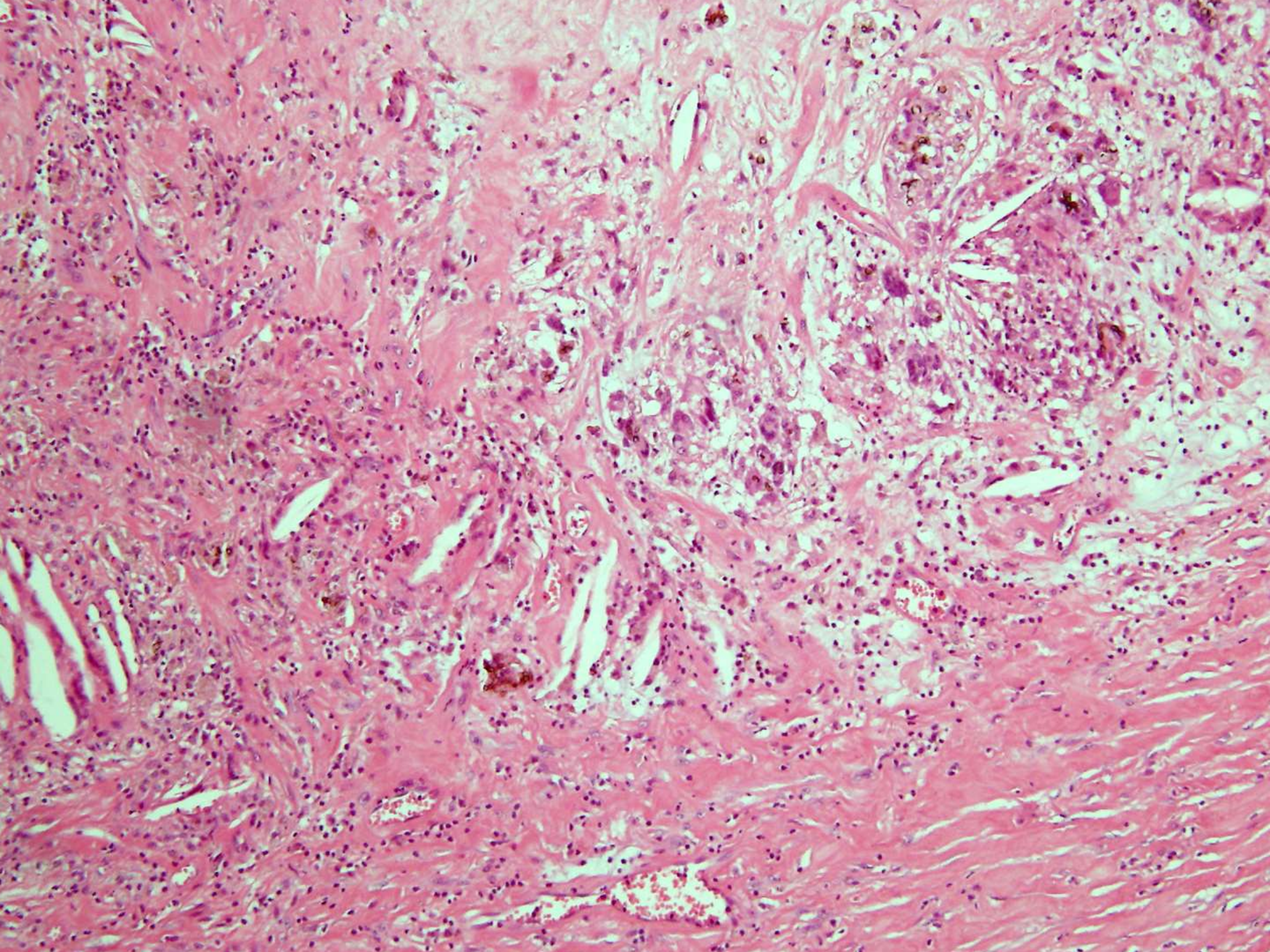
**Nabeen Nayak; Sir Ganga Ram
Hospital, New Dehli**

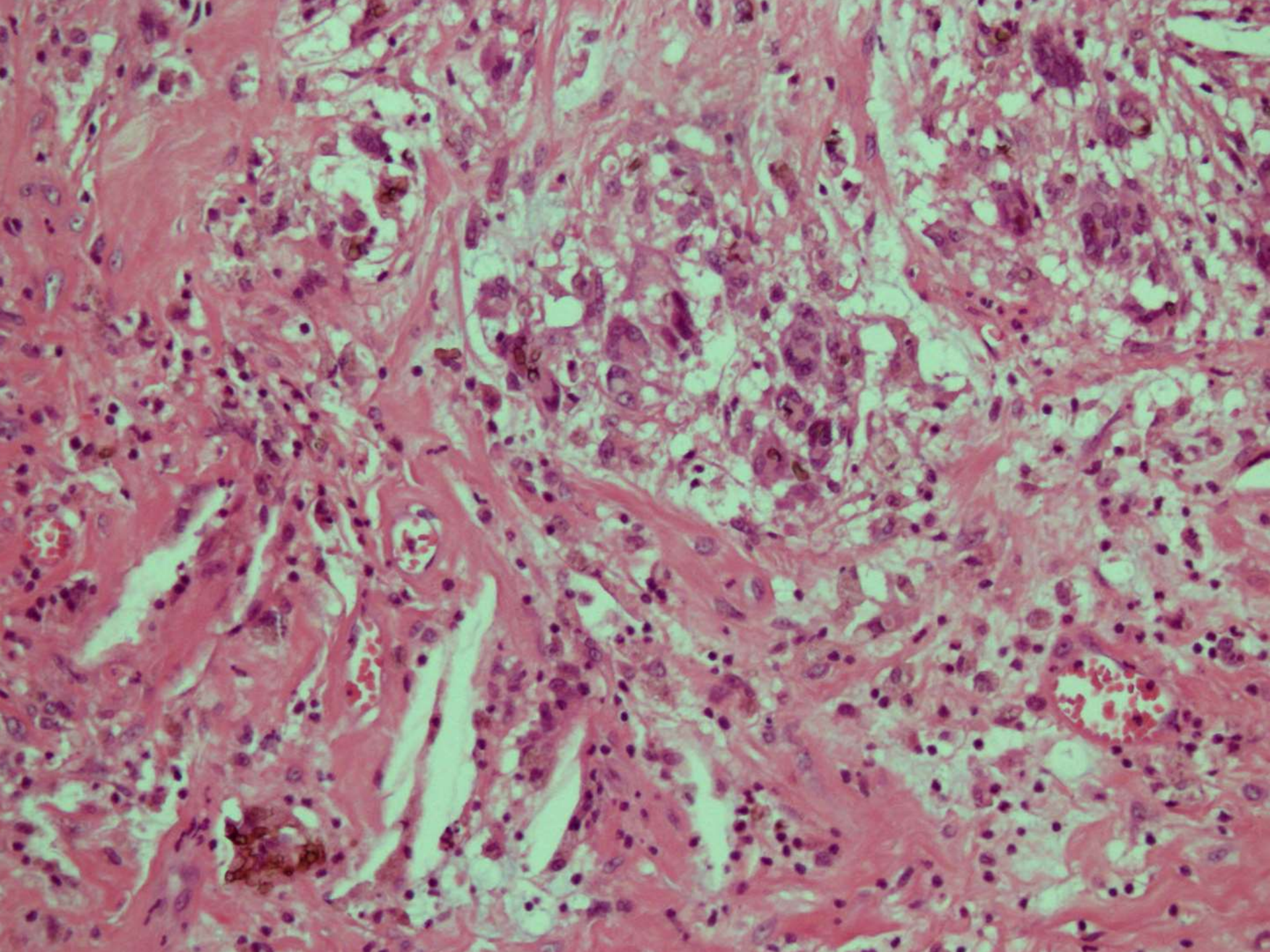
71-year-old male with nodular, partly
ulcerated skin lesions in both feet.

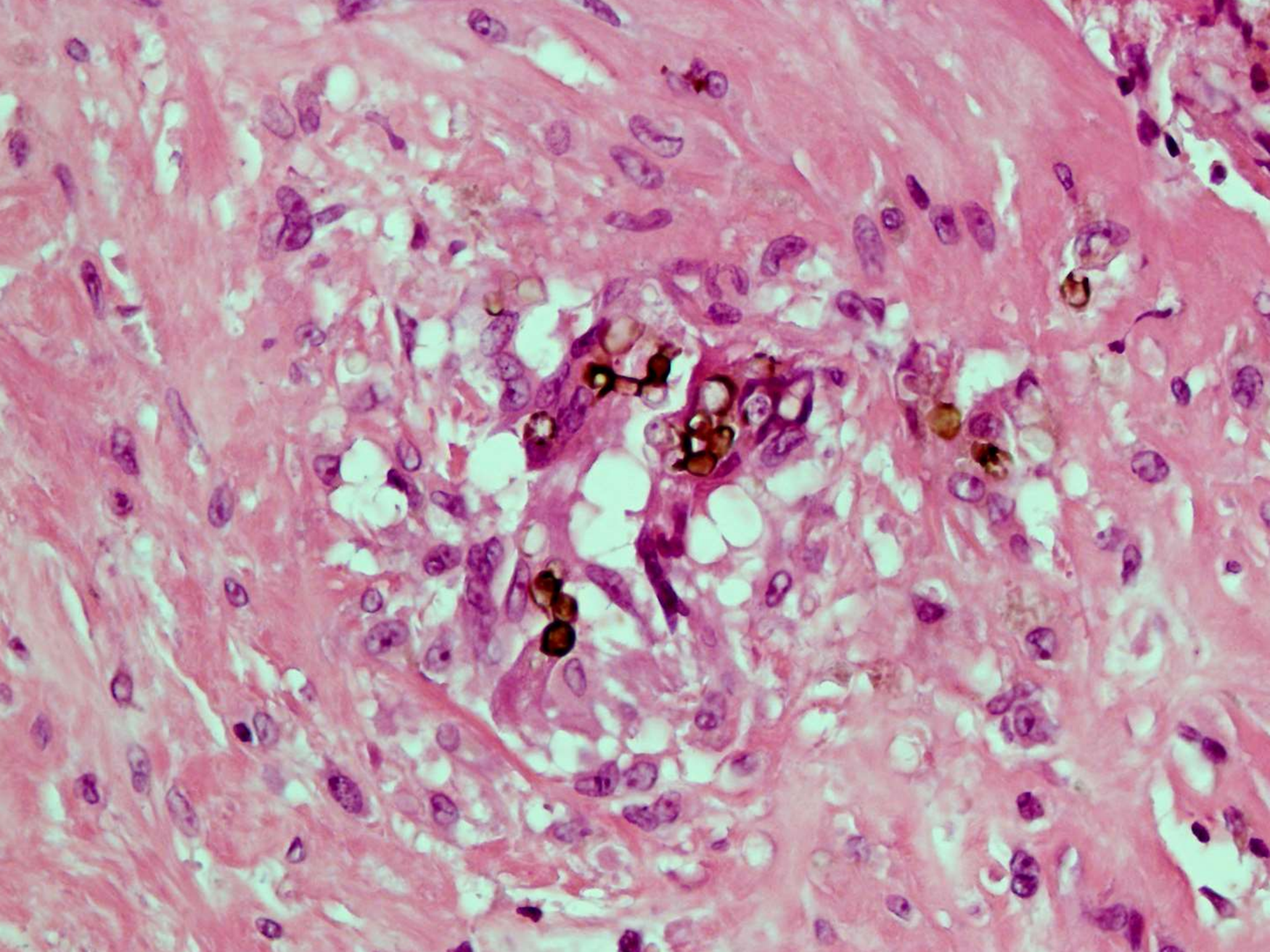


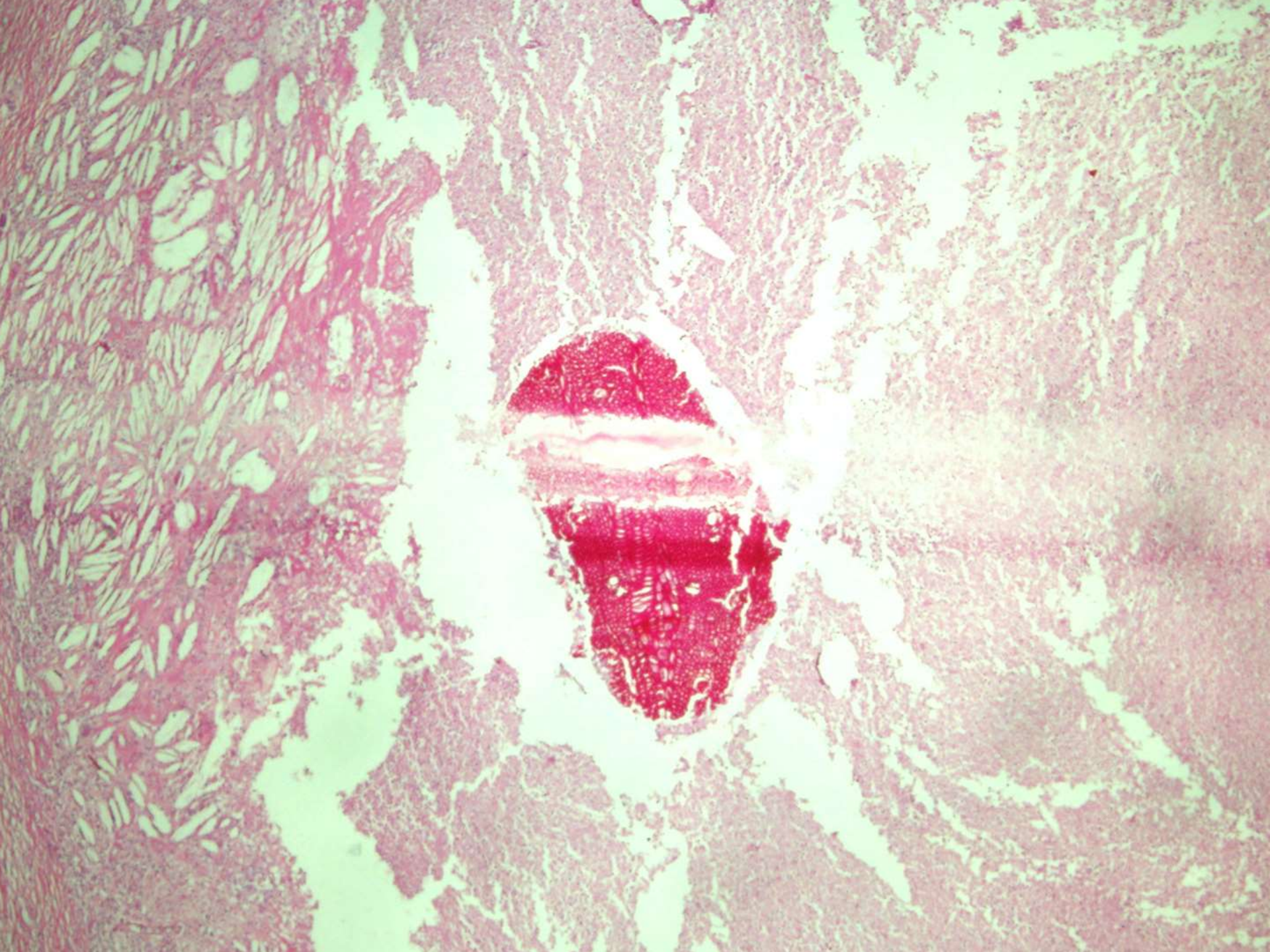


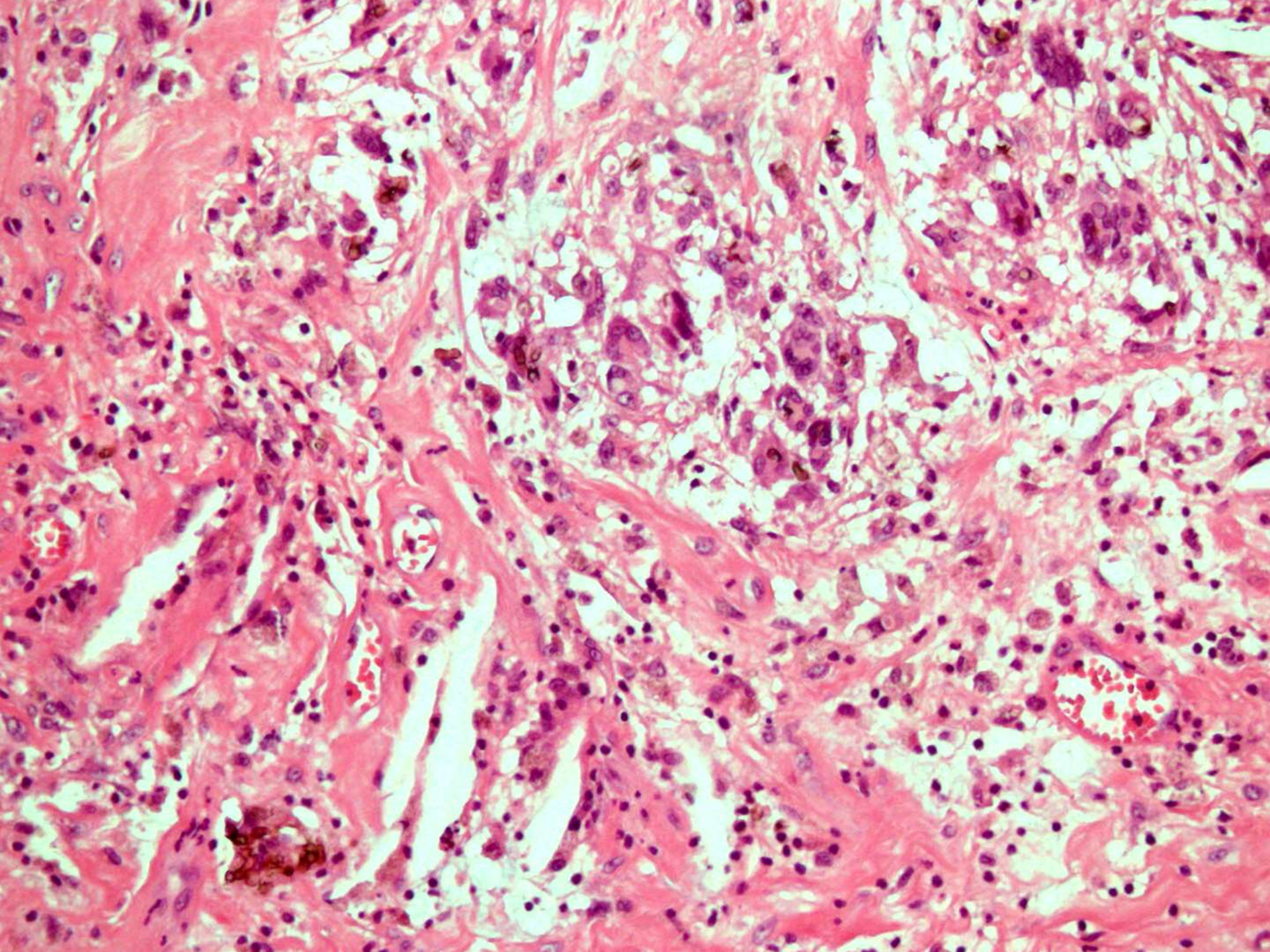
PAS stain

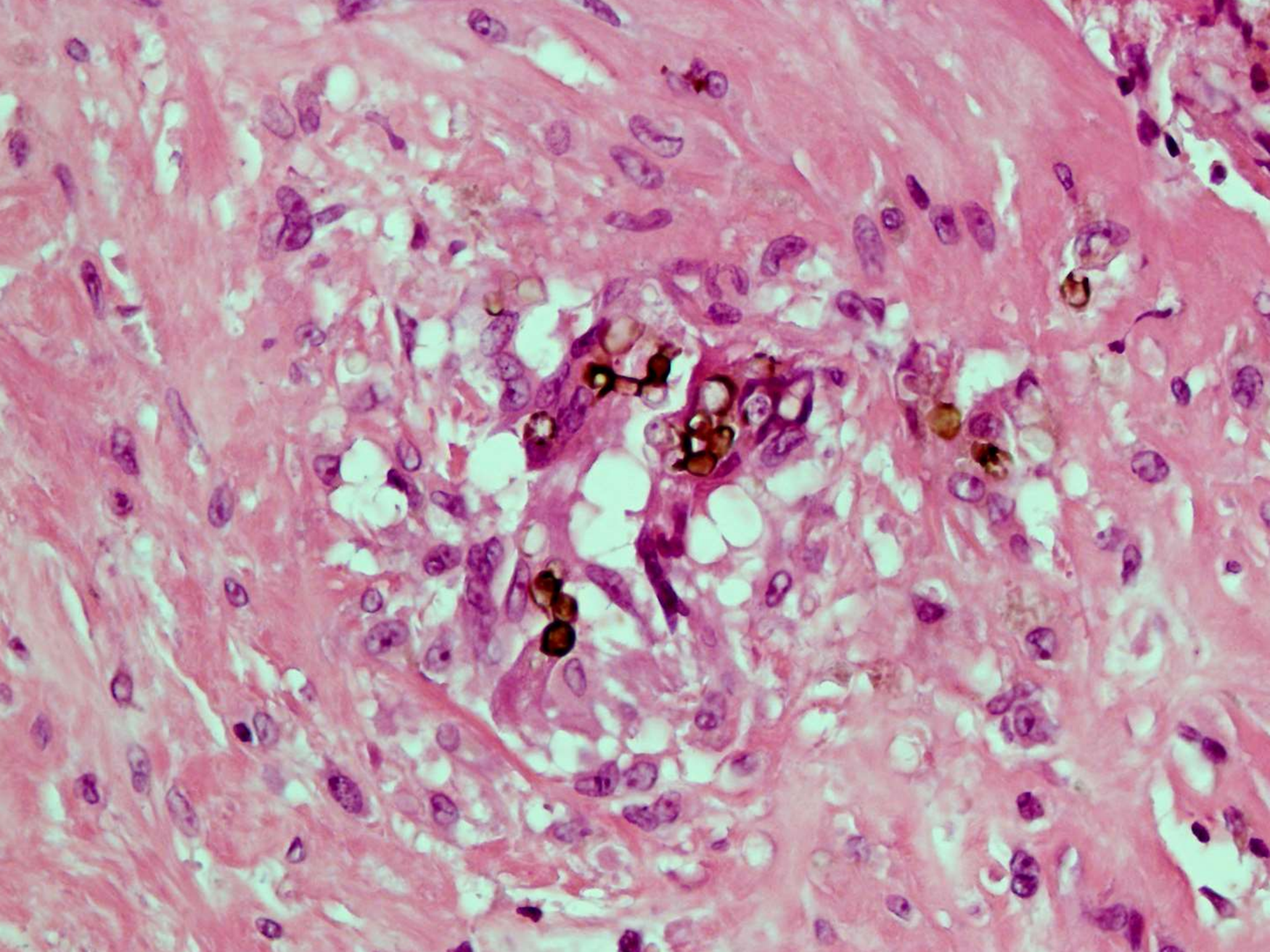


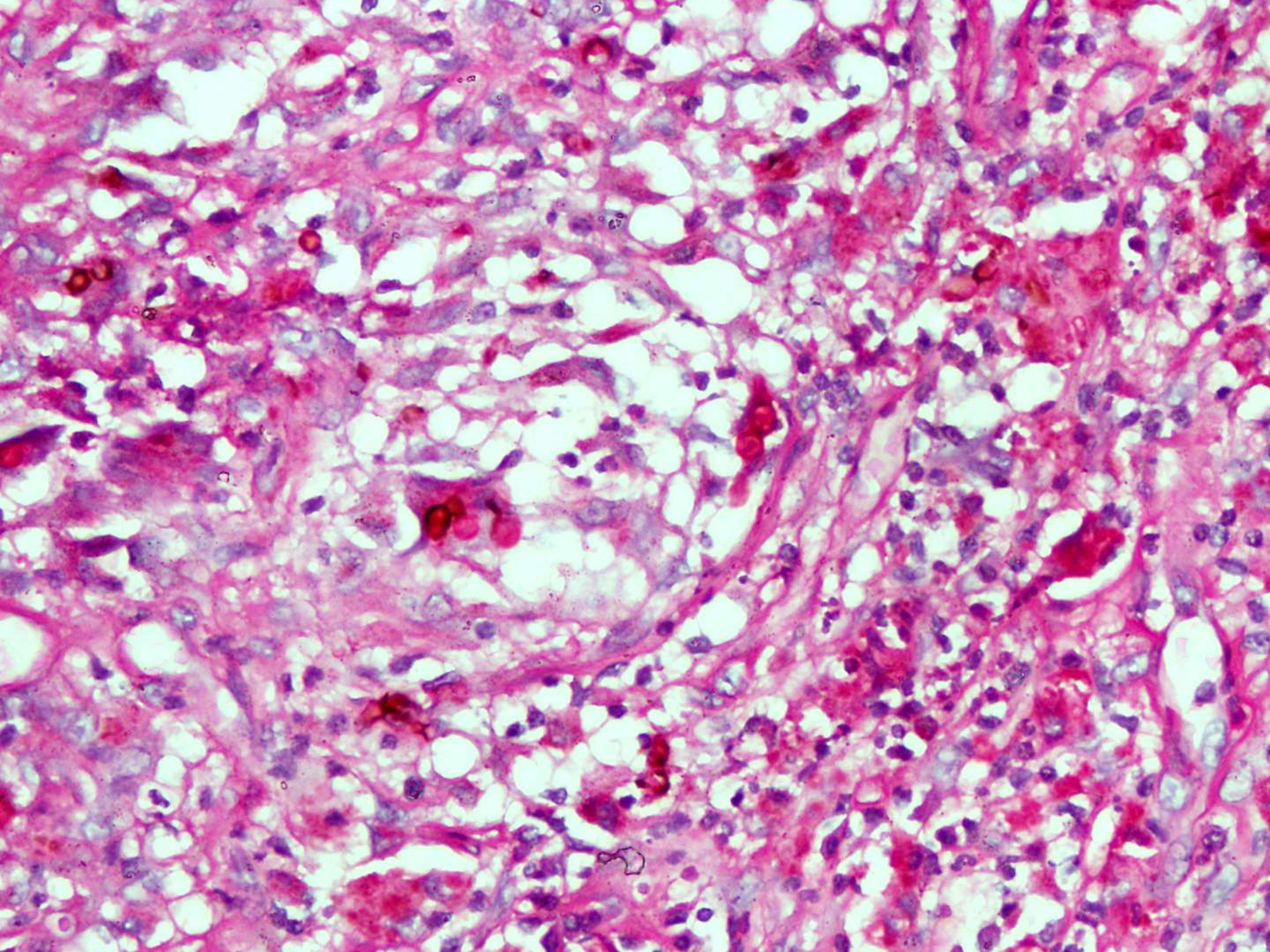


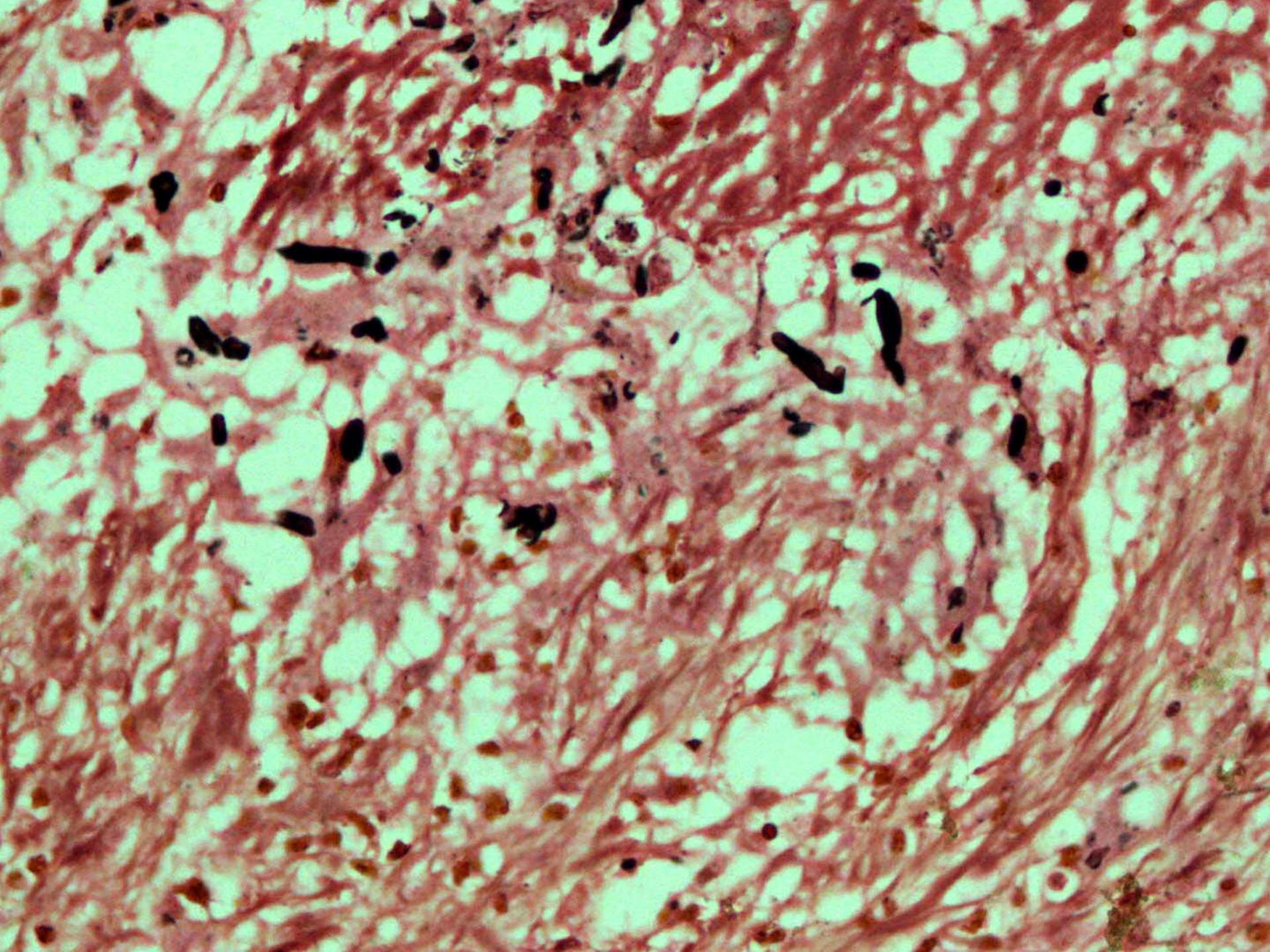


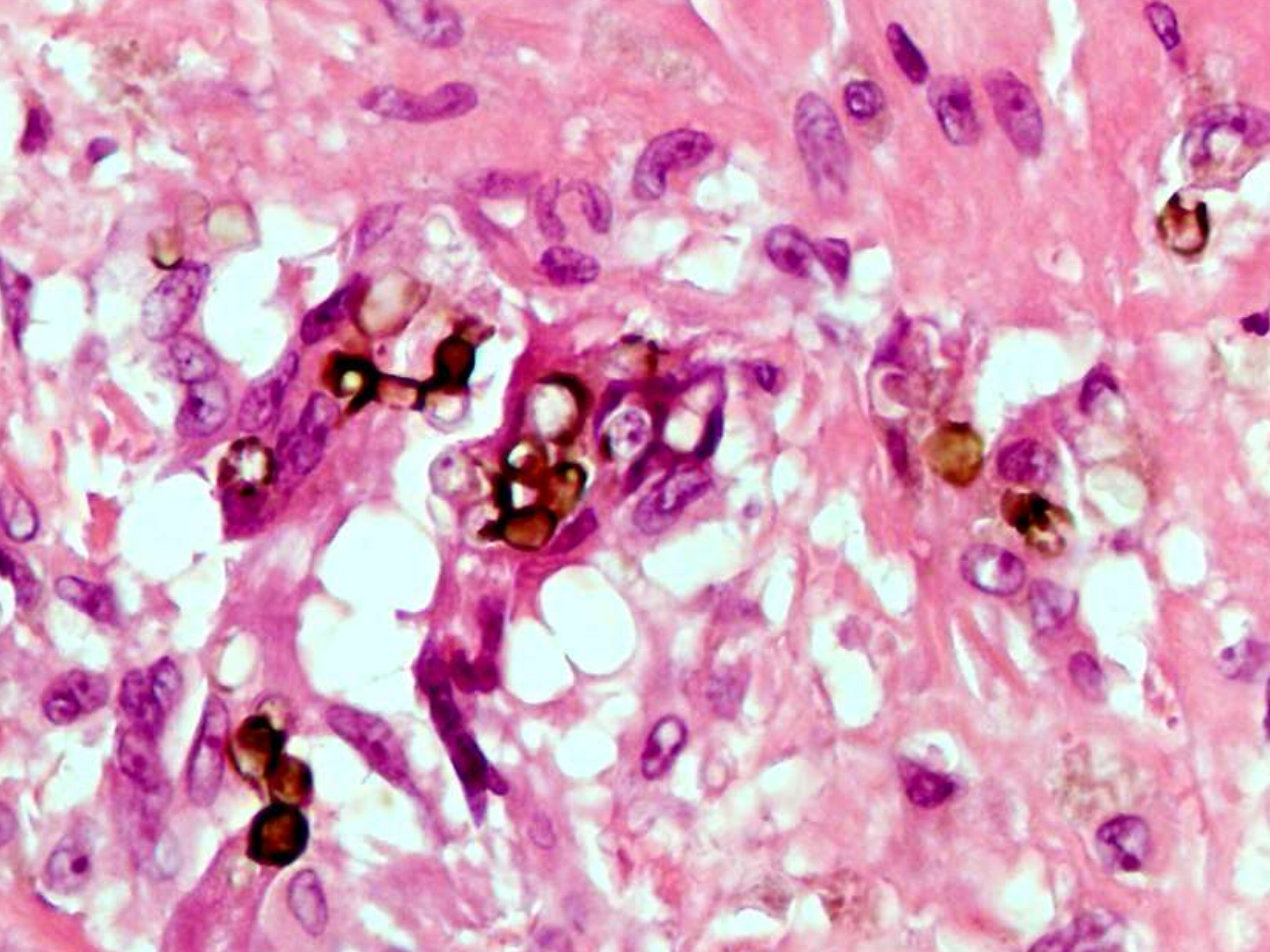












DIAGNOSIS: Chromoblastomycosis, skin and subcutaneous soft tissues of foot.

This infection, commonly affecting the skin and subcutis of the extremities, is caused by 6-7 different species of a dermatiaceous fungus, the most frequent one among which is *Funsecaea pedrosoi* (about 80% cases).



Geographical distribution of chromoblastomycosis based on CDC, and the Pub Med Base review

-The fungus grows on decayed wood, grass and leaves on the ground and is implanted in the human tissue through wounds (commonly in bare-footed farmers).

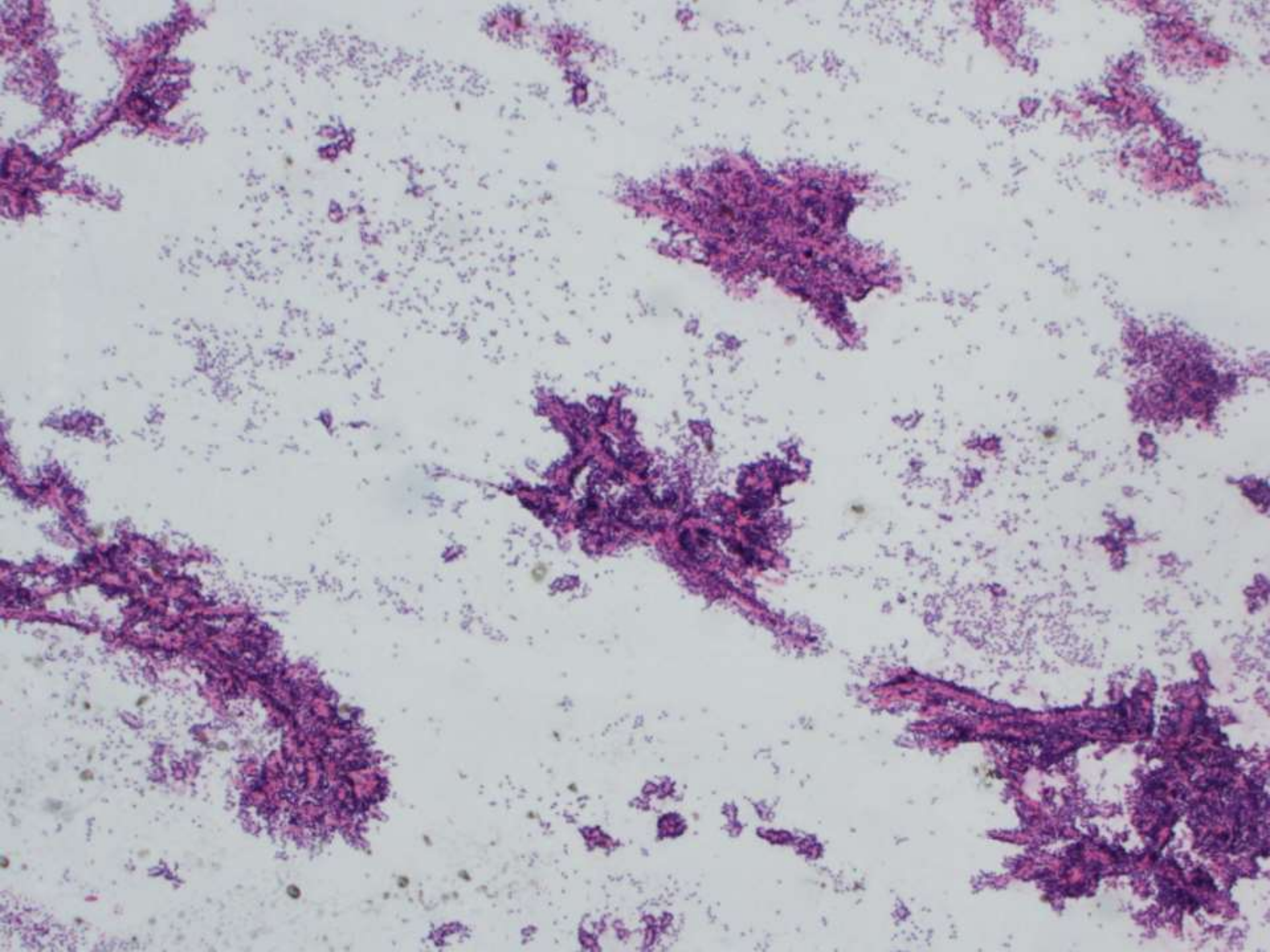
-The disease is chronic and very prolonged, fatality being extremely rare.

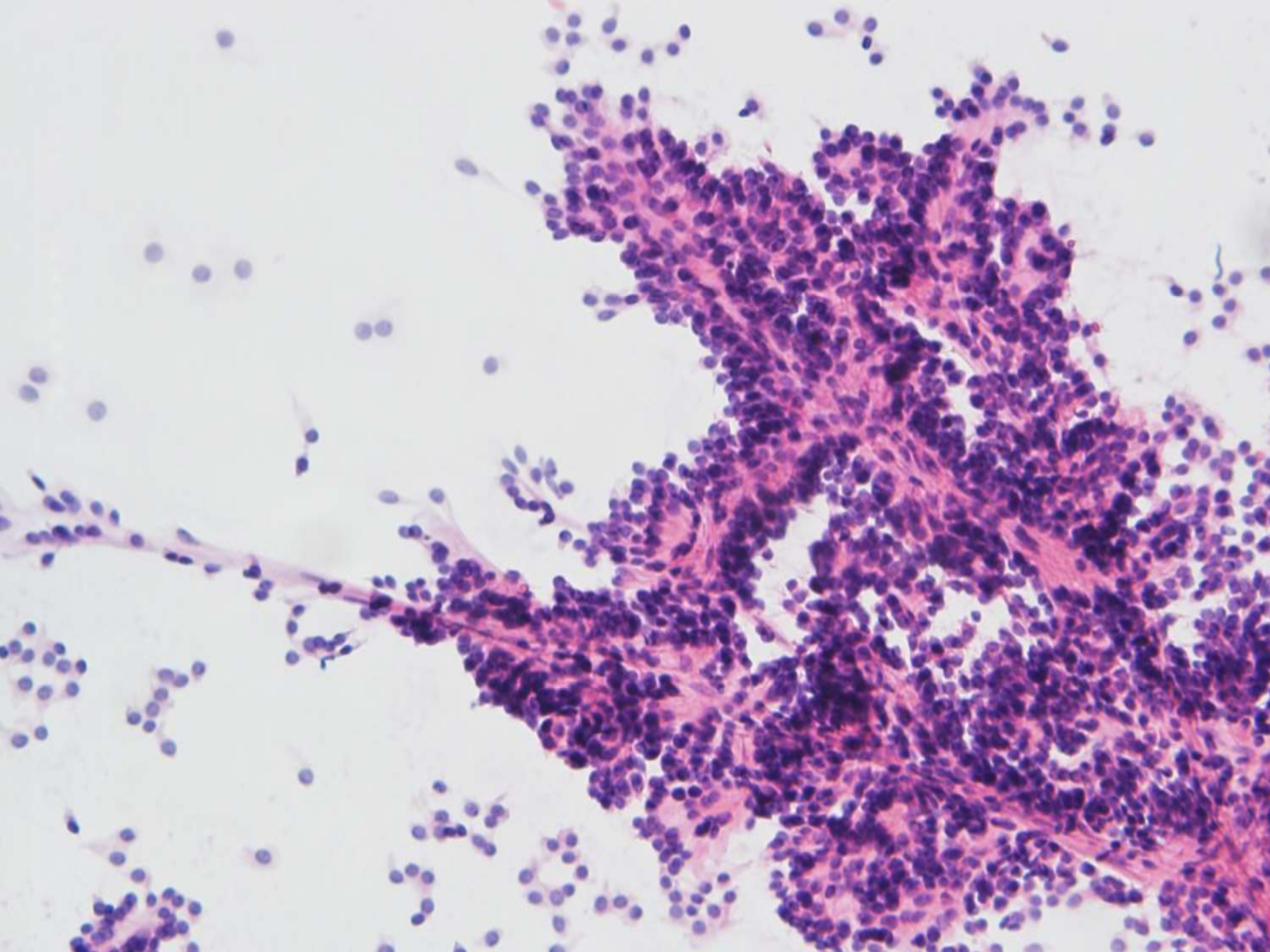
- Histological diagnosis is based on granulomatous/necrotic lesions with the so-called “Sclerotic” or “Medlar” bodies having dark brown, cigar colored round or cylindrical fungi which frequently divide by equatorial septation.

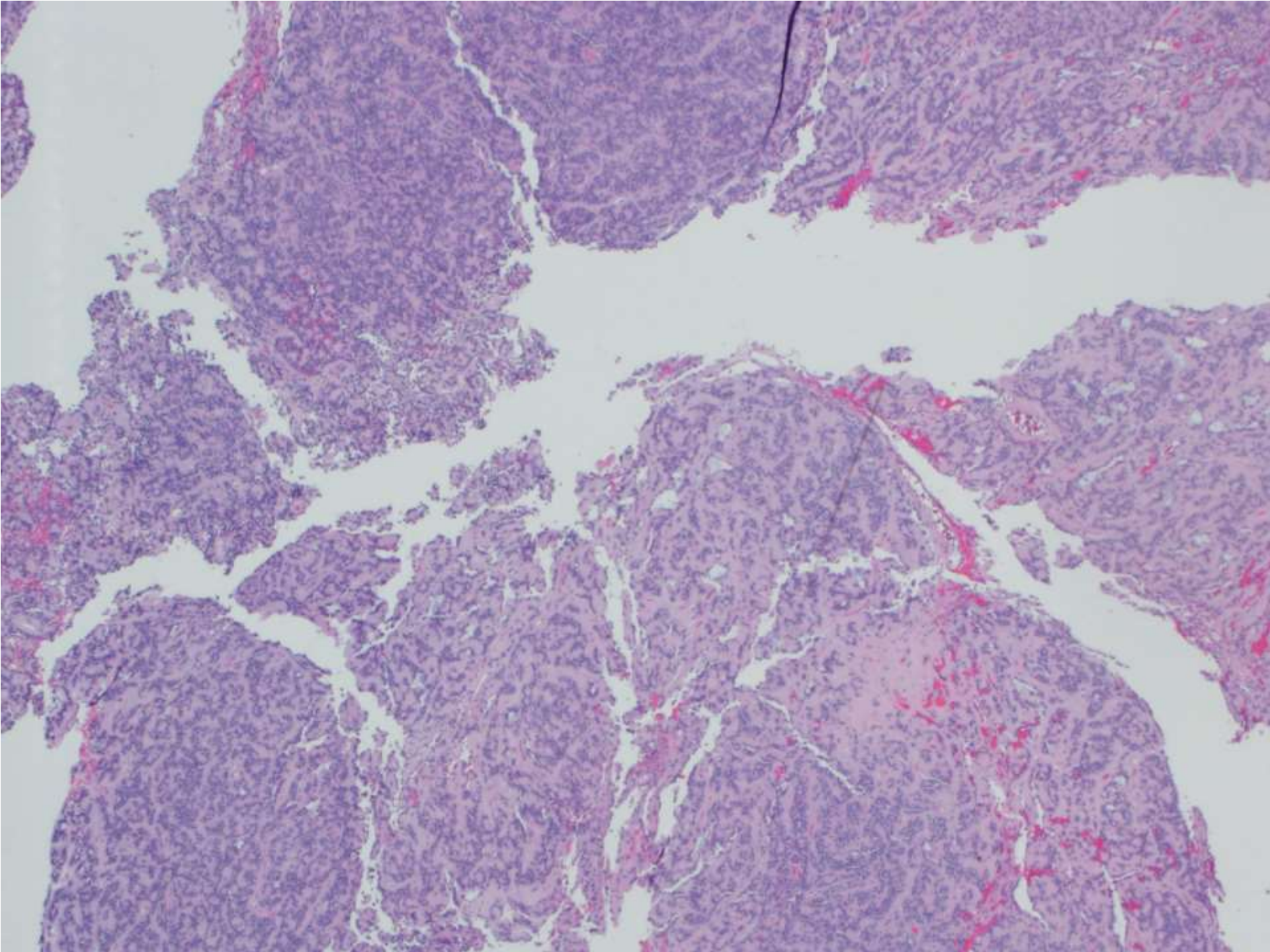
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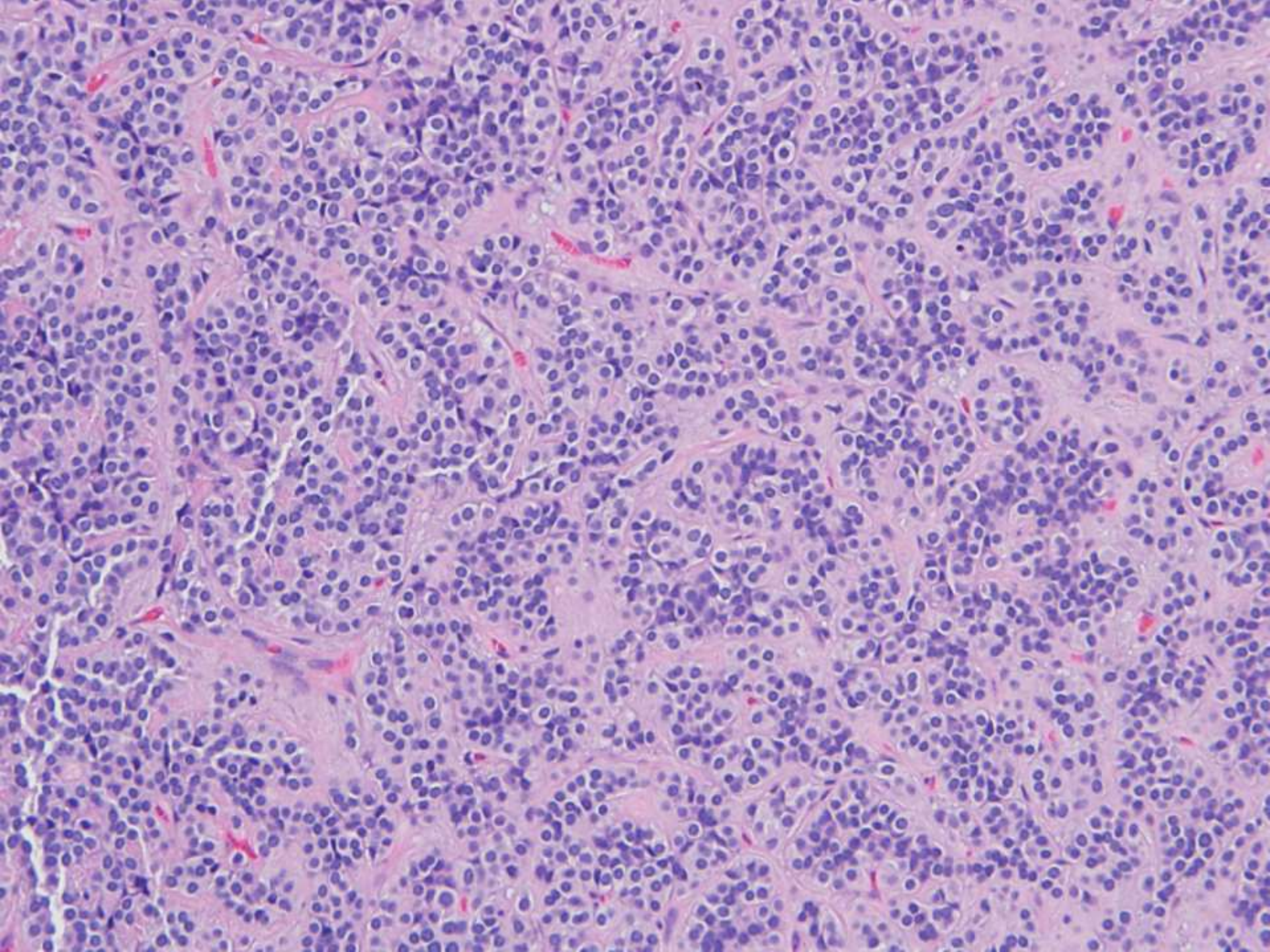
**Jonathan Lavezo/Erna Forgo/Hannes Vogel;
Stanford**

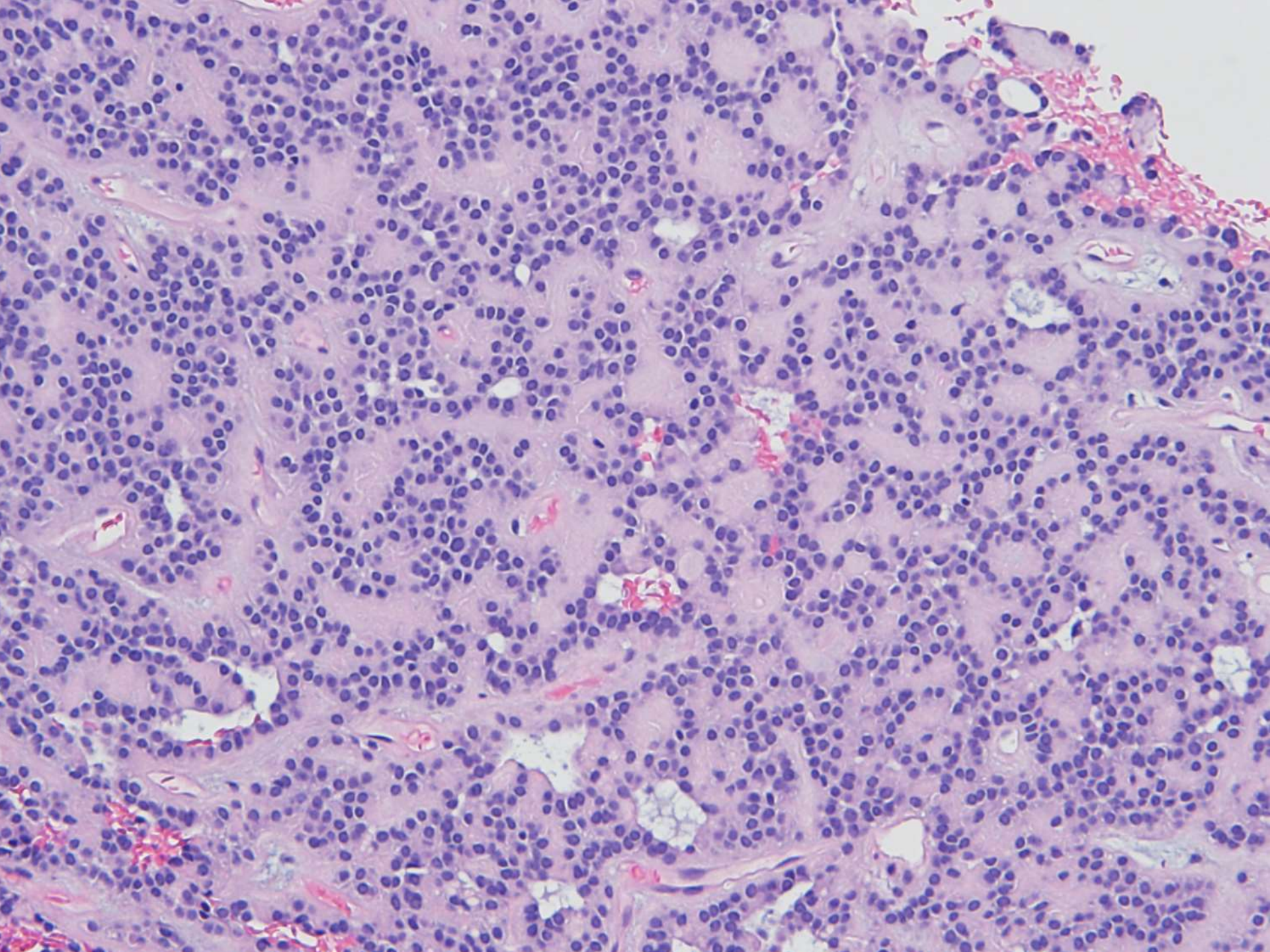
62-year-old female with an intramuscular
right cervical paraspinal mass.

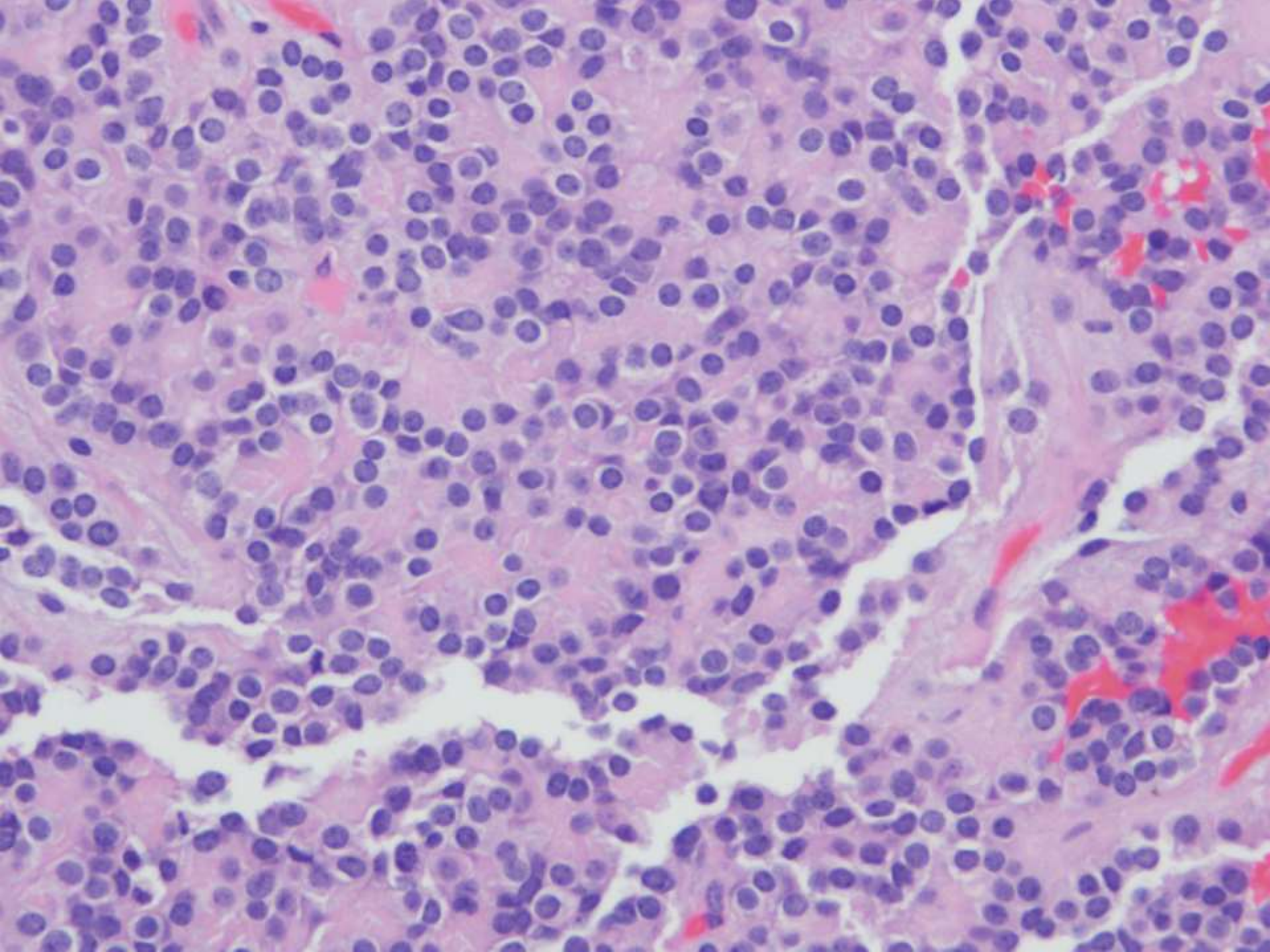


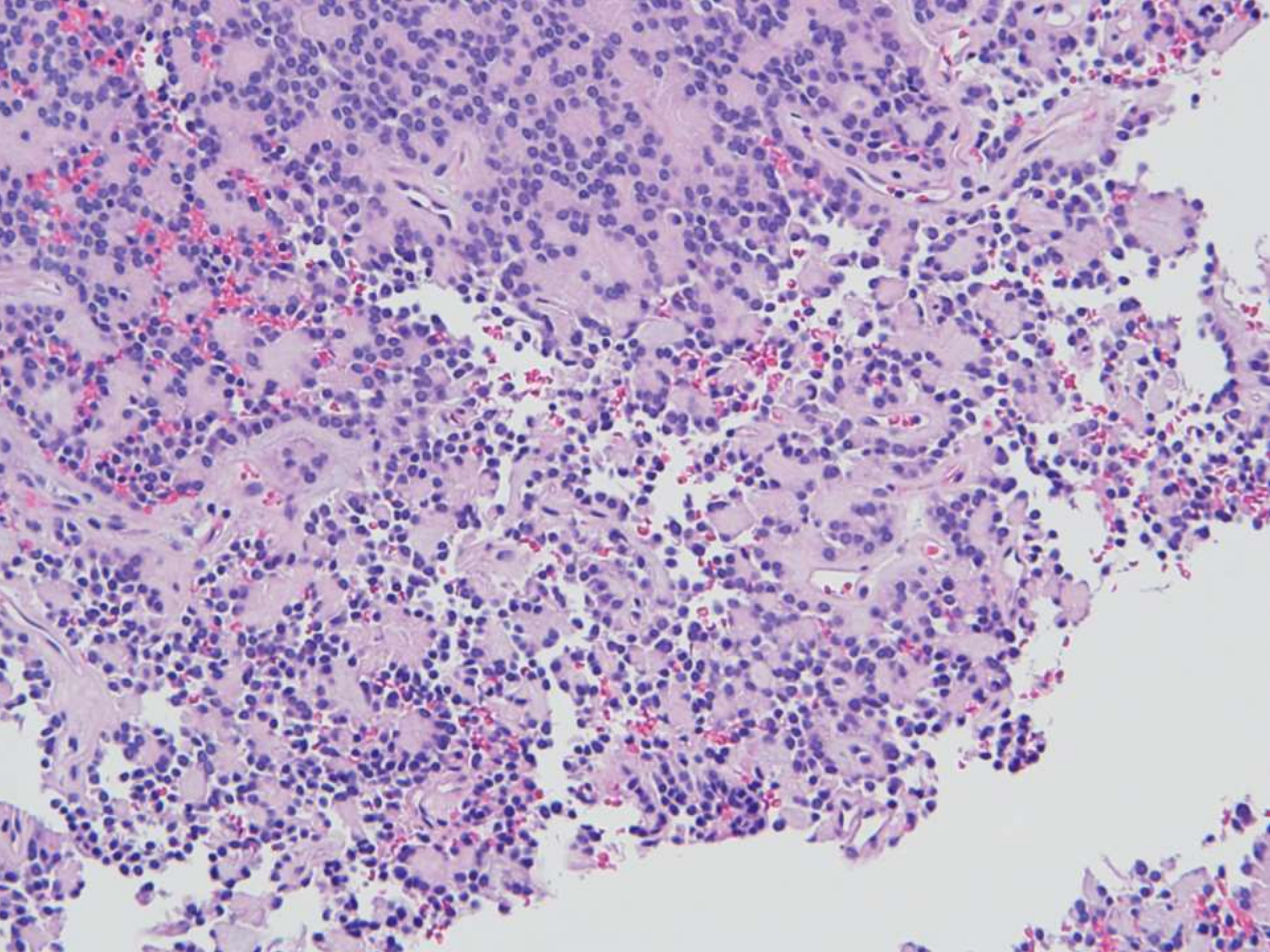






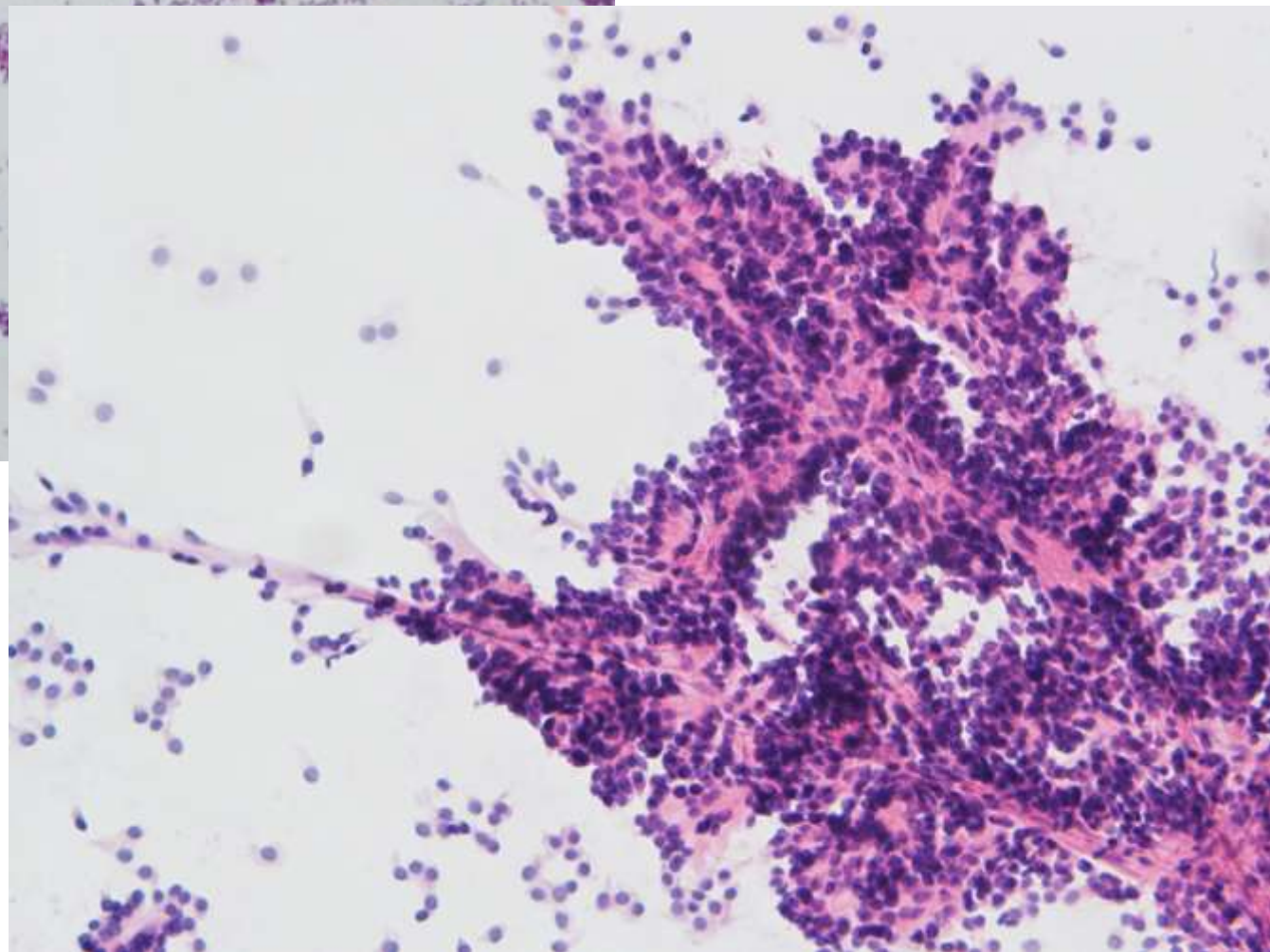
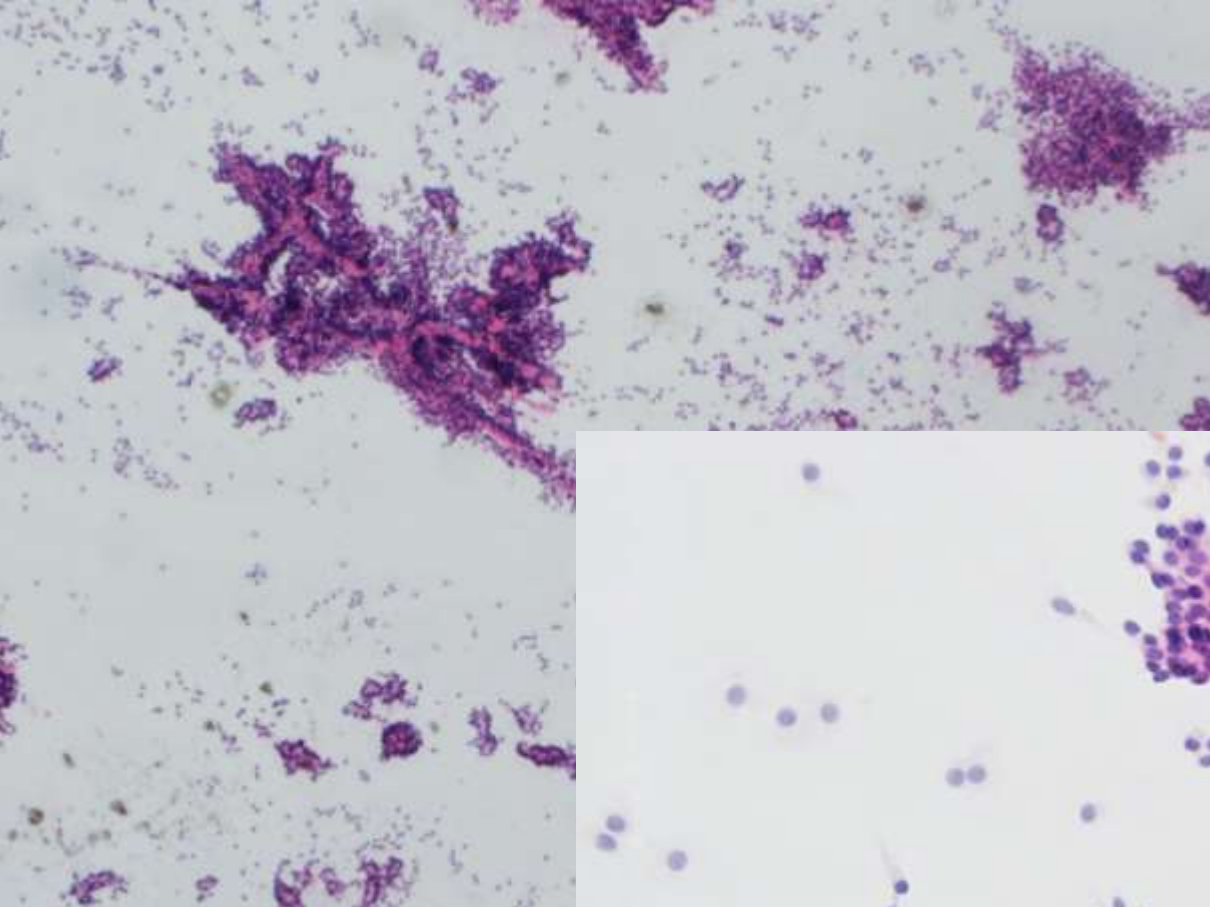


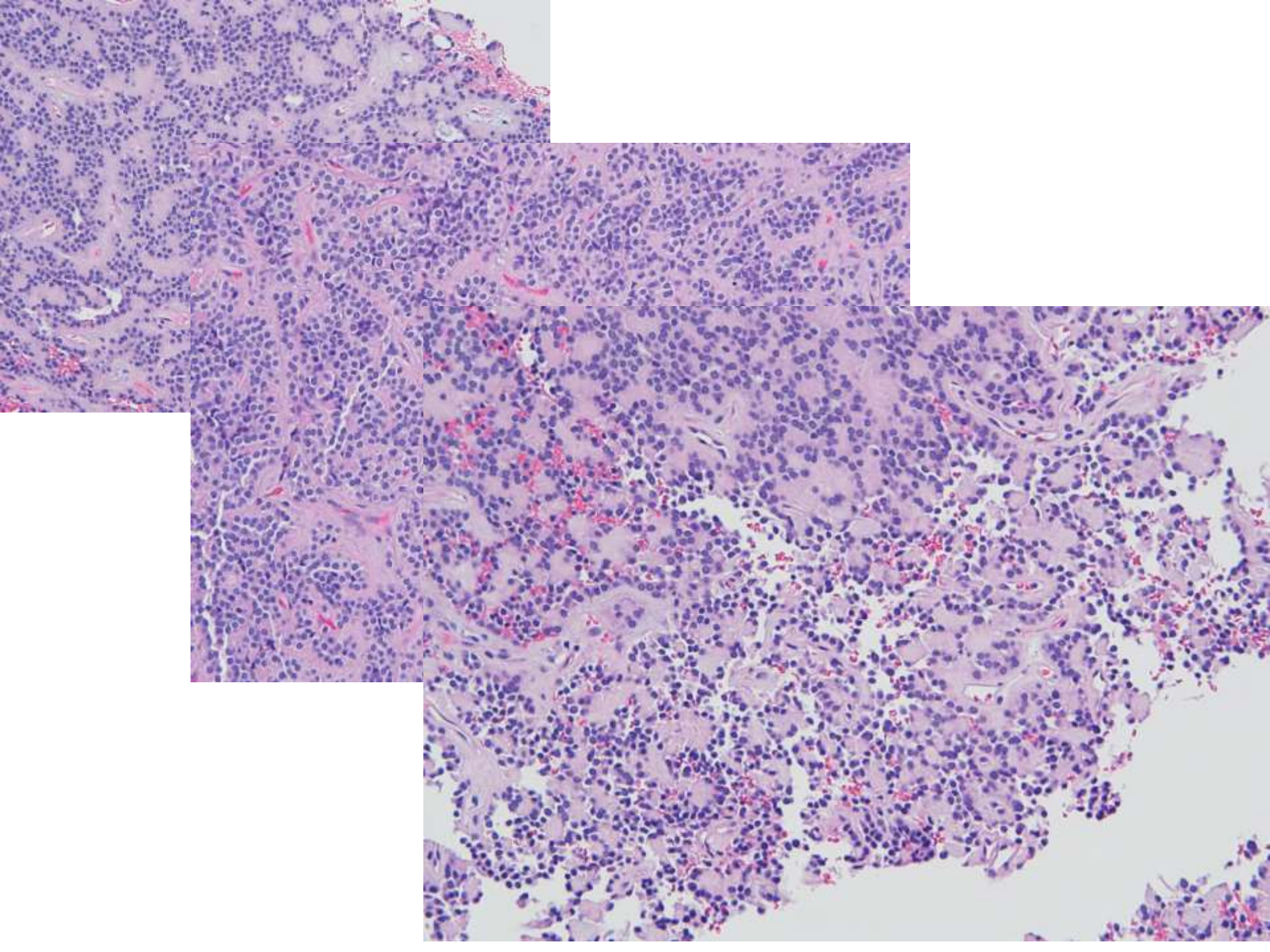




February 2018 - South Bay

Lavezo/Forgo/Vogel
Stanford University

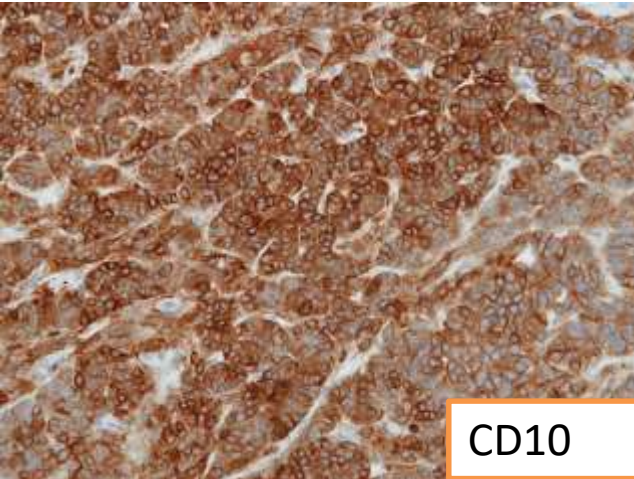




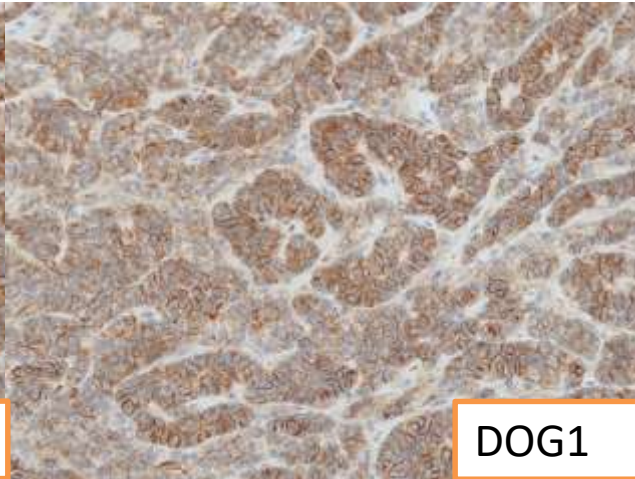
Differential Diagnosis

- Neuroendocrine tumor
- Glomus tumor
- Myxopapillary ependymoma
- Metastatic neoplasm
 - Salivary gland
 - Breast
 - Others

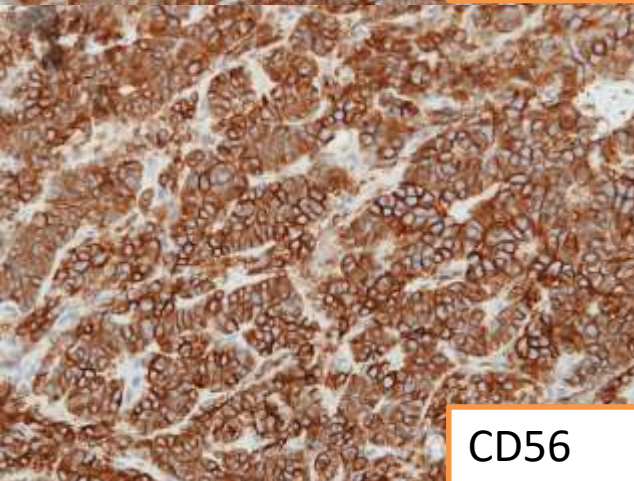
Negative



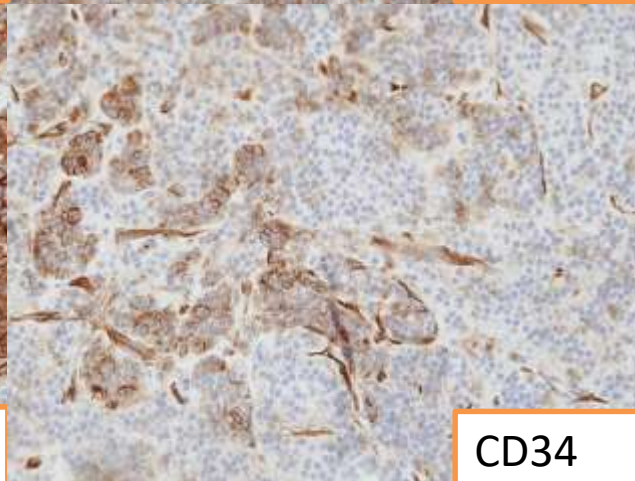
CD10



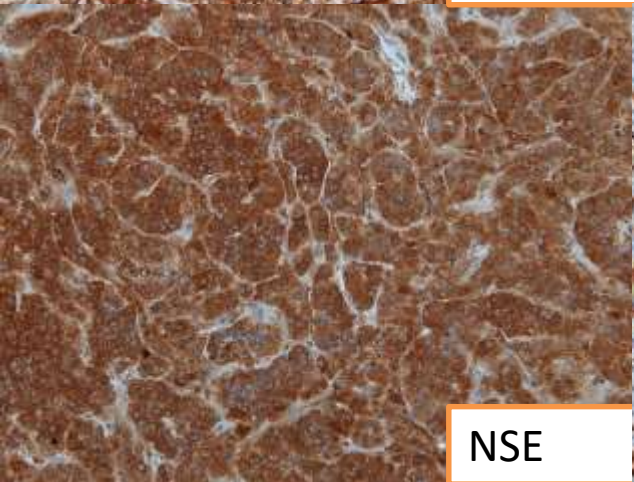
DOG1



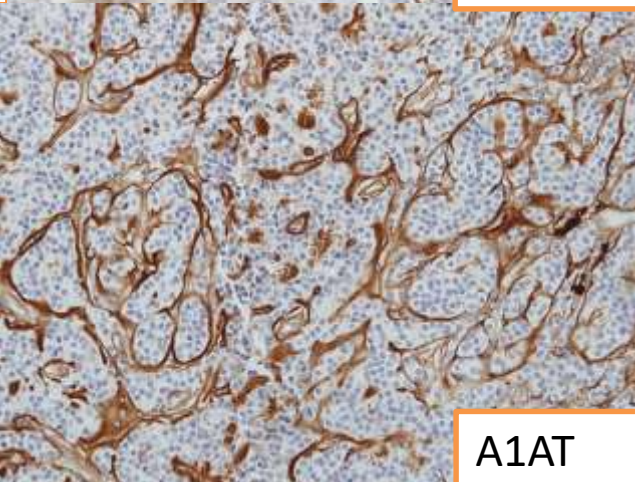
CD56



CD34

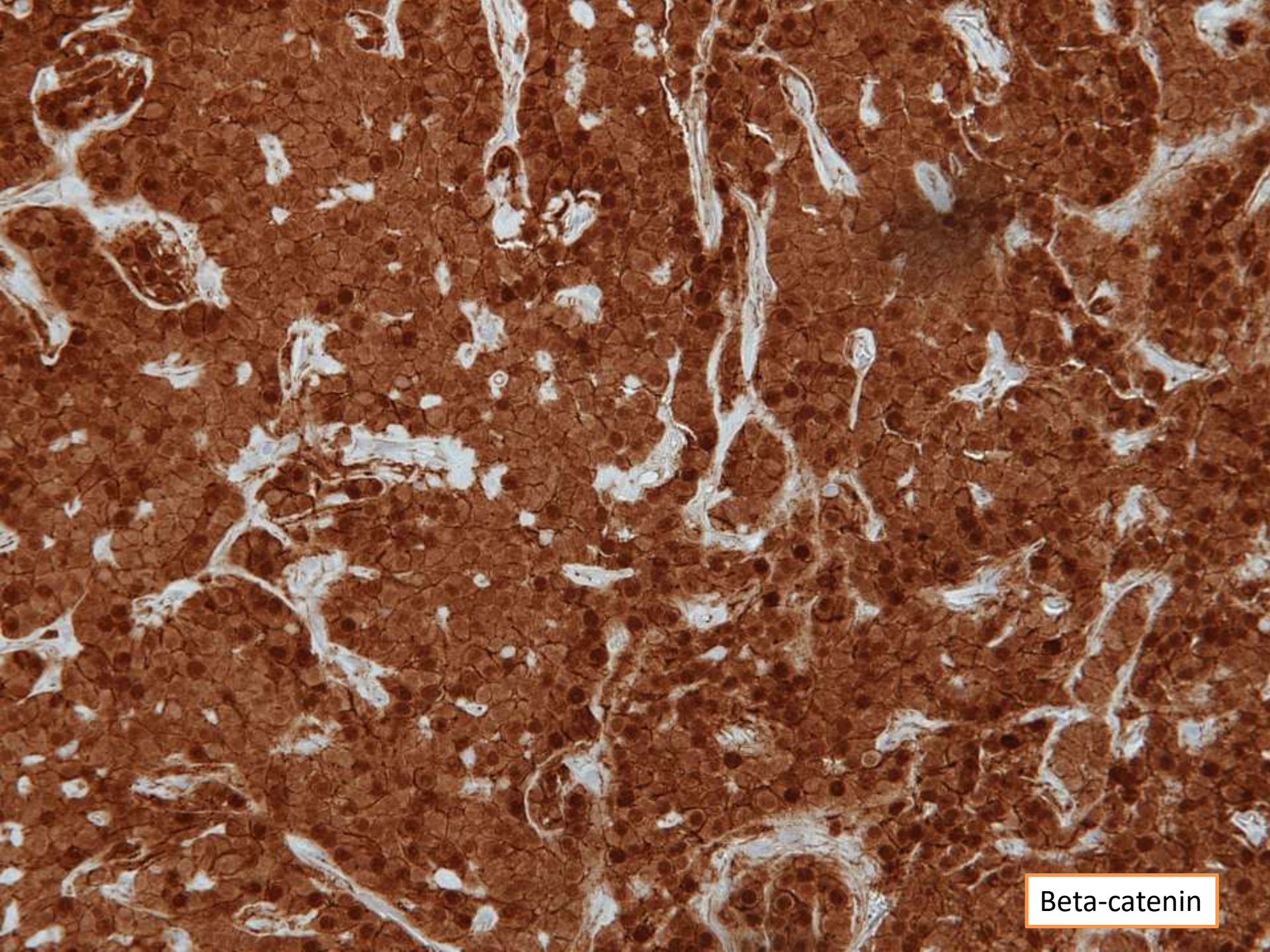


NSE



A1AT

SYNAP
CHROMO
INHIBIN
PR
CKMIX
CK7
CK20
CAM5.2
E-CADHERIN
P63
PAX8
TTF1
STAT6
S100
SOX10
MELAN-A
HMB45
SMA
DESMIN
CALDESMON
MYOGENIN
ERG
CD31



Beta-catenin

Sequencing Results

- **MUTATIONAL PROFILING BY STAMP**
 - **POSITIVE FOR *CTNNB1* S37F MUTATION**
 - **POSITIVE FOR *TERT* PROMOTER MUTATION**

Solid Pseudopapillary Neoplasm

- Low-grade malignant neoplasm
 - 0.9-2.7% of all exocrine pancreatic neoplasms
 - Predominantly in adolescent girls and young women (90% female; age range 7-79)
 - Metastases occur in 5-15% of cases
 - Usually peritoneum and liver
 - Exceptionally rare sites of metastases include lymph node and skin
 - Origin outside of the pancreas is uncommon with reports of retropancreatic, mesocolon, and ovary

Extrapancreatic Solid Pseudopapillary Neoplasm??

- Negative CT of chest, abdomen, and pelvis.
- Negative PET scan
- No residual neoplasm of post-operative MRI

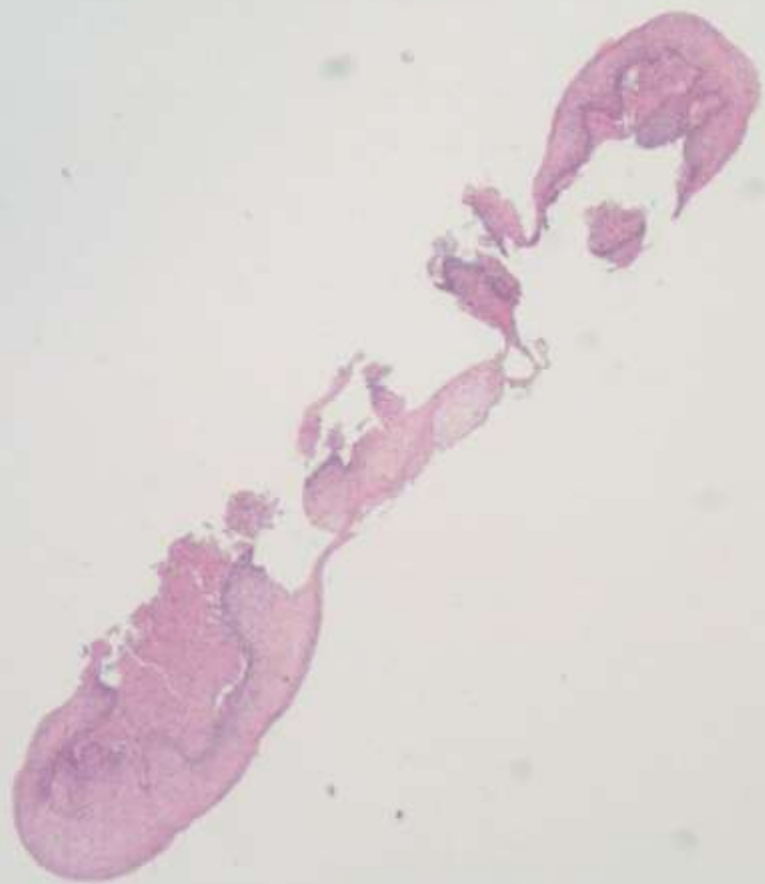
References

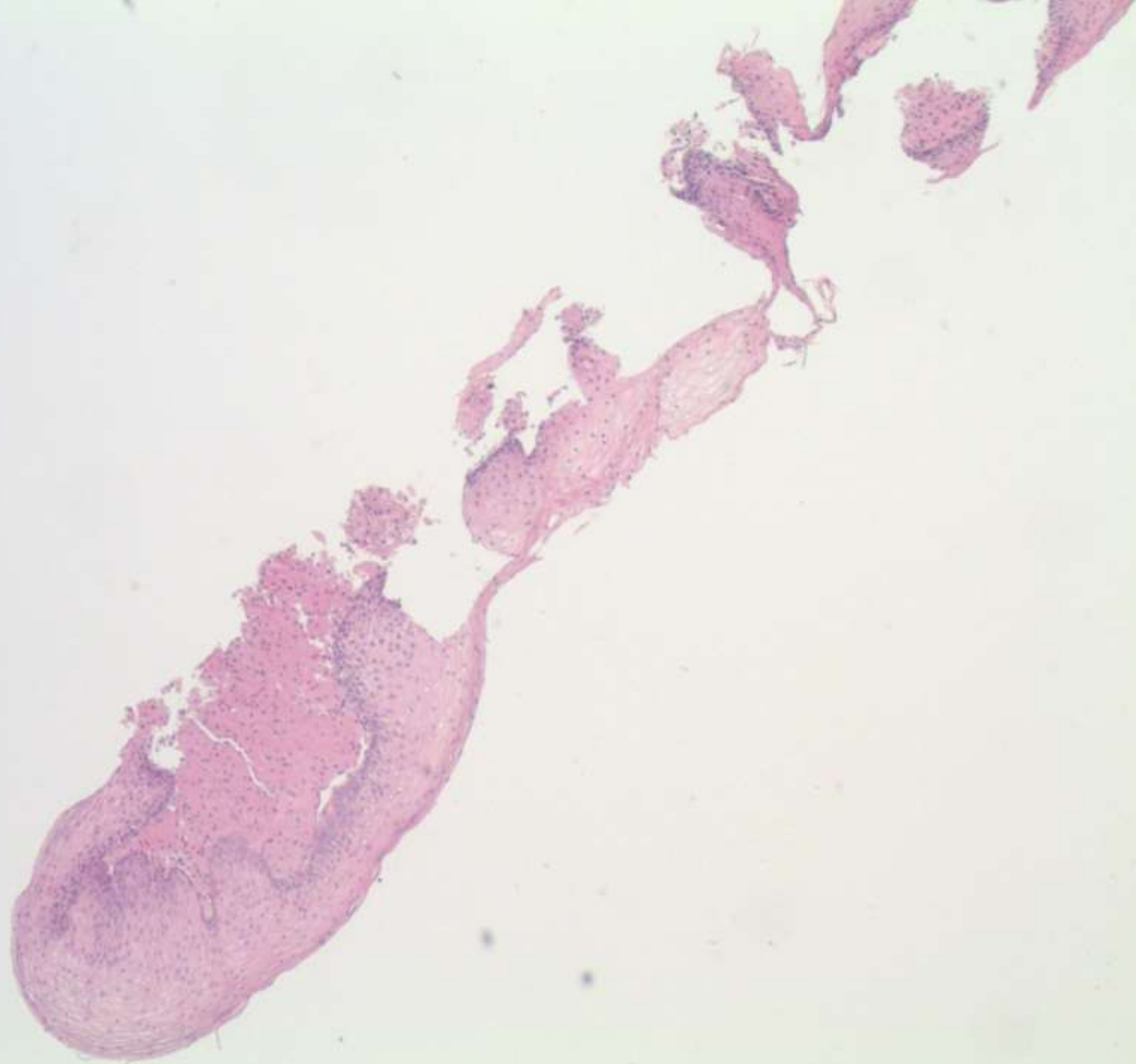
- WHO Classification IARC Tumours of the Digestive system. Fourth Edition. 2010.
- Deshpande V. et. al. Solid pseudopapillary neoplasm of the ovary: a report of 3 primary ovarian tumors resembling those of the pancreas. Am J Surg Pathol 2010 Oct; 34(10):1514-20.
- Guo X. et. al. Extrapancreatic solid pseudopapillary tumors: A clinicopathological analysis of two cases. Mol Clin Oncol. 2016 May; 4(5): 845-850.

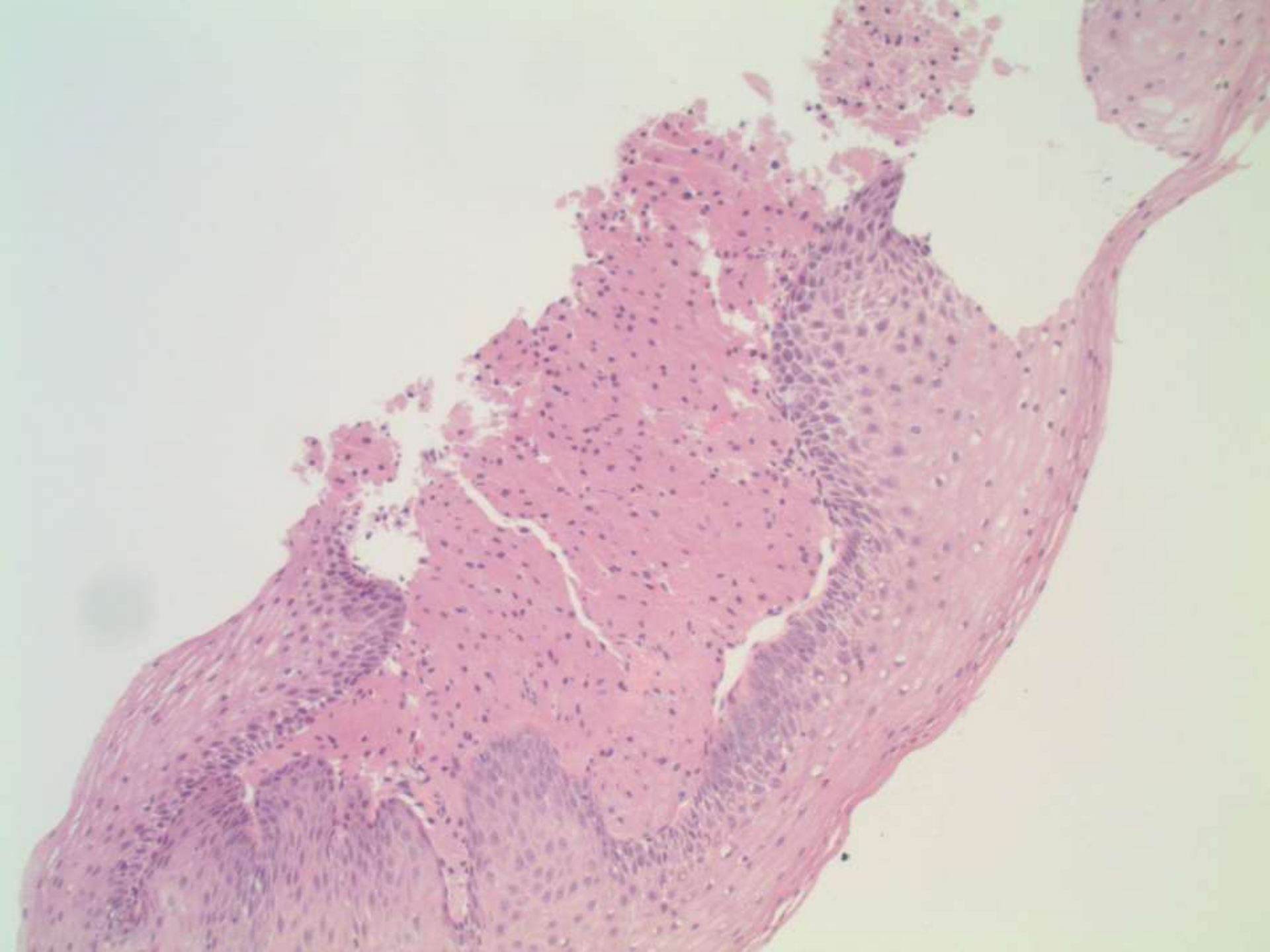
SB 6243

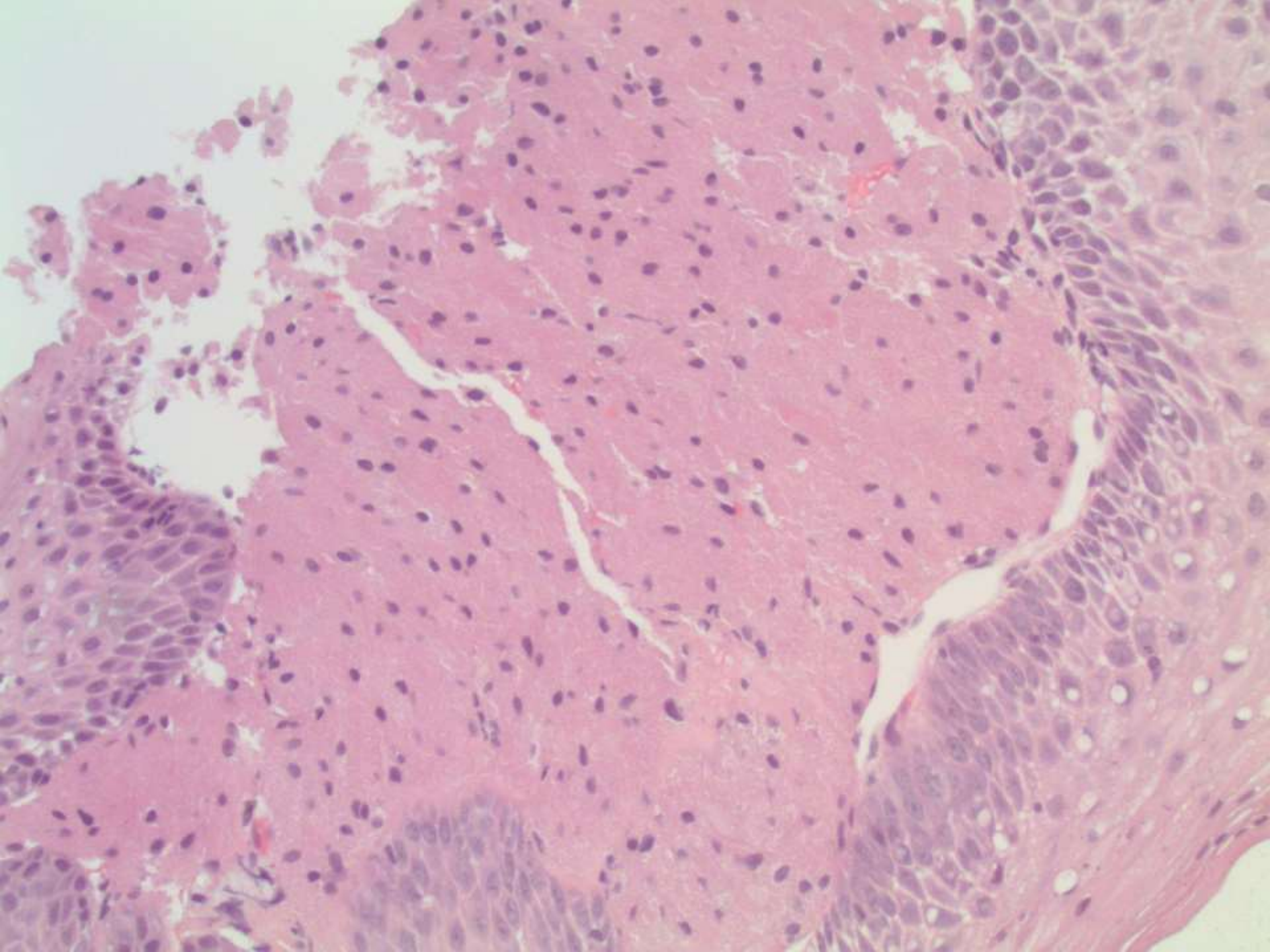
Keith Duncan; Mills-Peninsula

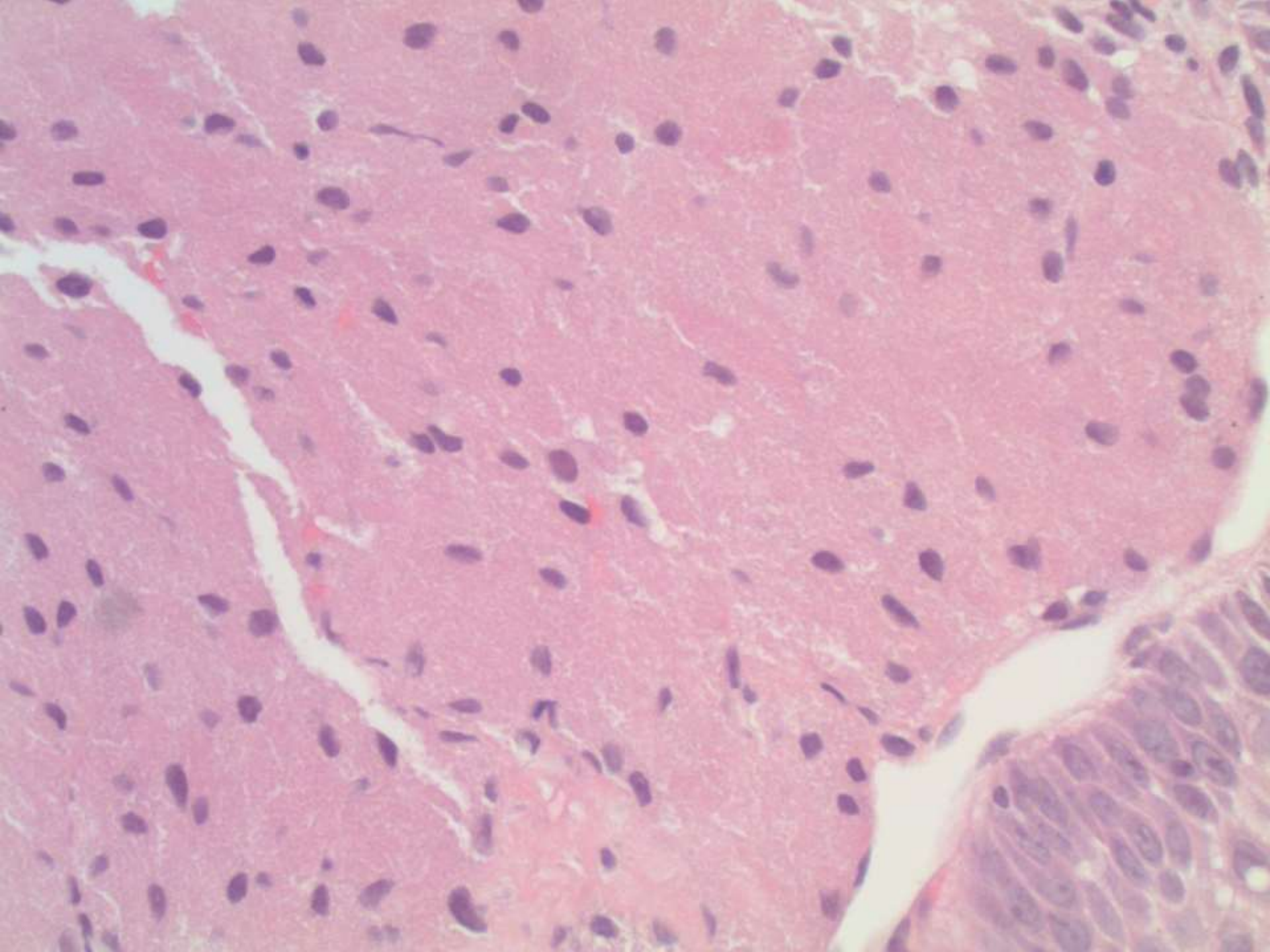
40-year-old female presents to GI doctor for upper abdominal pain. Pan-endoscopic work-up reveals small esophageal nodule which was biopsied.



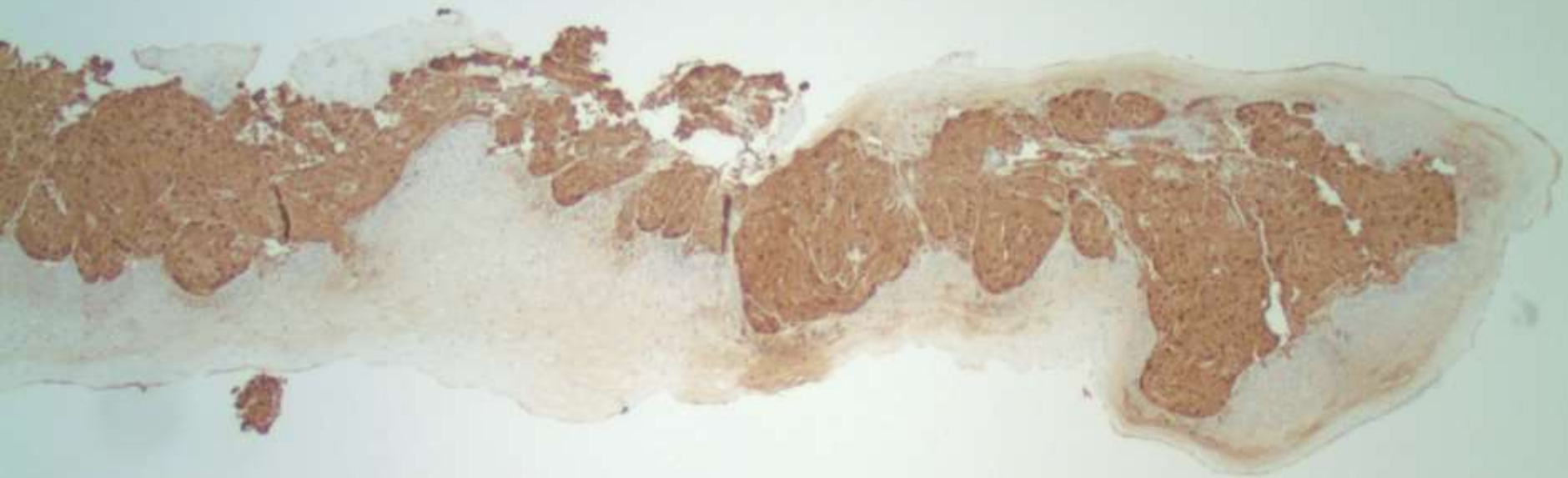




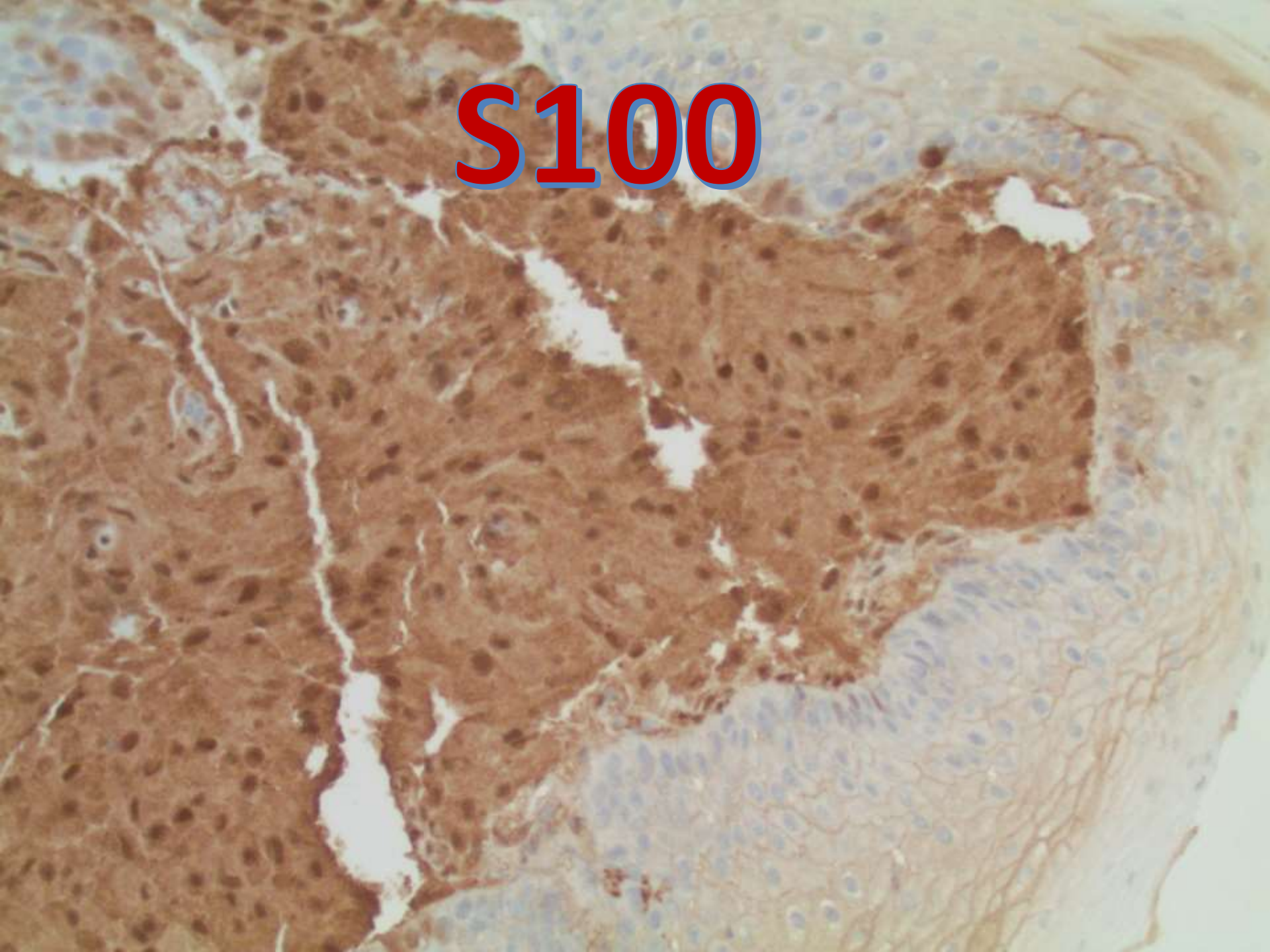


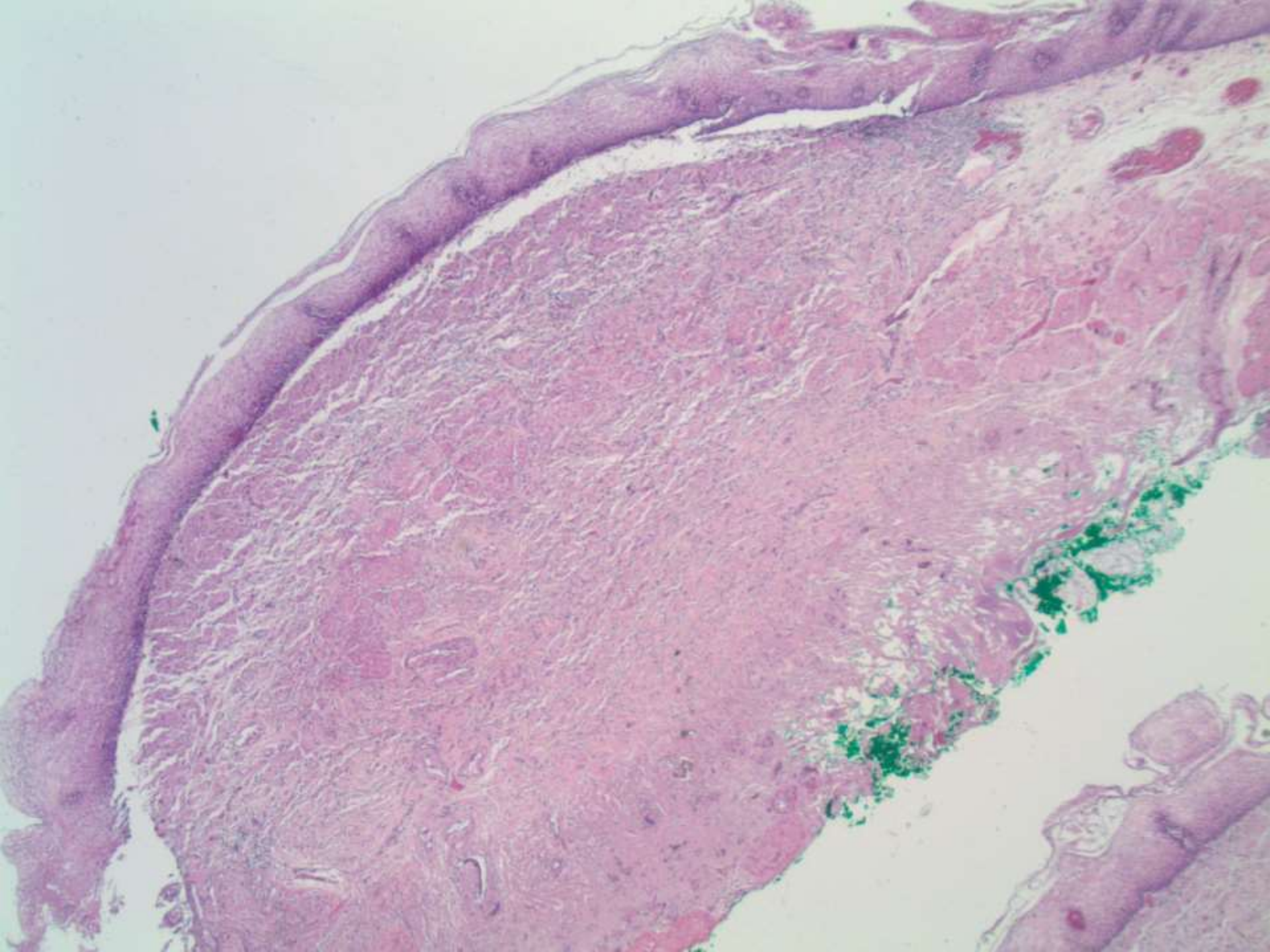


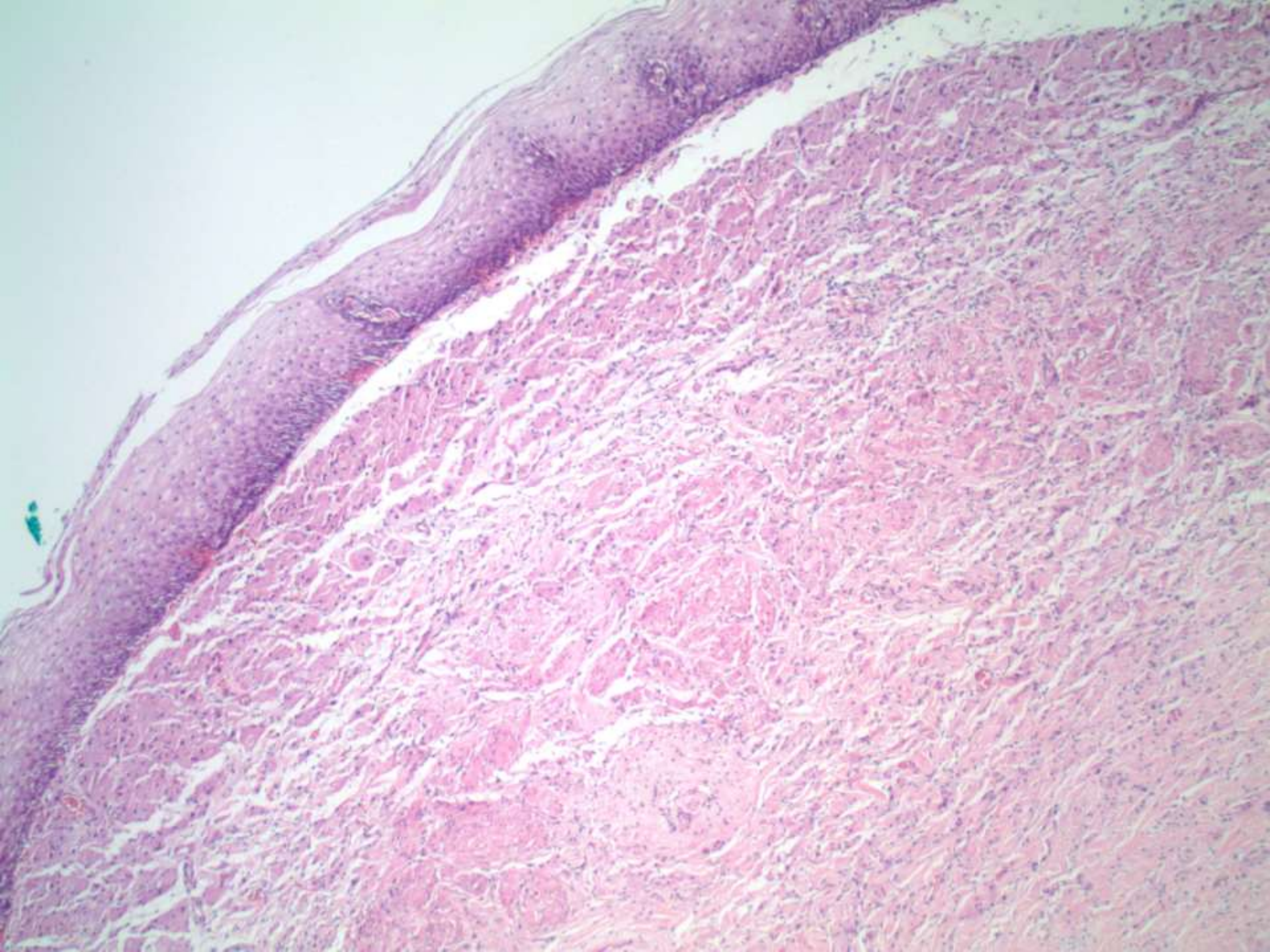
S100

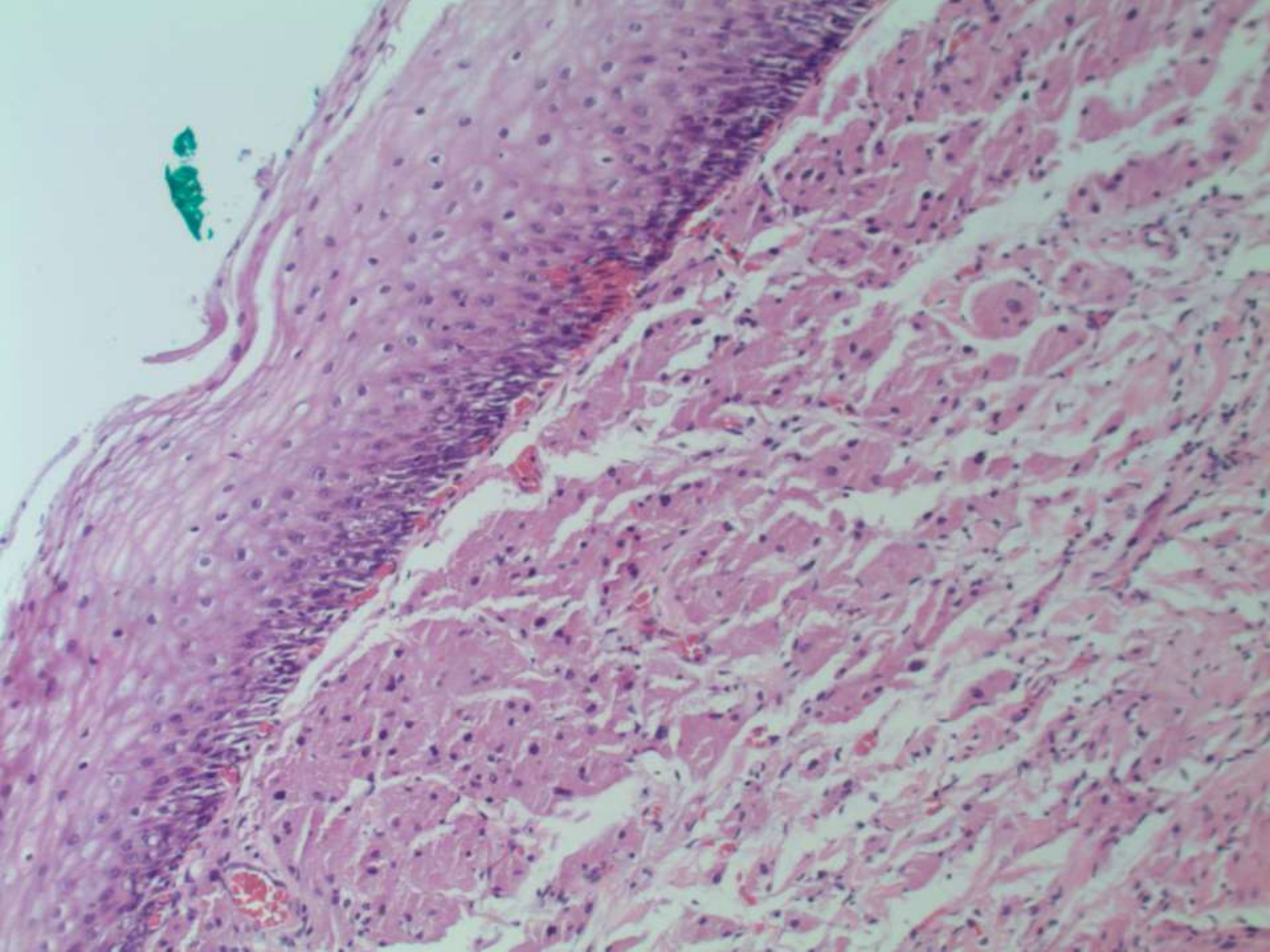


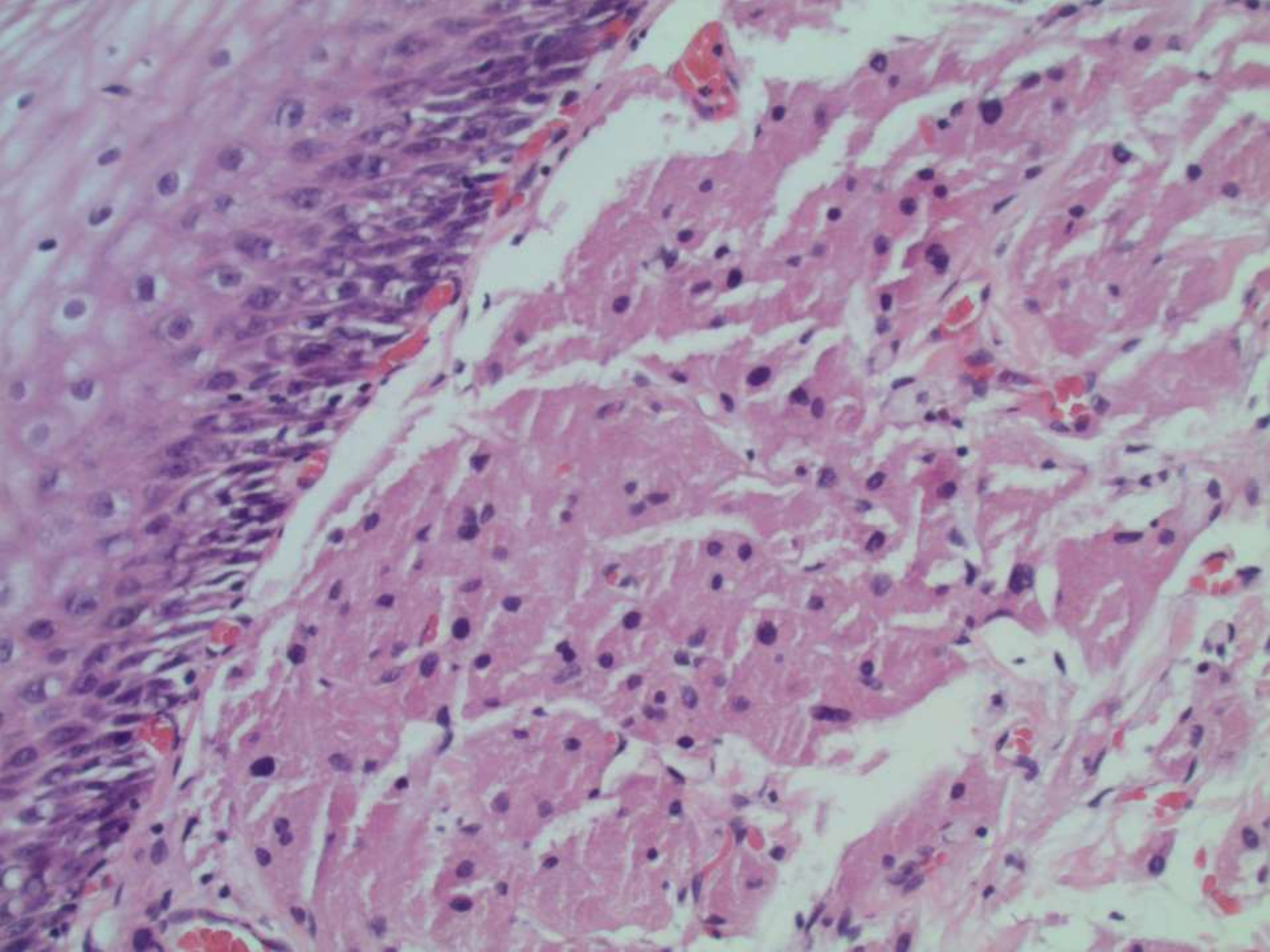
S100











Granular cell tumor of the Esophagus

- Most common site in GI tract
- #2 most common stromal tumor of esophagus after leiomyoma
- Usually incidental, in lower esophagus, 90% solitary
- May cause obstruction if large

Granular cell tumor of the Esophagus

Clinical features

- Schwannian origin
- Most common in women in 40s, African American
- May be underdiagnosed on superficial biopsies
- **Endoscopy:** sessile, yellowish white, firm, intact epithelium
- 1 - 3% are malignant (locally recur)
 - Associated with rapid growth, > 4 cm, tumor necrosis, increased cellularity, atypia, > 2 mitotic figures/HPF

Microscopic description

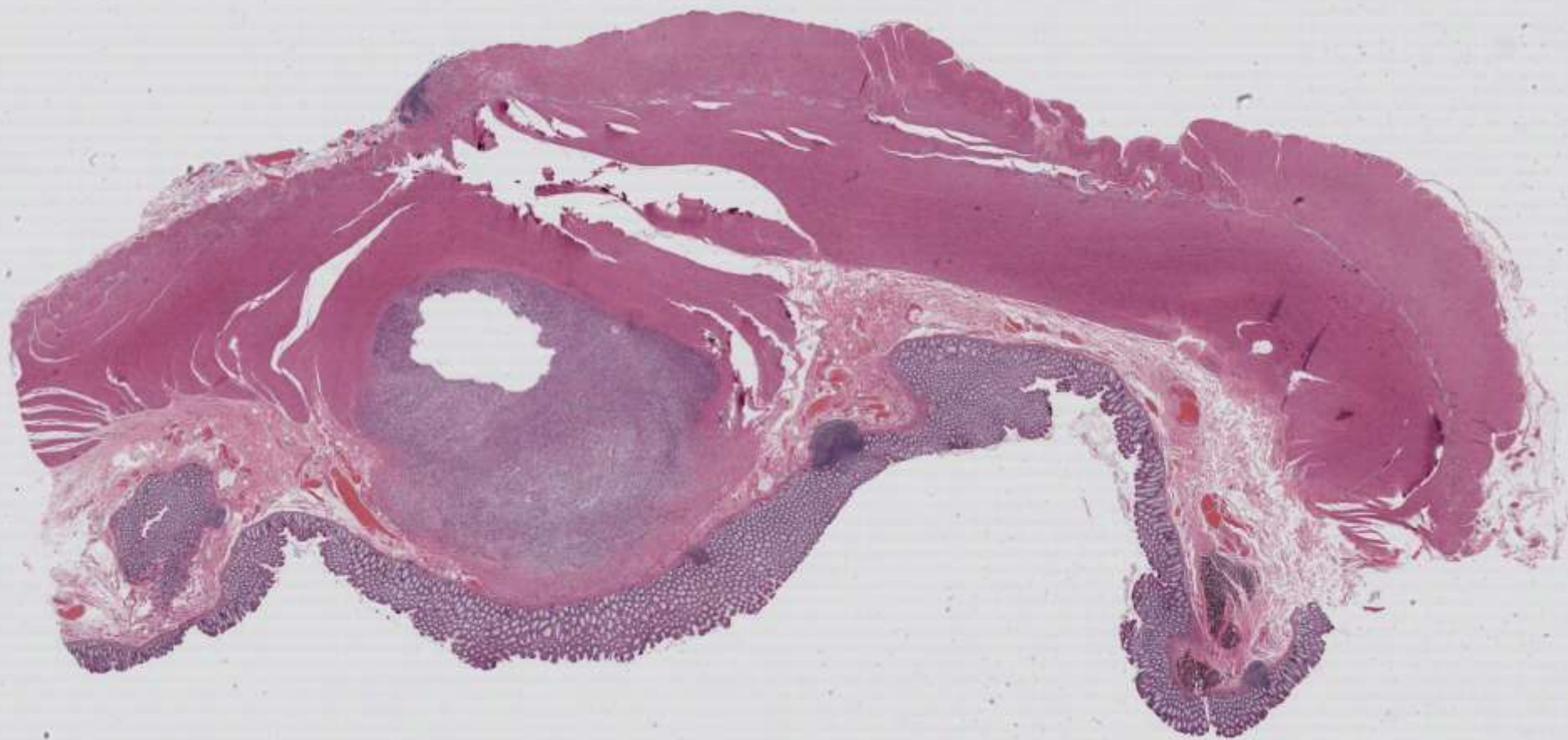
- Sheets/packets of uniform epithelioid cells with abundant eosinophilic granular cytoplasm and small nuclei
- Often pseudoepitheliomatous hyperplasia, which may mimic squamous cell carcinoma on small biopsies

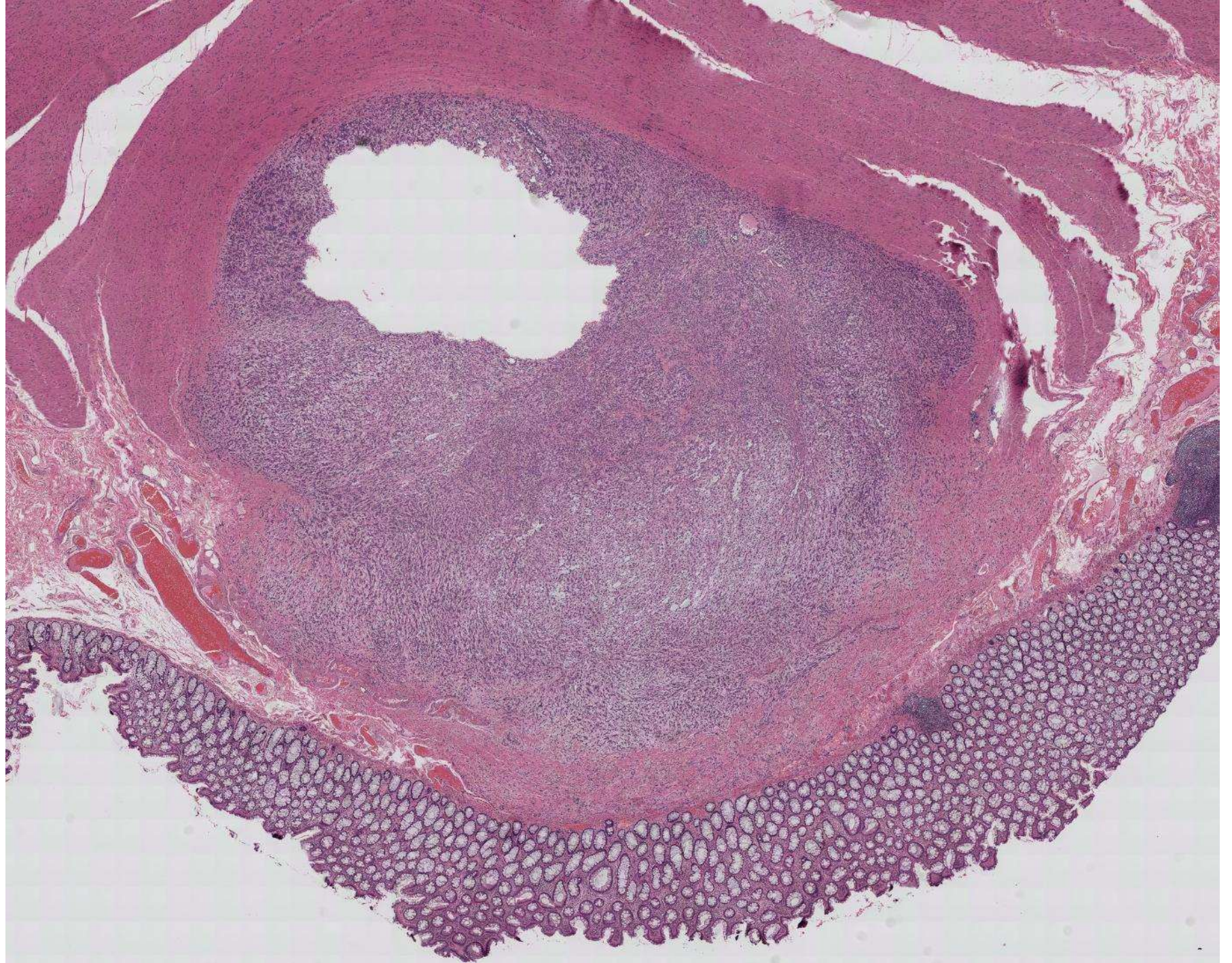
Positive stains

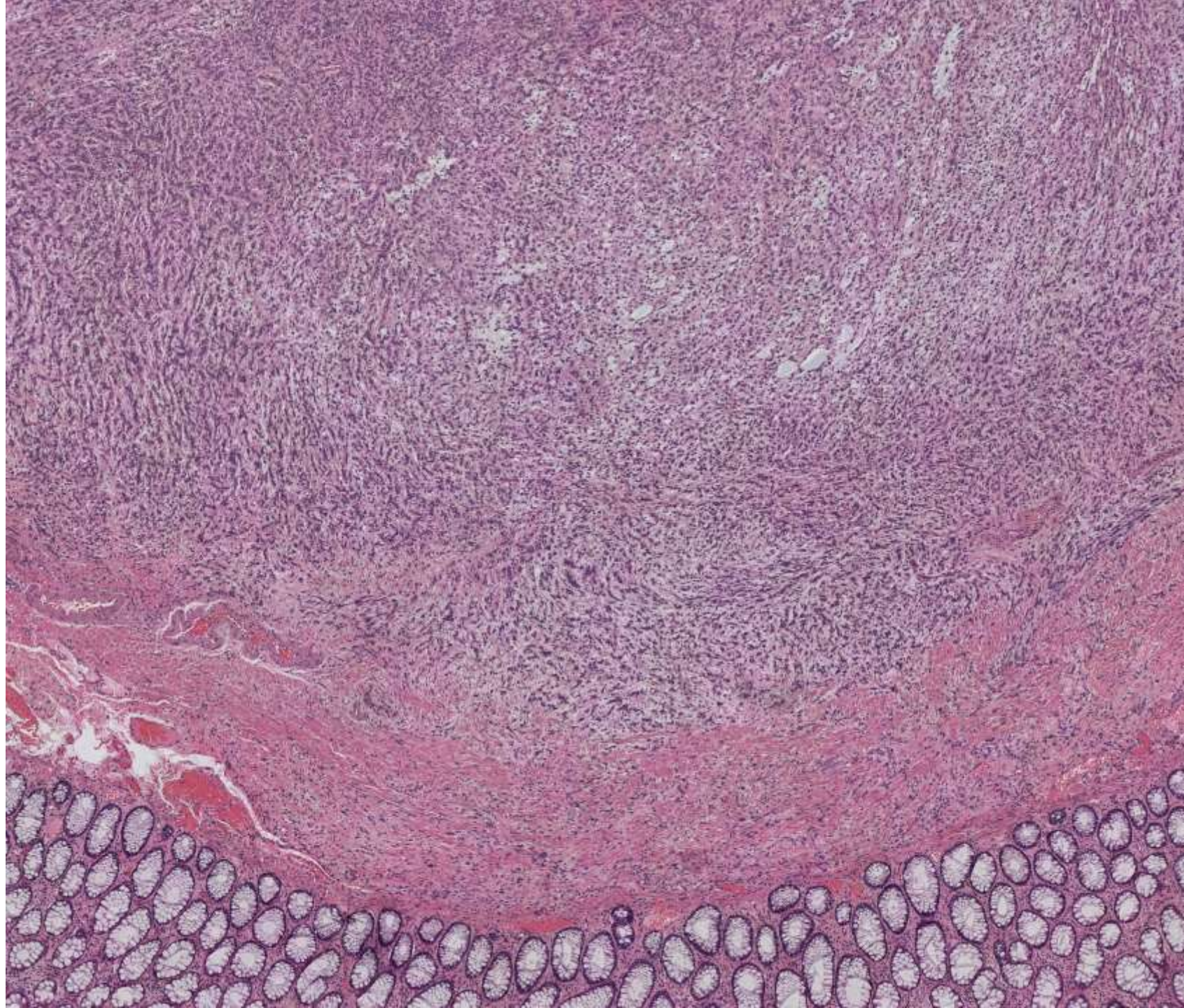
- [PAS](#), [S100](#), [inhibin alpha subunit](#), [CD68](#), [calretinin](#)
- Thumallapally et al: "Esophageal granular cell tumor: A case report and review of the literature." Cureus 8 (9): e782.

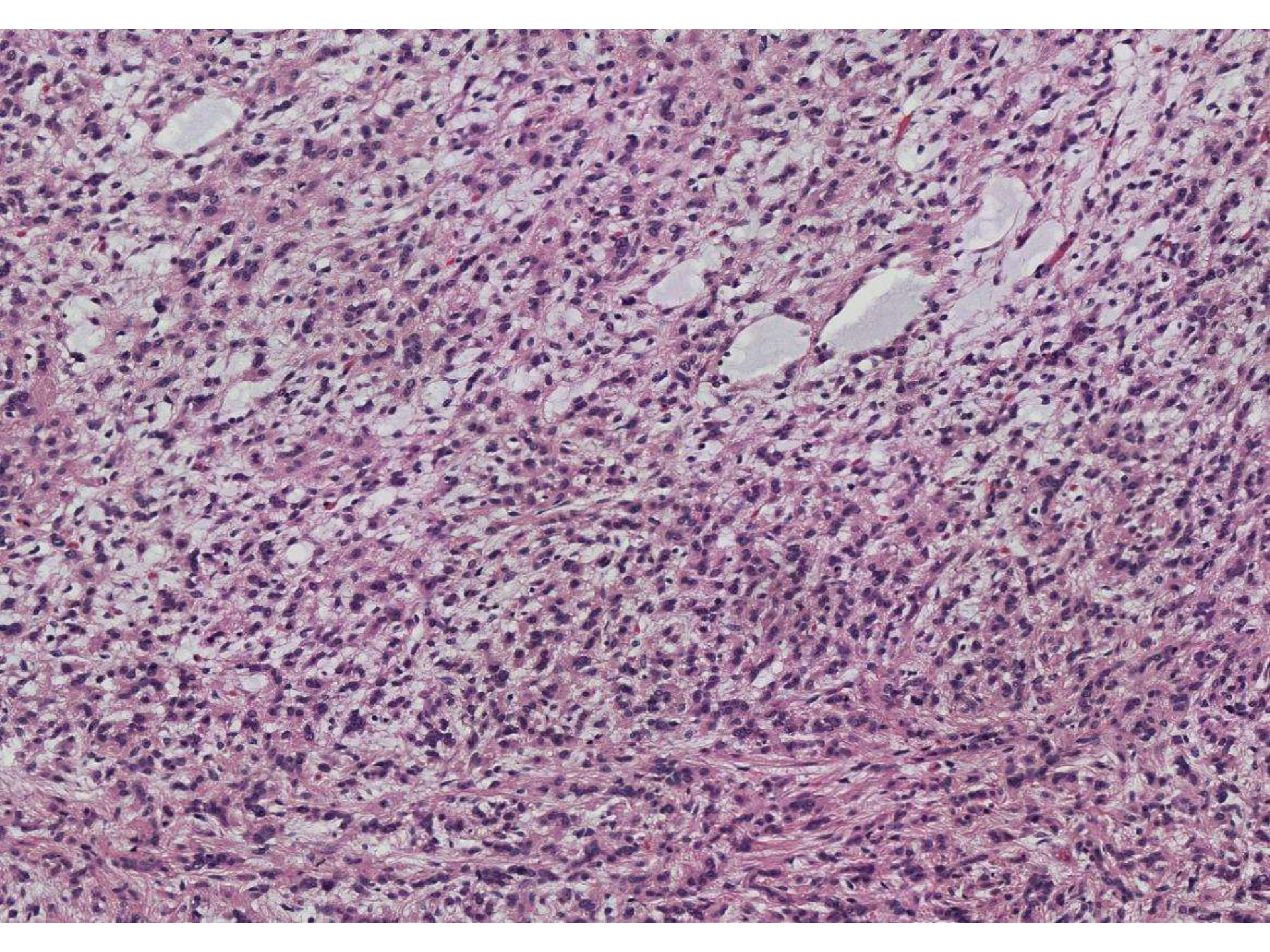
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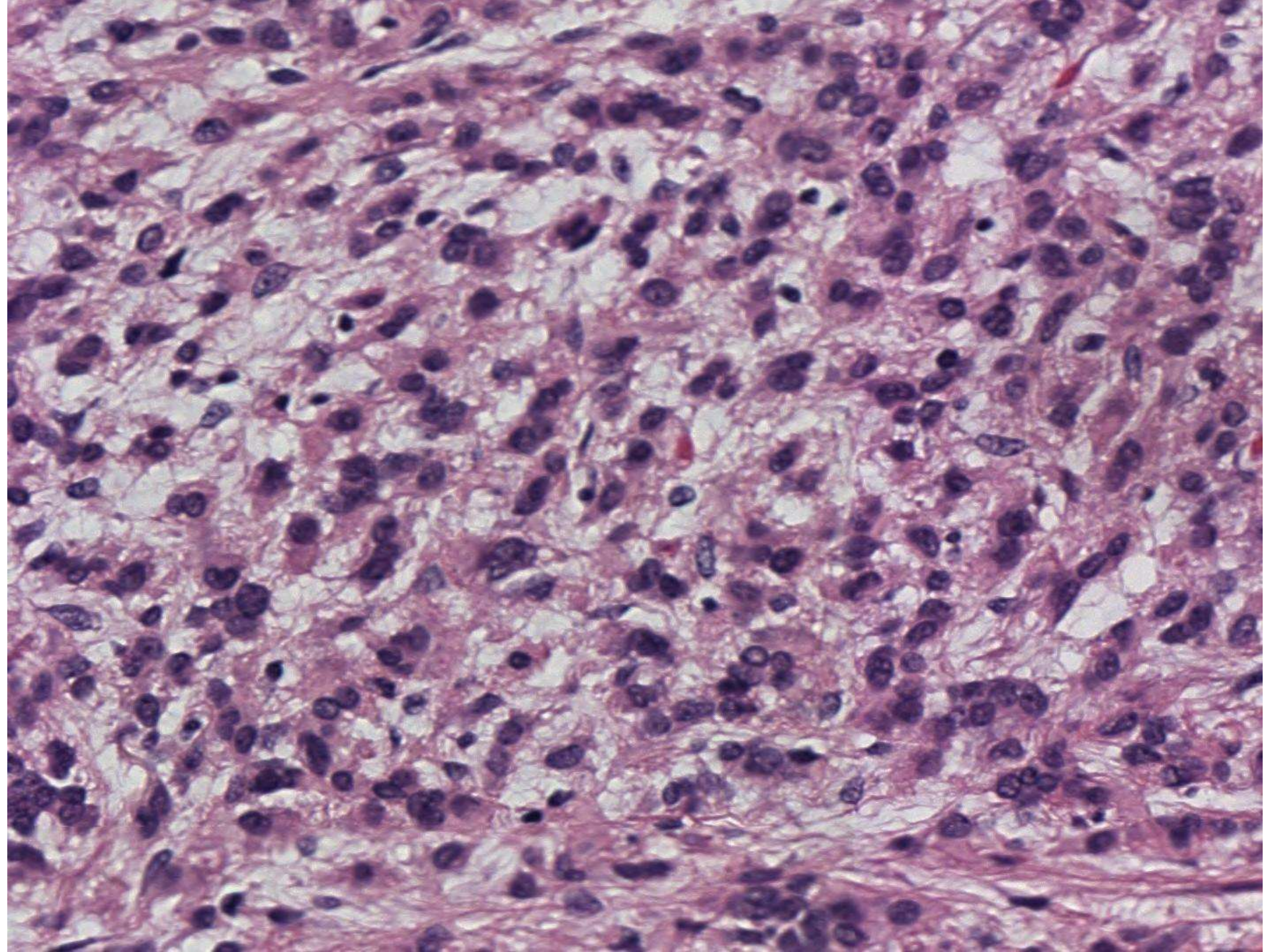
Justin Cuff; Mills-Peninsula
72-year-old female with 1.5cm
sigmoid colon mass.

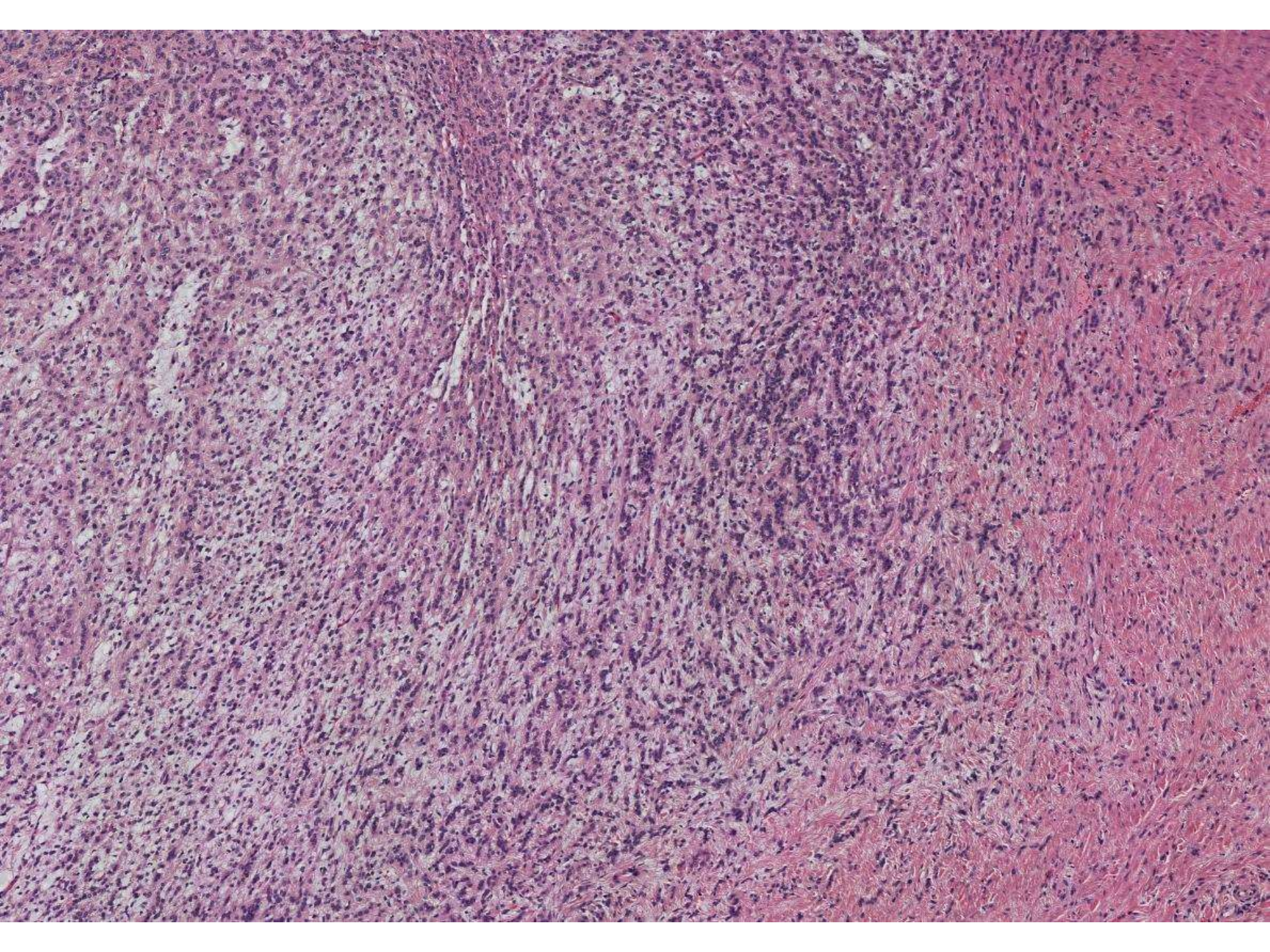


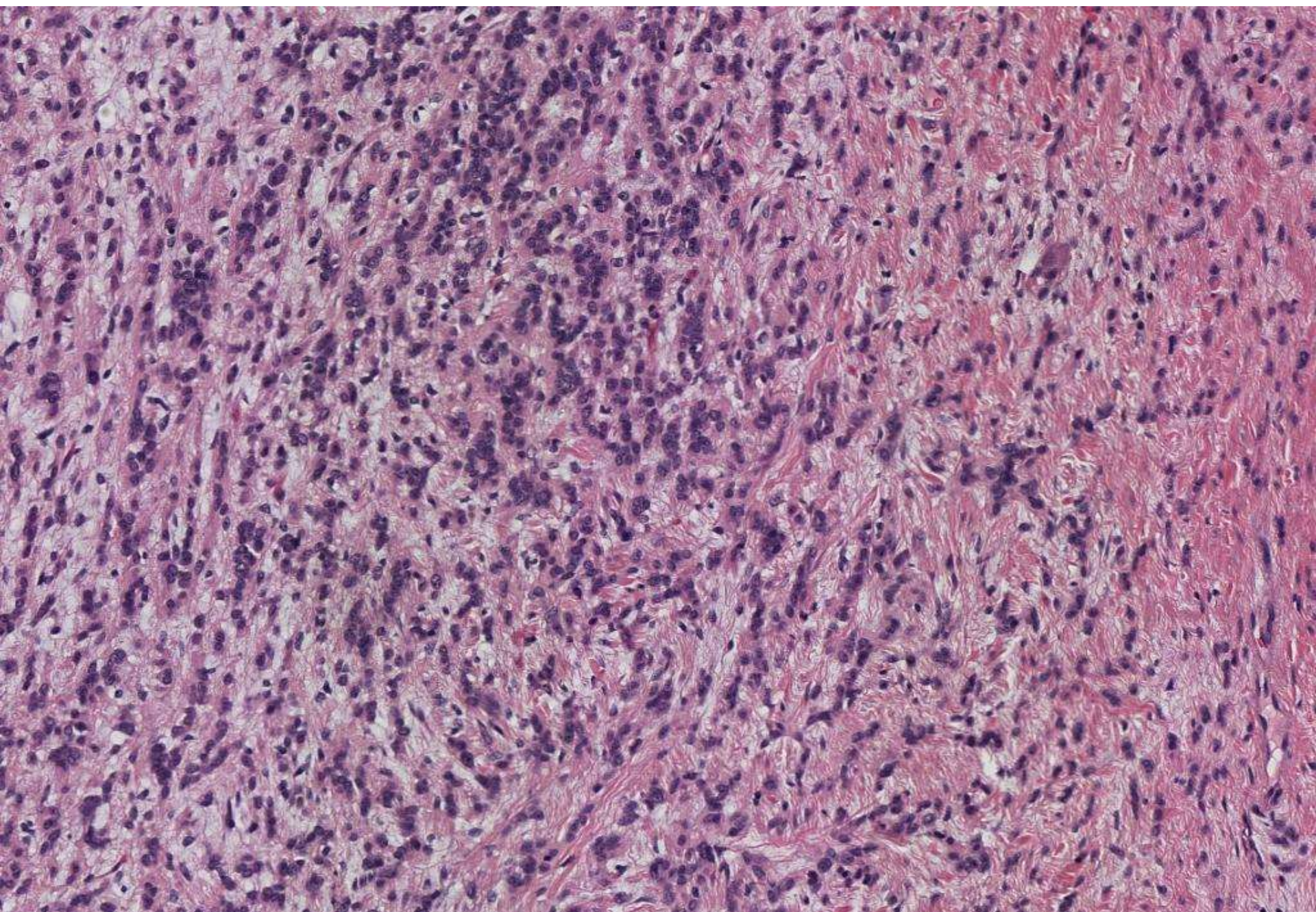


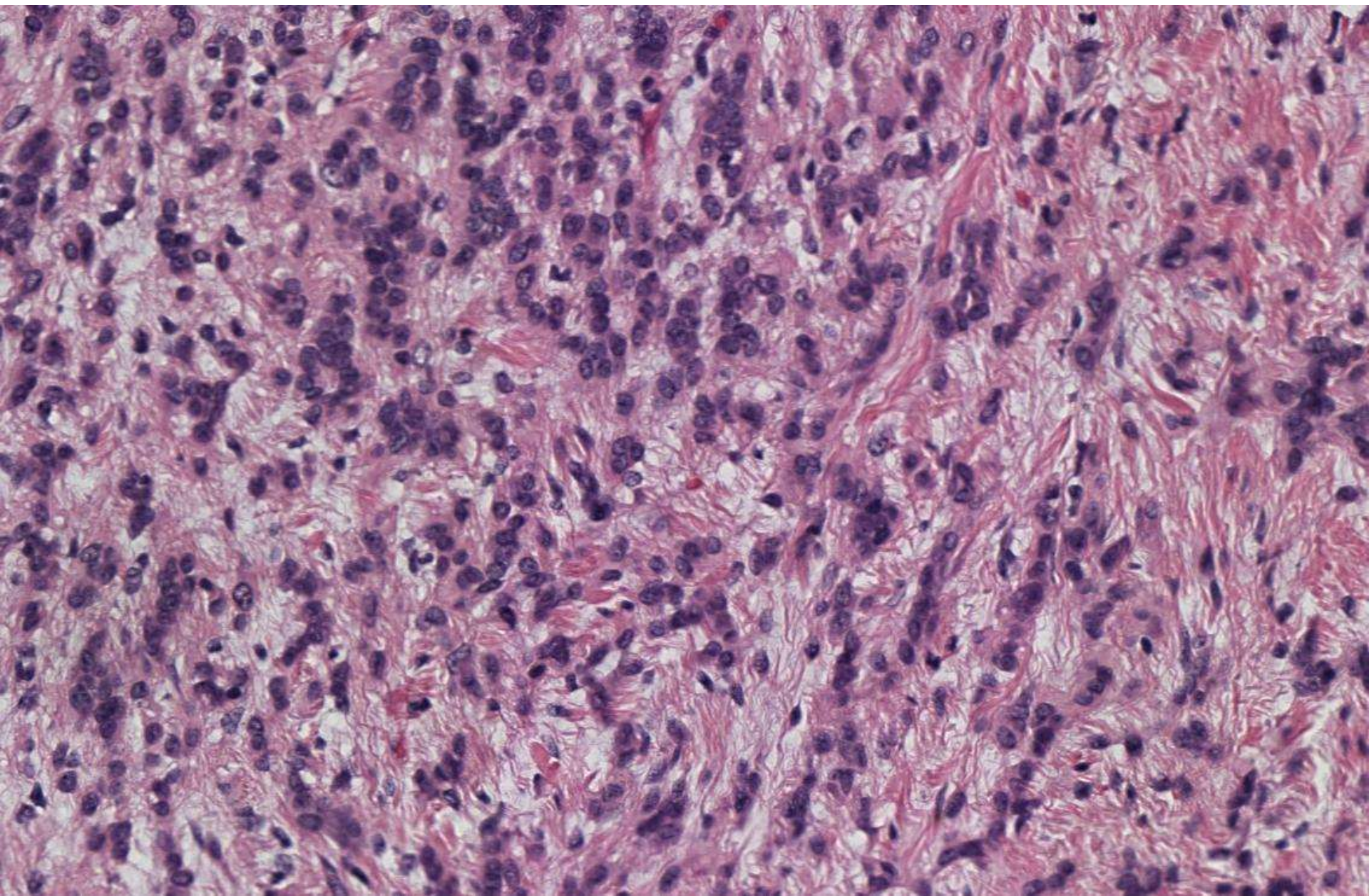












Mucosal Benign Epithelioid Nerve Sheath Tumor

- A distinct subset of mucosal peripheral nerve sheath tumors characterized by small epithelioid cells and a benign clinical course
- The largest series (n=7) shows
 - Average age at presentation 59
 - Predominantly left colon and a single bladder lesion
 - Range in size from 0.2–1.0 cm
 - May present on screening colonoscopy or during work up for a GI bleed
 - No known link to neurofibromatosis

Benign Epithelioid Peripheral Nerve Sheath Tumors

- Epithelioid variants of nerve sheath tumors are often small, well-circumscribed, encapsulated tumors (cutaneous variants) and lack typical features of schwannoma and neurofibroma
 - Do not often show Antoni A or Antoni B
 - Lack of intra-lesional neuraxons or any association with peripheral nerves.
 - GI schwannomas lack alterations in the NF2 gene found in many sporadic, conventional schwannomas from other sites.
- Lesions that have been classified as GI schwannomas differ from the conventional somatic soft tissue schwannomas histologically by having peripheral lymphoid cuffs, lacking fibrous capsules or vascular hyalinization, and rarely showing degenerative changes

Morphology and Phenotype of BENST

- Nuclei show frequent intra-nuclear pseudo-inclusions with spindled to epithelioid cells with clear to eosinophilic fibrillary cytoplasm arranged in nests and whorls
- The epicenter of the lesions are typically in the lamina propria with extension into the superficial submucosa
- Lesions lack: a distinct lymphoid cuff, ganglion cells and have no mitotic activity
- Immunohistochemical characteristics
 - Strong and diffuse S-100 protein staining
 - Variable CD34
 - Negative CD117

Differential Diagnosis

- Melanoma
- GIST
- Carcinoma
- Carcinoid
- Leiomyoma
- Ganglioneuroma
- Perineurioma
- Mucosal schwann cell hamartoma*

Epithelioid Variants of Peripheral Nerve Sheath Tumors

- GI tract schwannomas exhibit unique morphologic and genetic features compared to sporadic schwannomas
- Classification of these lesions as schwannomas or neurofibromas is difficult because of their rarity and location in a site where conventional-appearing schwannomas are known to exhibit both morphologic and genetic features distinct from other sporadic schwannomas.
- The main importance of this lesion is to recognize epithelioid nerve sheath tumor as a benign lesion amongst the differential diagnosis of epithelioid lesions of mucosal sites

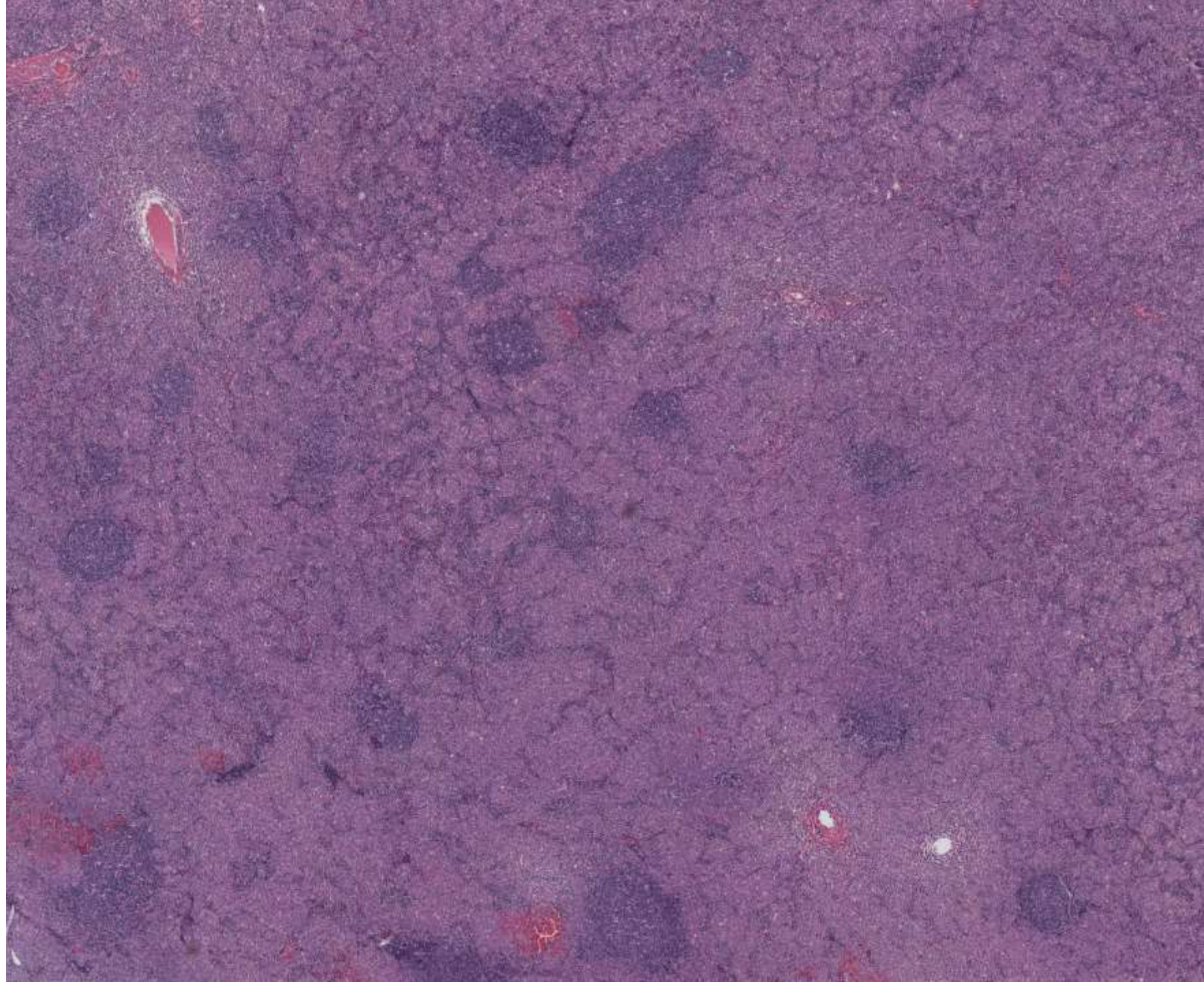
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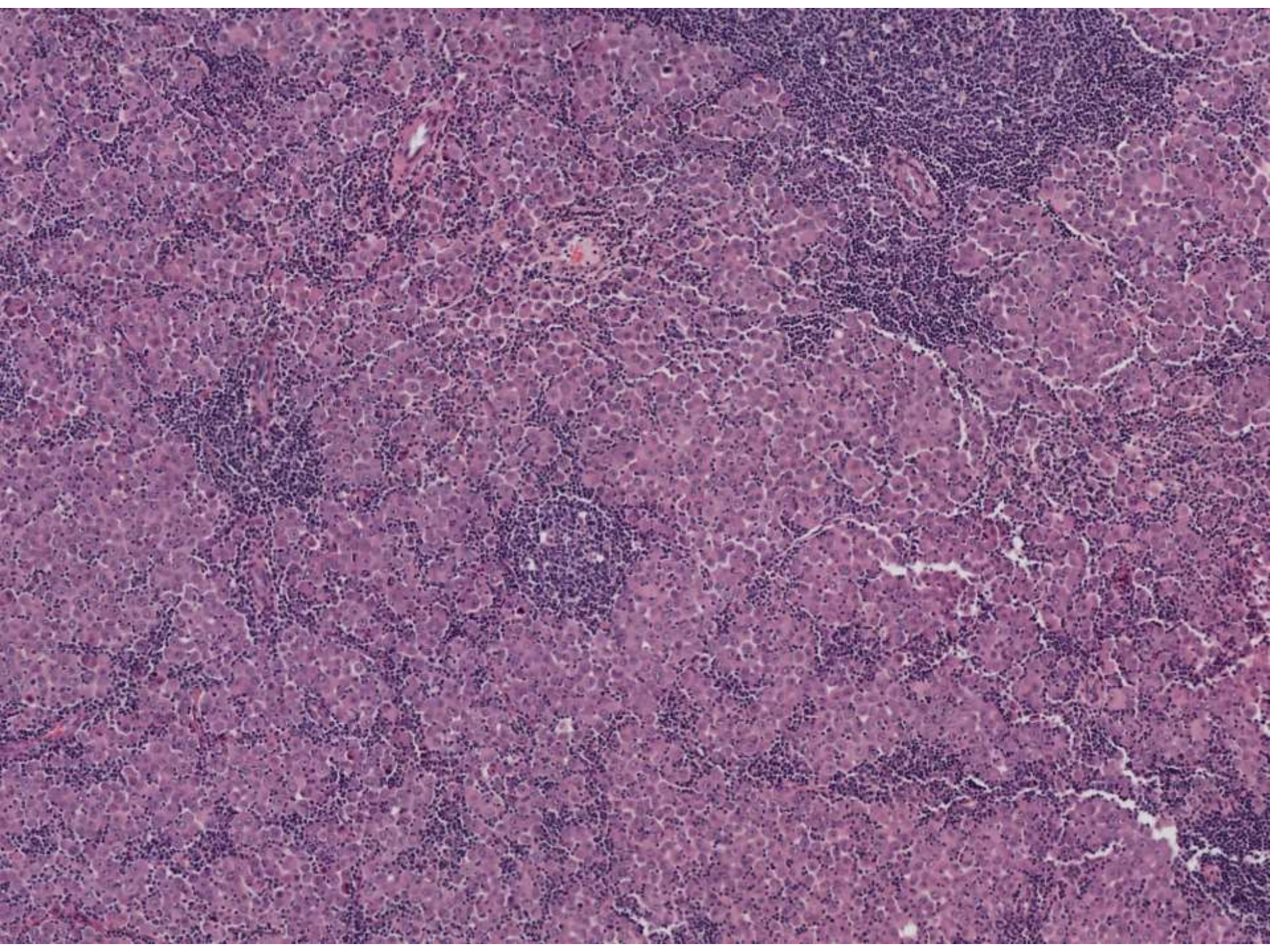
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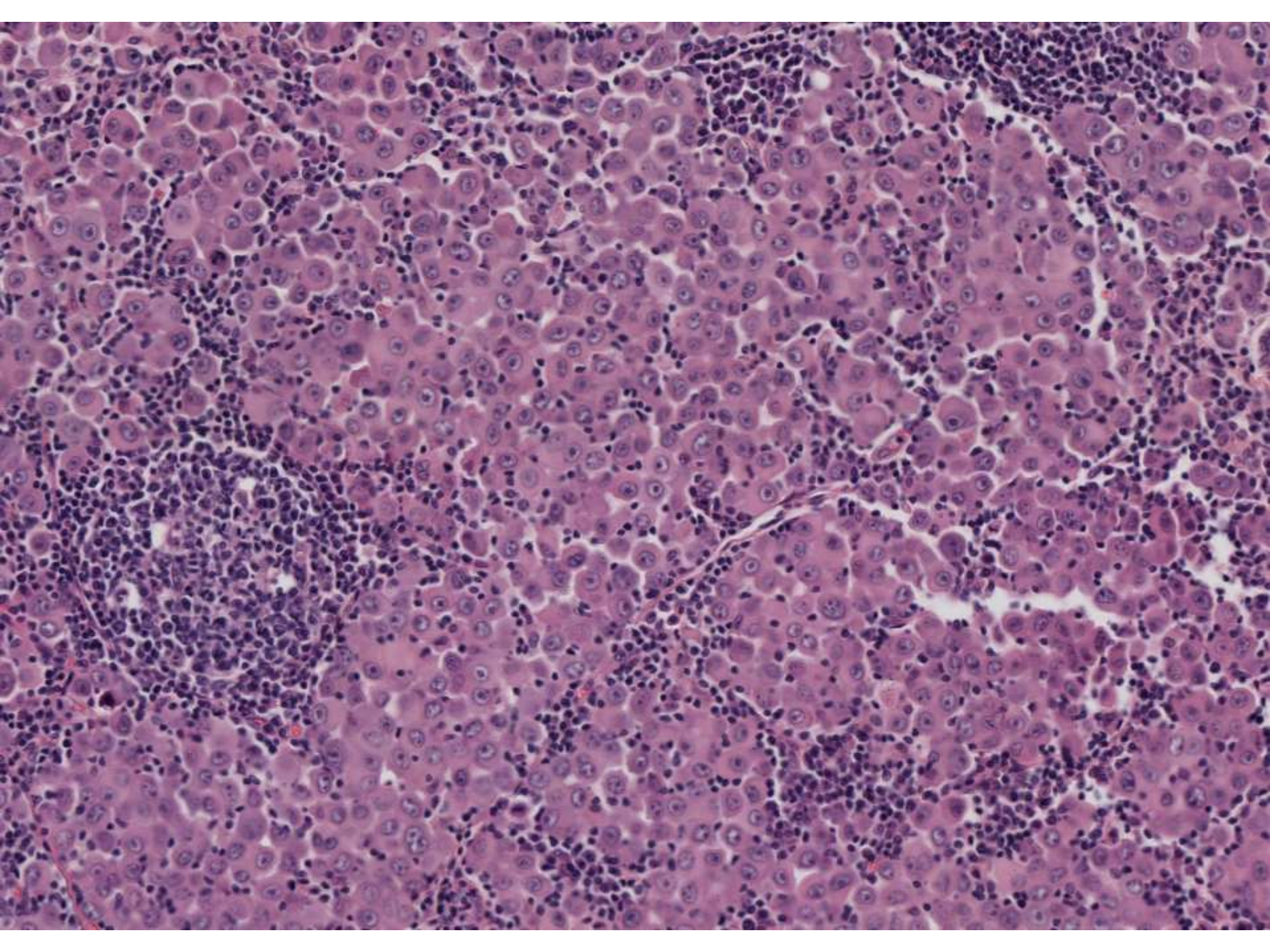
Kelly Mooney/Megan Troxell; Stanford

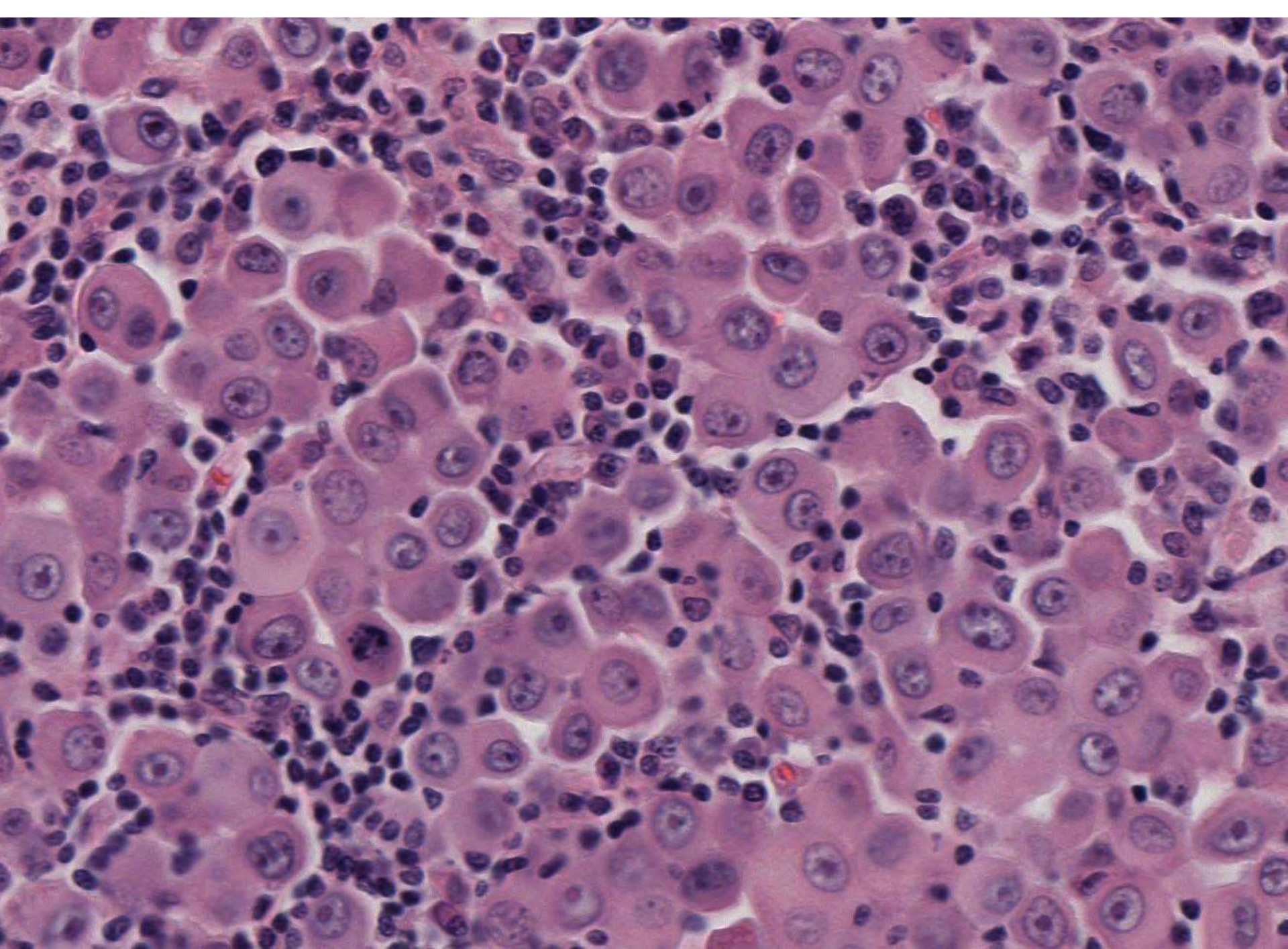
70-year-old female with negative
mammogram one year ago, presenting with
10 pound weight loss and axillary mass.









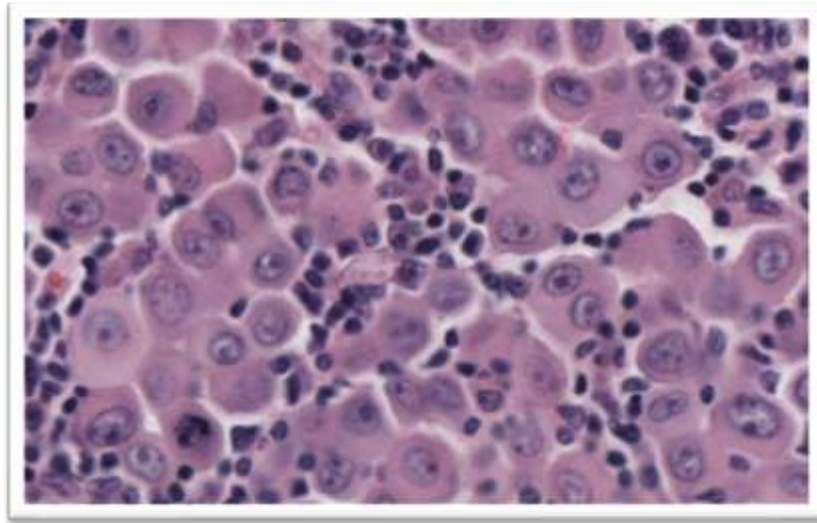


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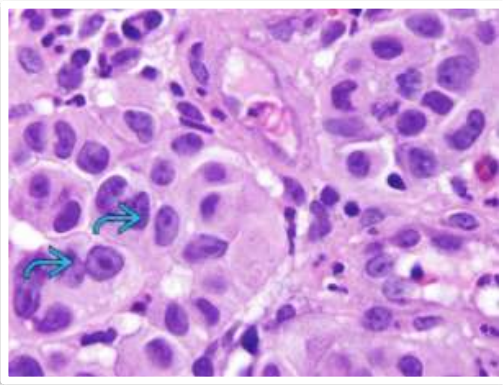
February 2018

Kelly Mooney, MD (PGY-2) / Megan Troxell, MD PhD

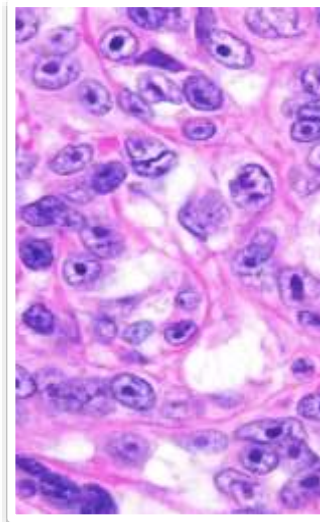




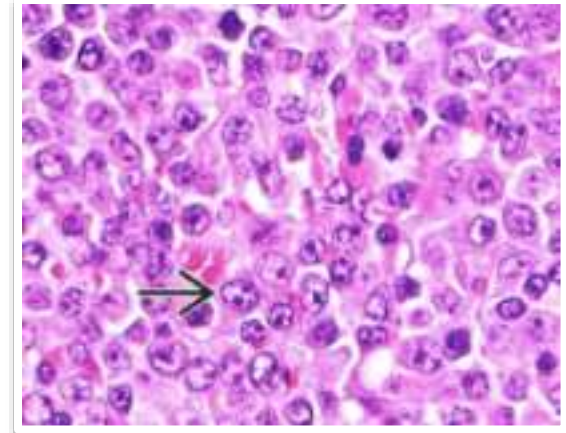
Lymph node effaced by large discohesive cells with round nuclei, prominent nucleoli, and abundant eosinophilic cytoplasm



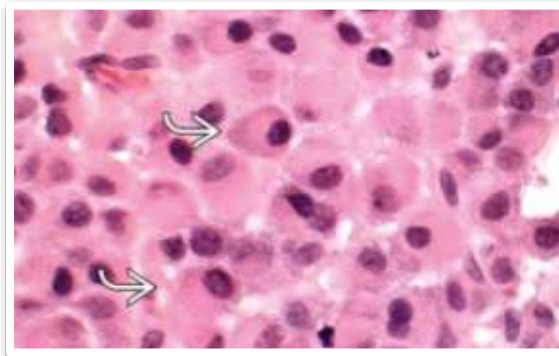
Melanoma



Clear cell sarcoma



Large B-cell lymphoma
(Immunoblasts)



Carcinoma
With apocrine features
(invasive apocrine,
lobular breast, salivary
gland)

Immunohistochemical work-up

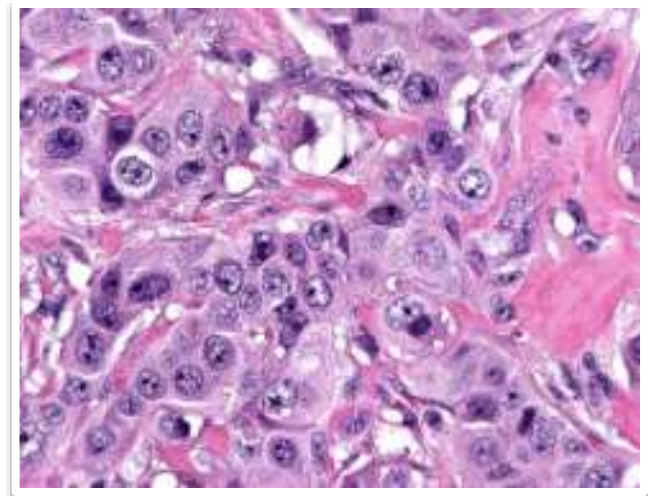
Negative:

| | |
|----------------|--------------|
| <i>Melan-A</i> | <i>CD45</i> |
| <i>S100</i> | <i>CD3</i> |
| <i>HMB45</i> | <i>CD20</i> |
| <i>MiTf</i> | <i>CD10</i> |
| | <i>CD15</i> |
| <i>Desmin</i> | <i>CD30</i> |
| <i>Actin</i> | <i>BCL1</i> |
| | <i>BCL2</i> |
| <i>CDX2</i> | <i>BCL6</i> |
| <i>TTF1</i> | <i>MUM1</i> |
| | <i>CD21</i> |
| | <i>PAX-5</i> |

| | |
|-------------------|------------------|
| GATA-3 | Positive |
| BRST2 (GCDFP15) | Positive |
| Mammaglobin | Focally positive |
| CK7 | Positive |
| CK20 | Negative |
| CKMIX | Positive |
| Androgen receptor | Positive |
| E-cadherin | Negative |
| Ki67 | High (90%) |
| ----- | |
| ER | Negative (<1%) |
| PR | Negative (<1%) |
| HER2 | Negative (0) |

Diagnosis:
Metastatic high grade
carcinoma, **favor**
pleomorphic apocrine
lobular carcinoma

Differential: occult salivary gland,
apocrine skin/ sweat gland



High grade salivary duct carcinoma

Pleomorphic (apocrine) lobular carcinoma

Definition: lobular carcinoma variant characterized by larger cells, more abundant eosinophilic cytoplasm (apocrine features), distinct nucleoli

Clinical: post-menopausal women

Immunohistochemistry: AR, GCDFP-15 positive, E-cadherin negative, ER/PR/HER2 negative.

Genetics: Gene expression profiling shows that the subtype is more closely genetically related to classical ILC than invasive ductal carcinoma

Outcomes: Overall, seems to be more aggressive than ILC with higher recurrence risk (12% vs 4%)

Occult breast carcinoma presenting as axillary lymph node metastasis

<1% patients present with axillary node metastasis as first clinical manifestation

Studies show that about 65% of cases of metastatic adenocarcinoma in axillary lymph nodes from occult breast carcinoma have large cells, **often with apocrine features**

MRI reveals abnormalities in ~60% of these patients (high false + rate)

Case follow-up

Imaging: Breast MRI & full body PET only with axillary lymphadenopathy
CT and ultrasound head and neck with no masses

Genetics assay: 89% probability salivary gland/ head & neck,
7% breast

Favored breast primary (more common/ expected than occult salivary gland to axilla without neck lymphadenopathy)

Treated with neoadjuvant chemoradiation therapy/ axillary lymph node dissection with metastatic carcinoma in 3/17 sclerotic lymph nodes

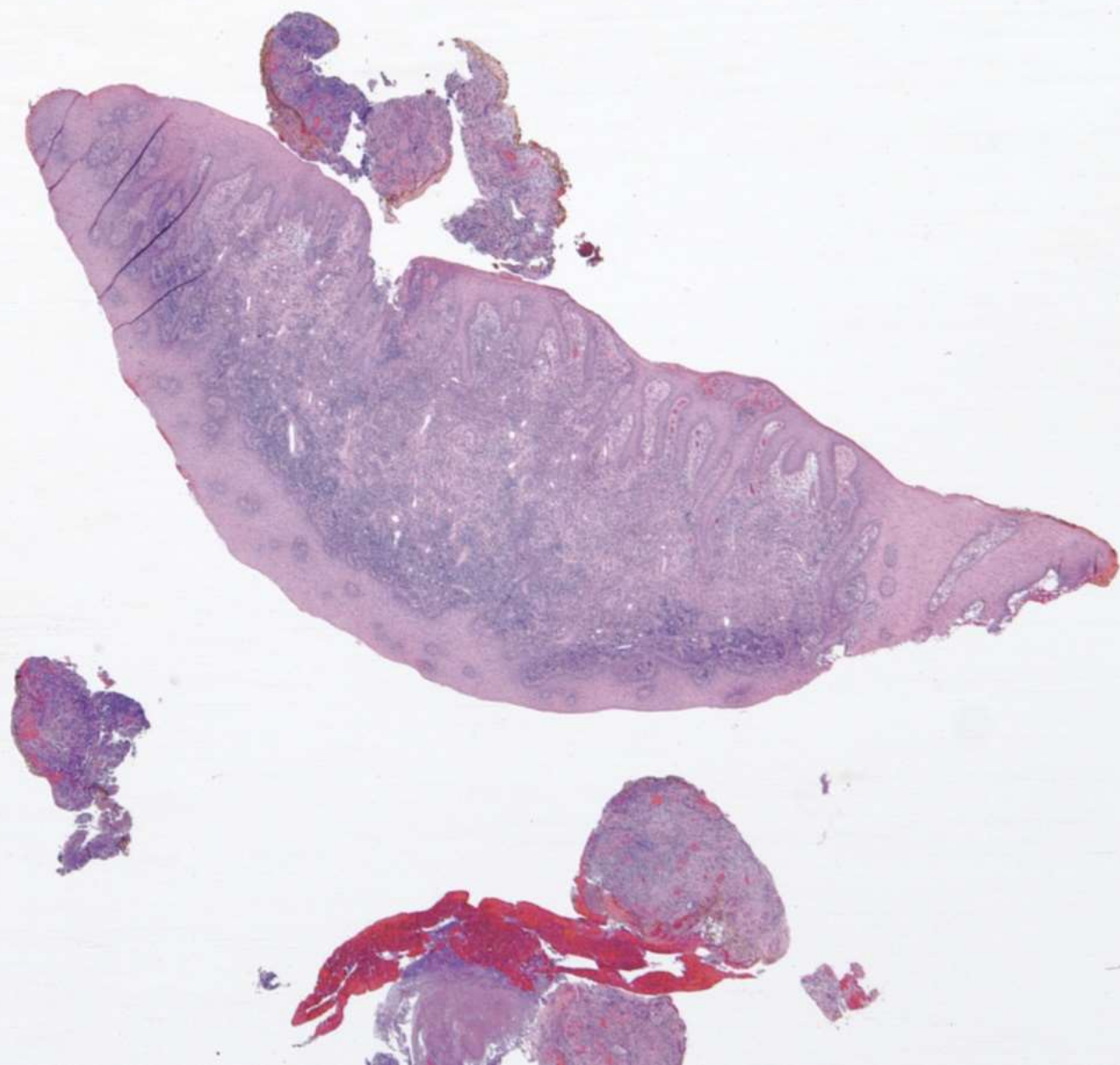
Per latest clinic notes doing “fairly well”

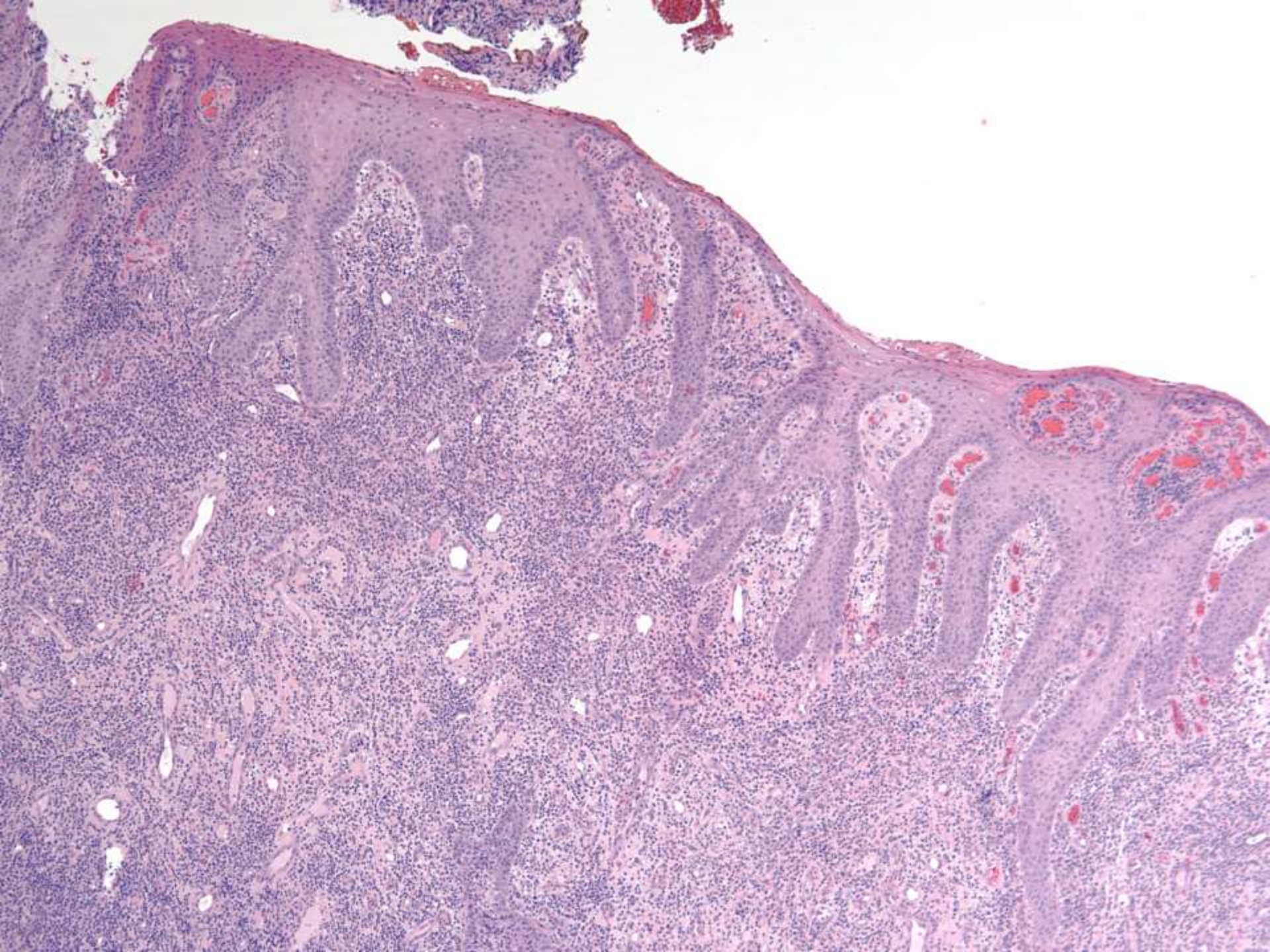
References

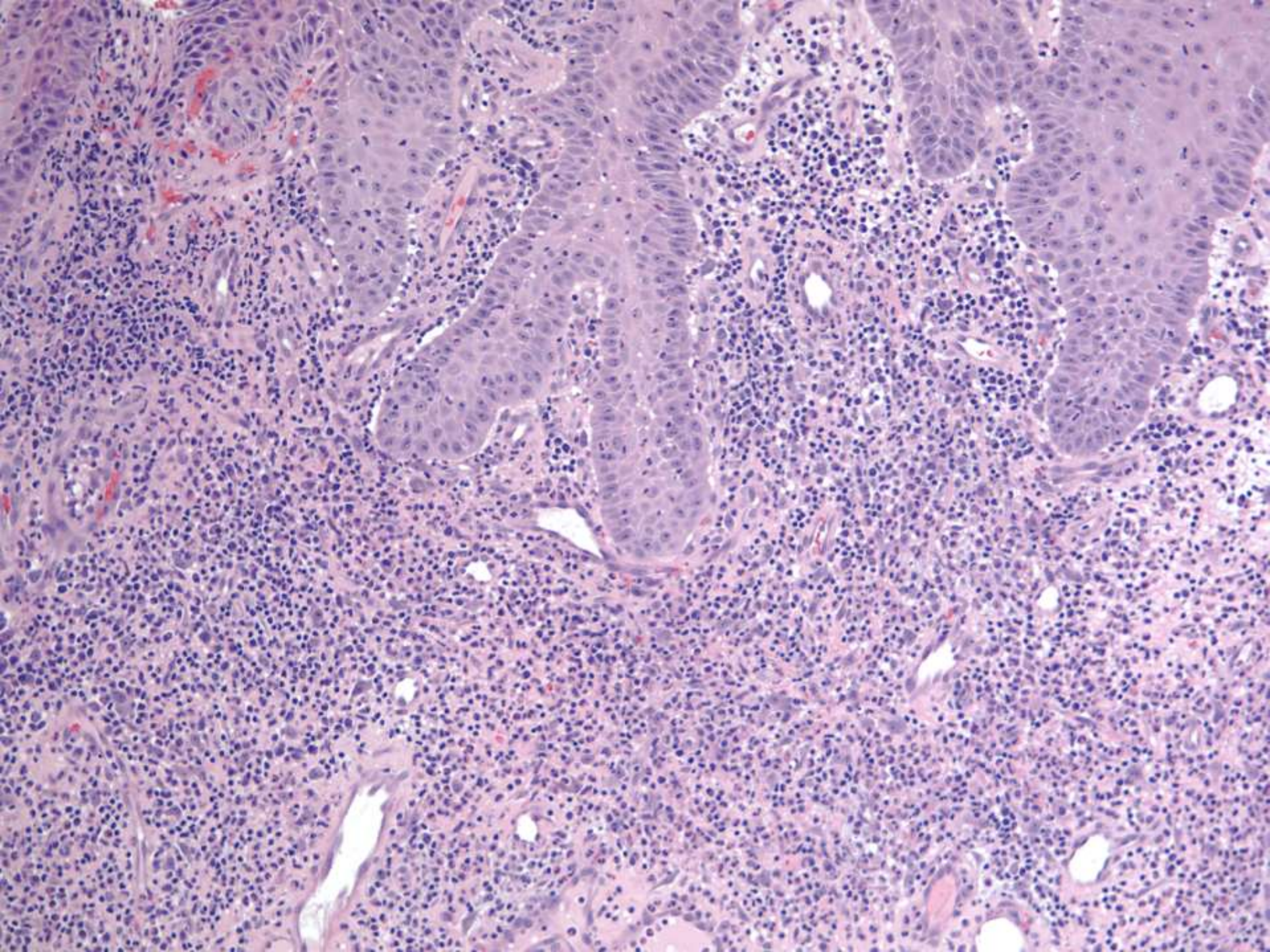
1. Hoda, S.A., P.P. Rosen, E. Brogi, and F.C. Koerner. *Rosen's Breast Pathology*. Wolters Kluwer Health, 2014.
2. Gown AM, Fulton RS, Kandalaft P et al. Markers of metastatic carcinoma of breast origin. *Histopathology*. 2016;68(1):86-95.
3. Monhollen L, Morrison C, Ademuyiwa FO et al. Pleomorphic lobular carcinoma: a distinctive clinical and molecular breast cancer type. *Histopathology*. 2012;61(3):365-77

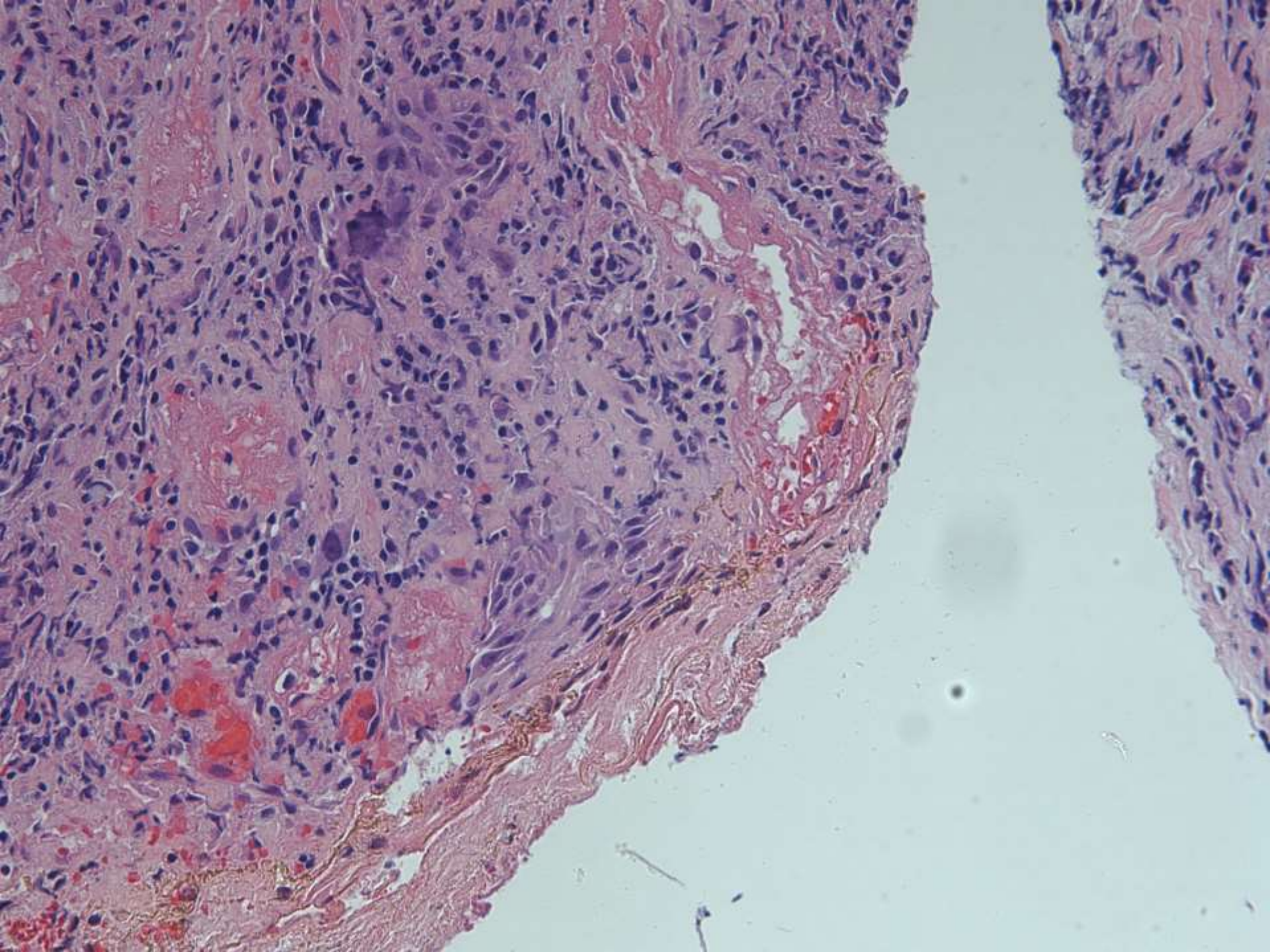
SB 6246

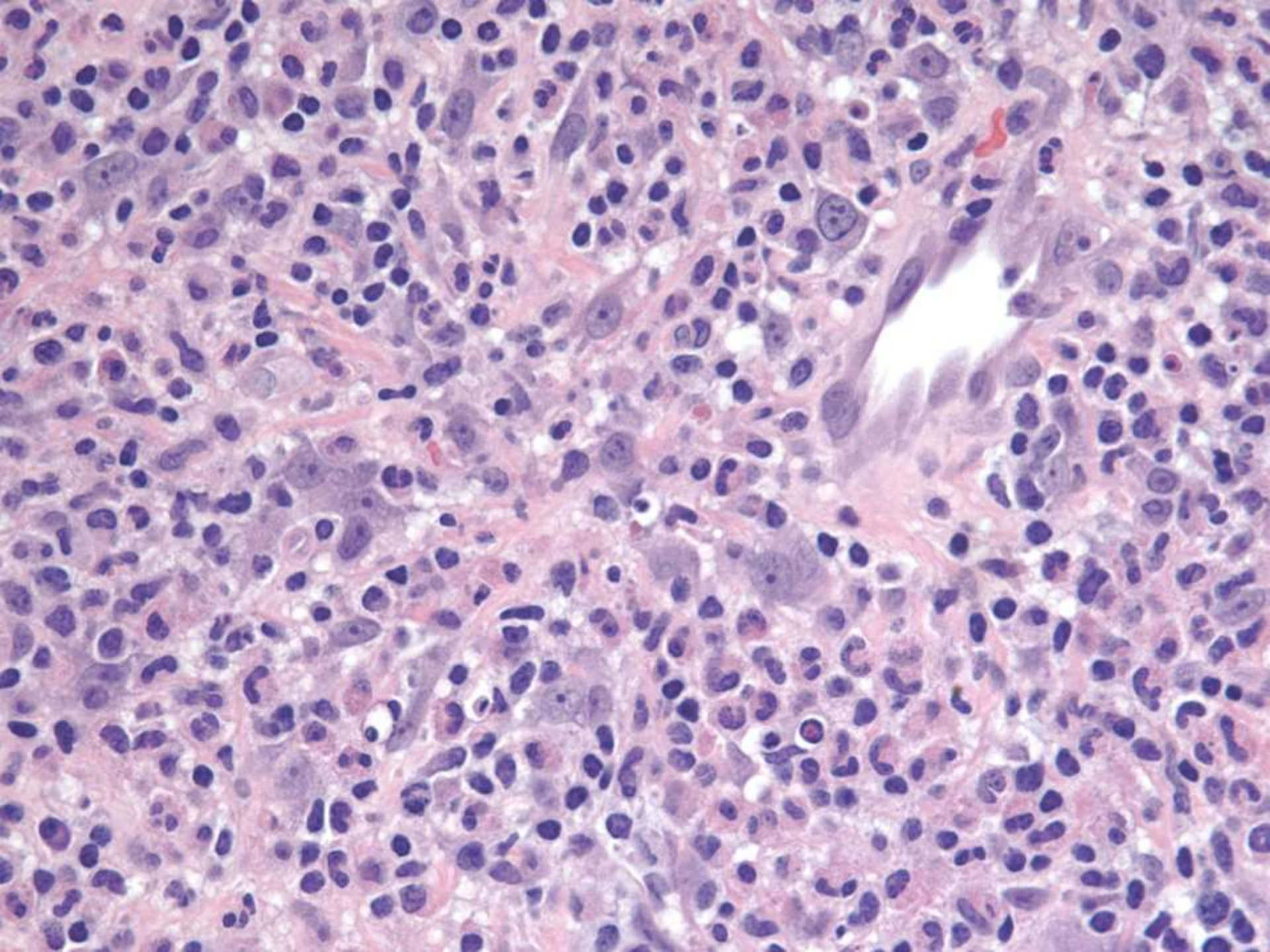
Kevin Ko/Bart Singer/John Higgins; Stanford
59-year-old male with history of HepC, HCC, s/p
orthotopic liver transplant, who presented with
>2cm oral ulcer for 4 weeks.





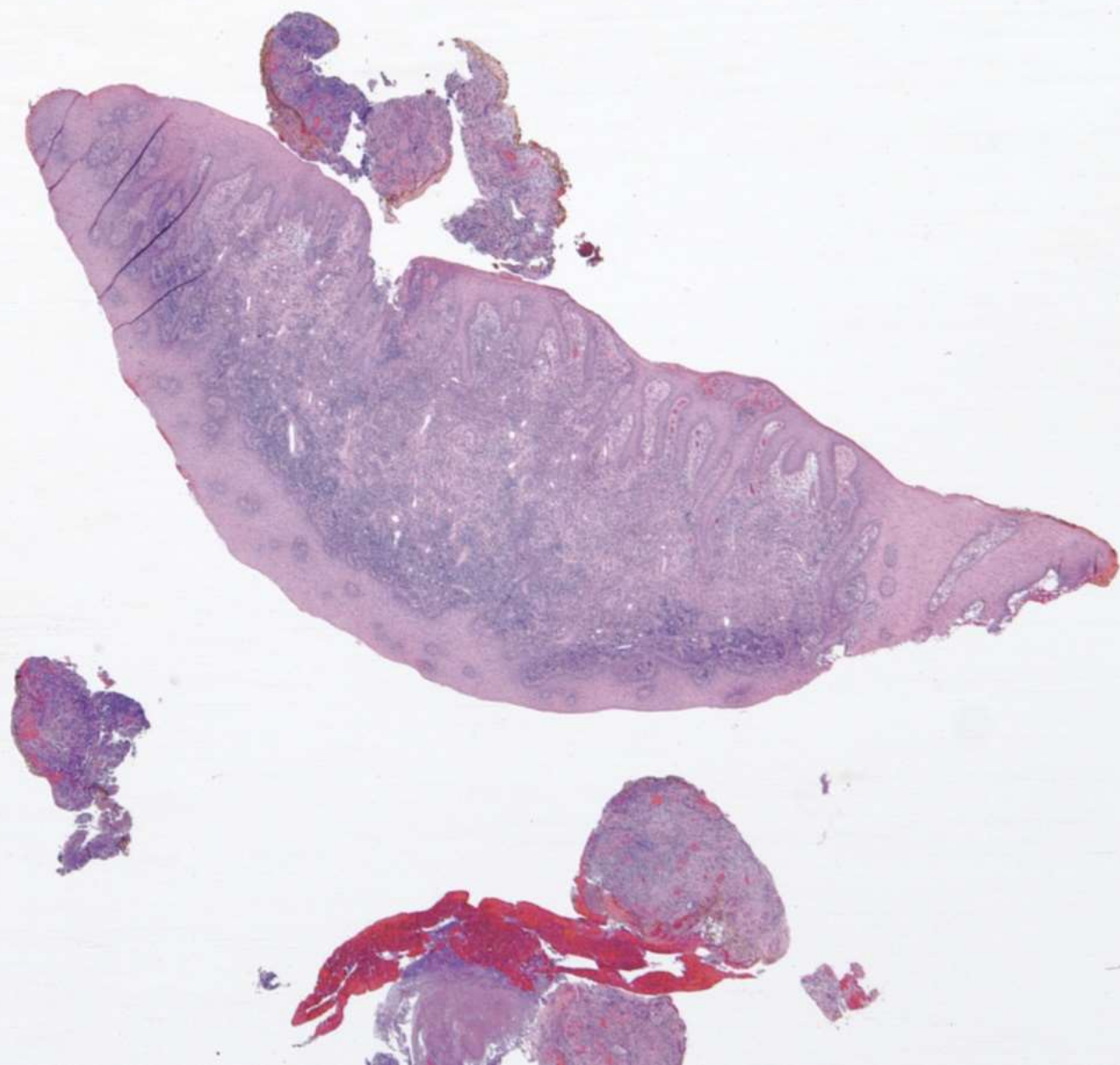


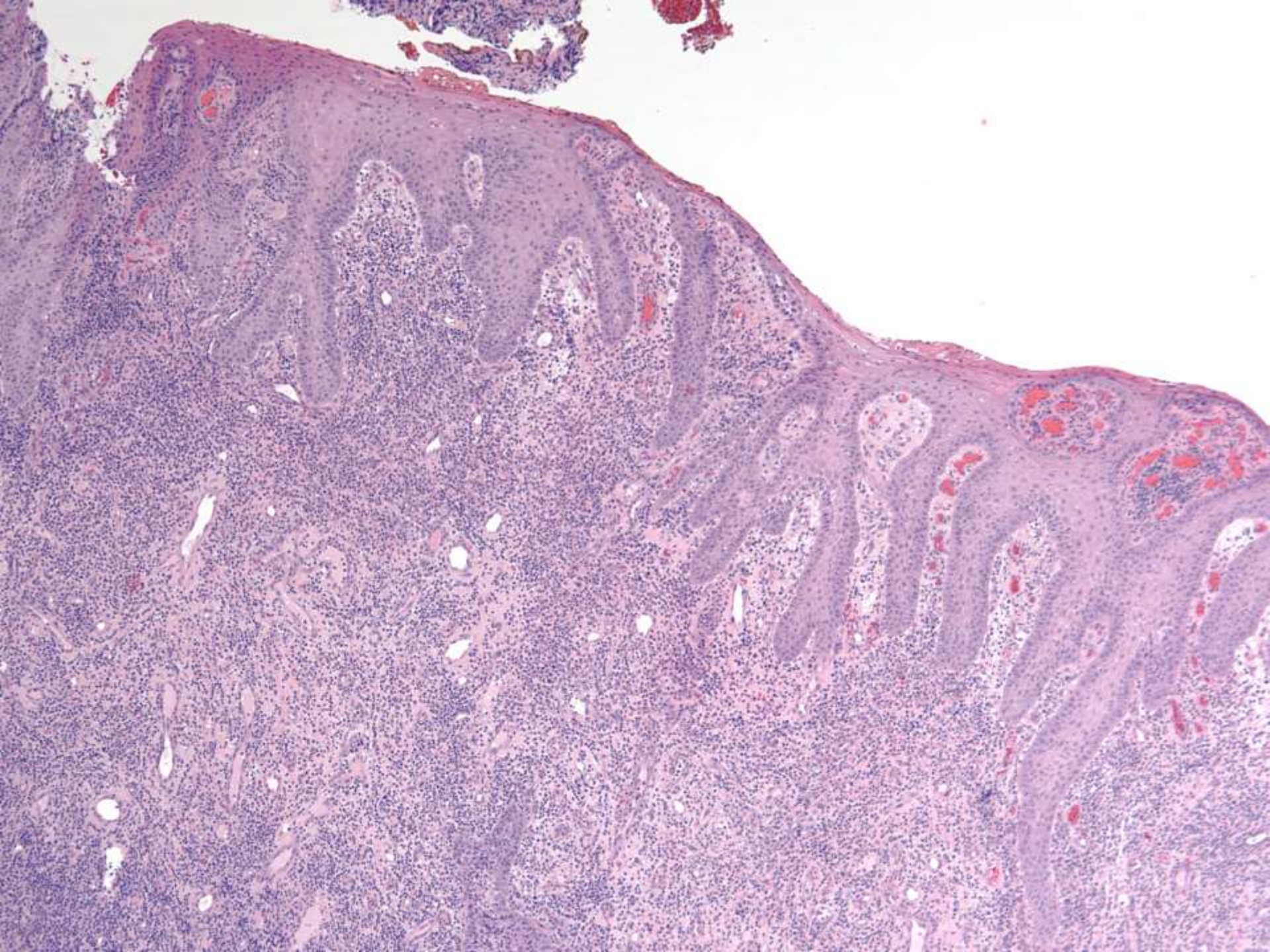


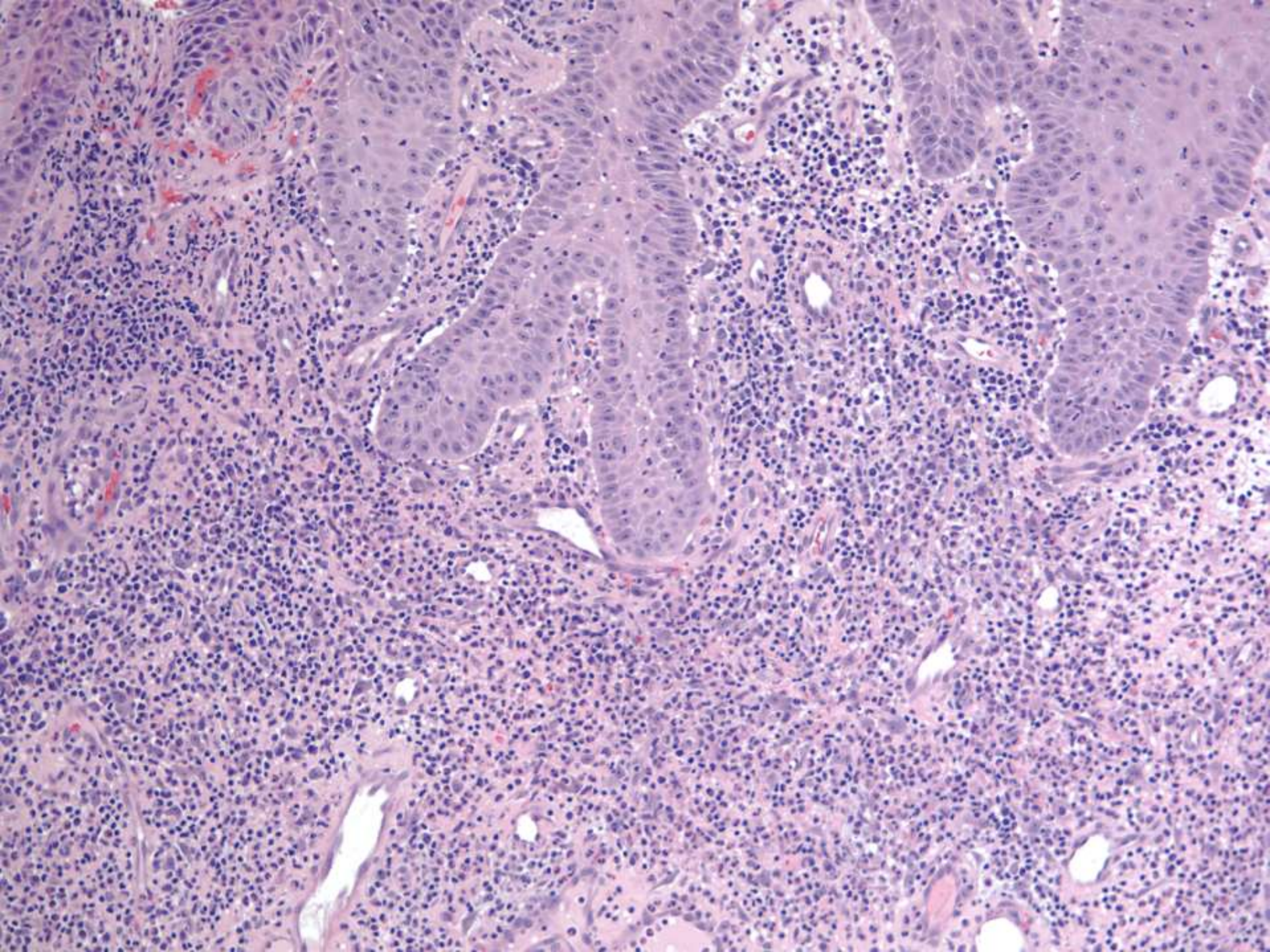


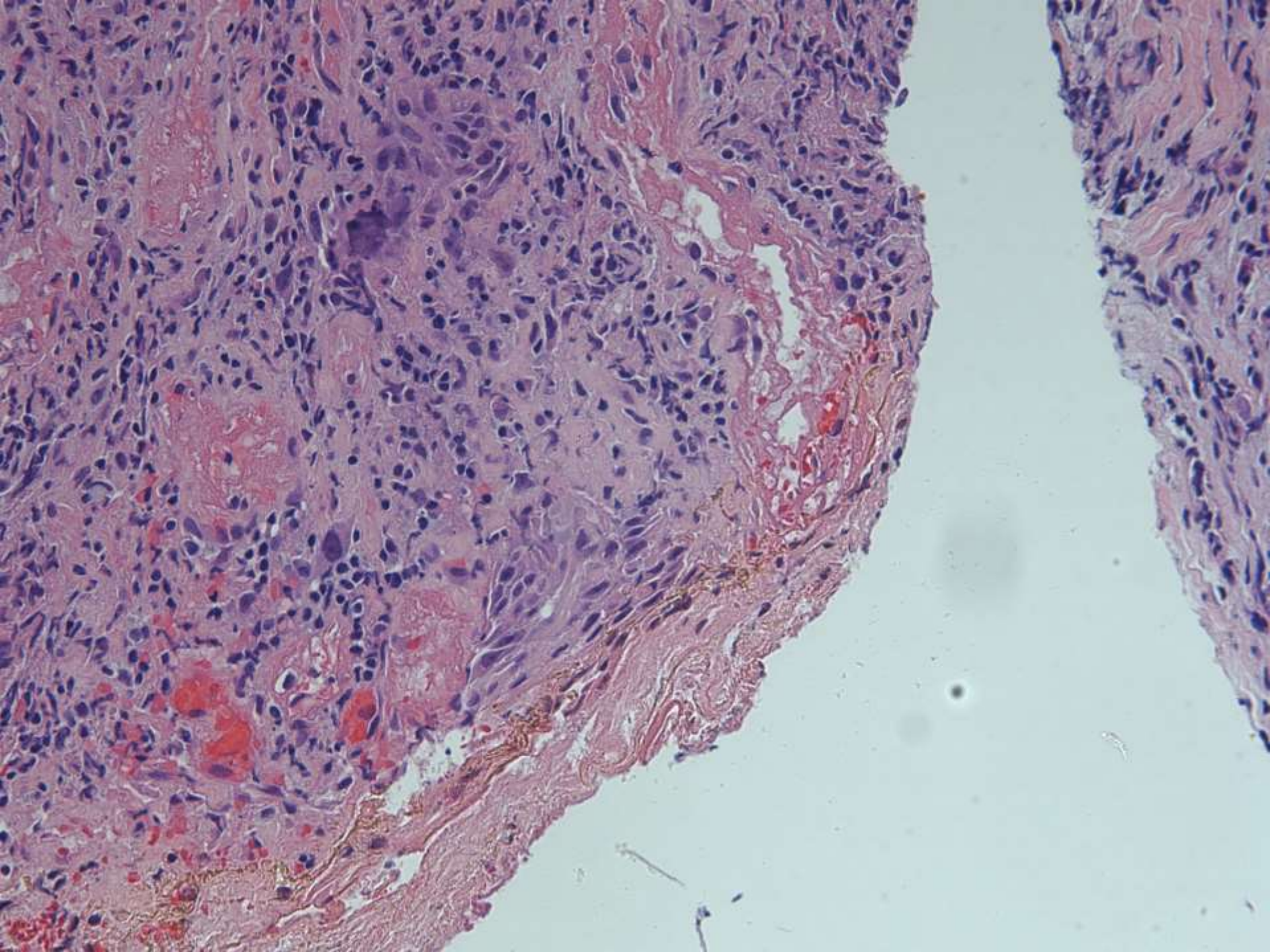
Southbay Presentation

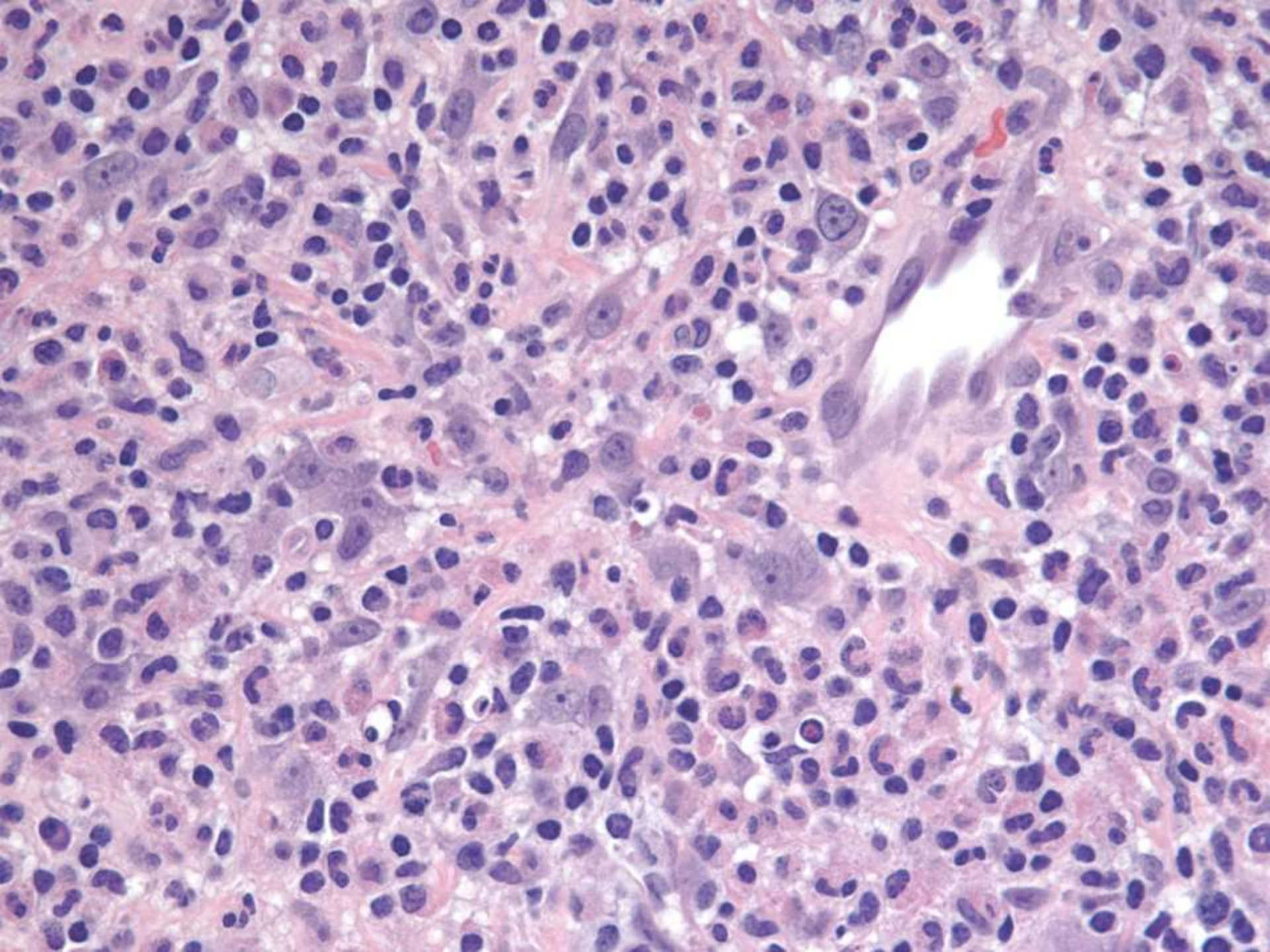
Kevin Ko/Bart Singer/John Higgins; Stanford
59-year-old male with a history of hepatitis C,
HCC, s/p orthotopic liver transplant who
presented with >2cm oral ulcer for 6 weeks









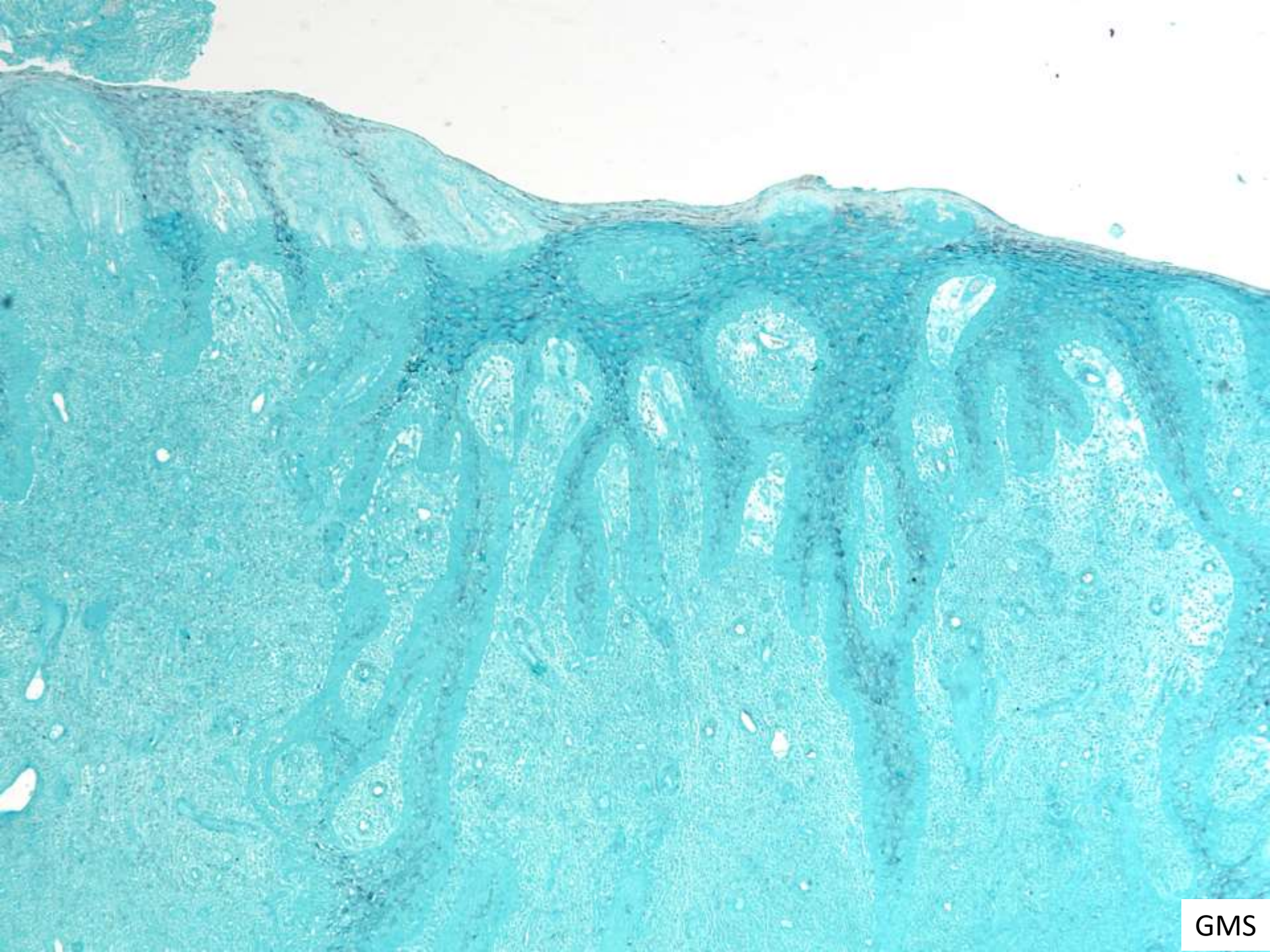


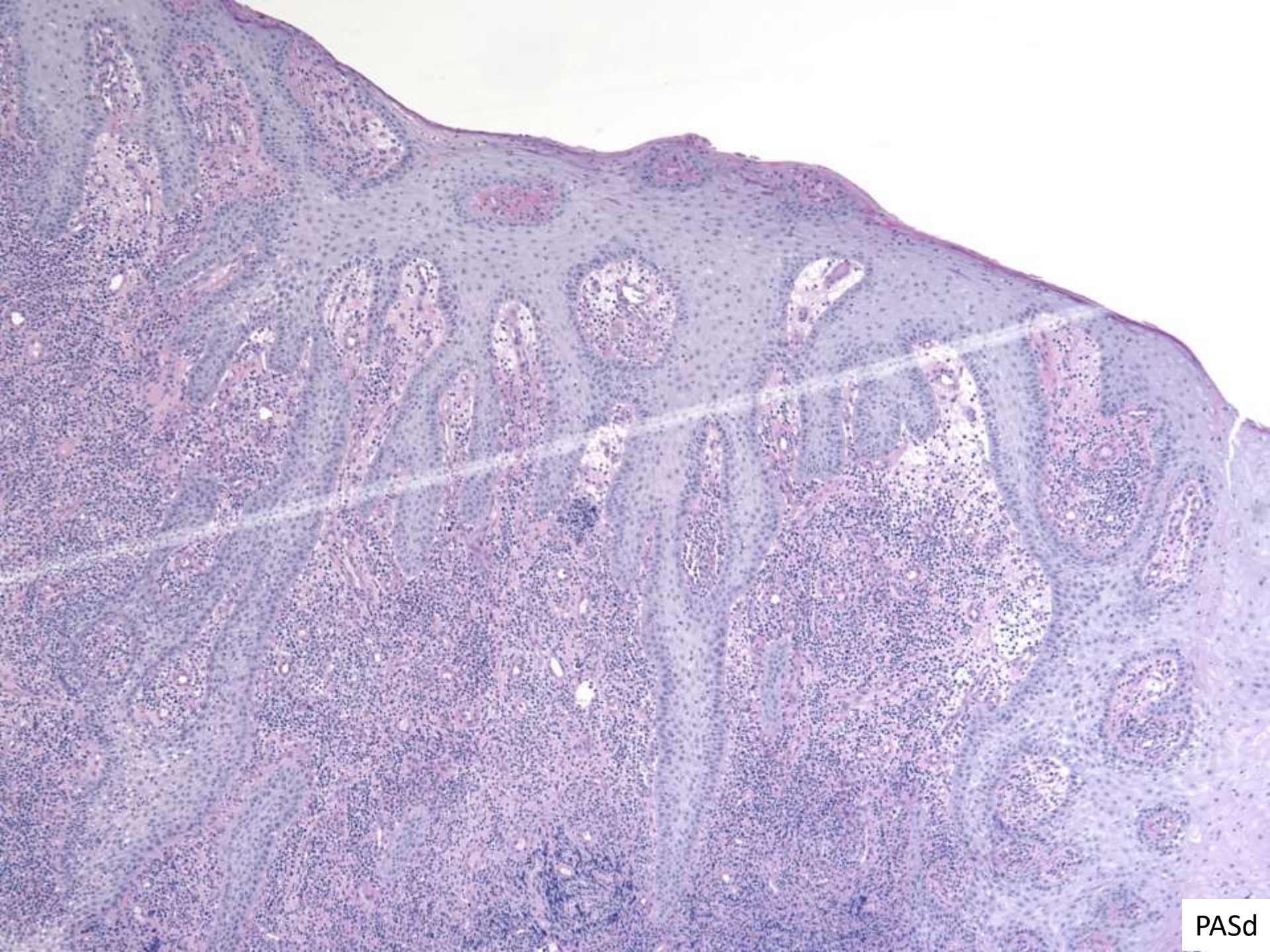
More History

- 8/31/2017- Initial presentation/Office visit
 - CC: oral ulcer, painful, ~ 1 week
 - Started on Acyclovir 800mg TID for 13 days
 - Started on Nystatin
- 10/2/2017 - ED
 - Worsening oral ulcer, ~4 weeks
 - Having difficulty eating, lost weight
 - Viscous lidocaine prescribed
- 10/10/2017- ENT clinic

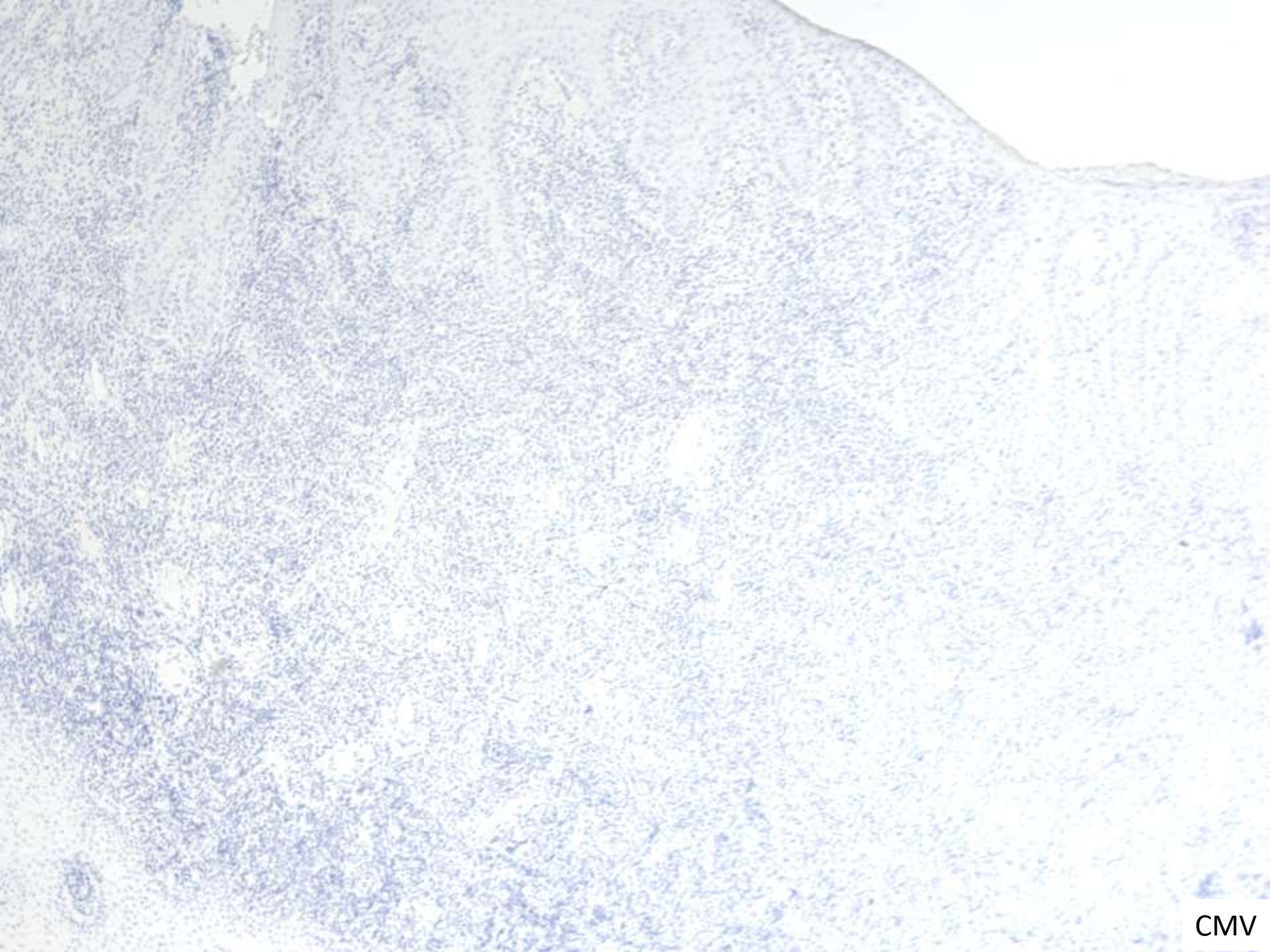
Surgeon's assessment:

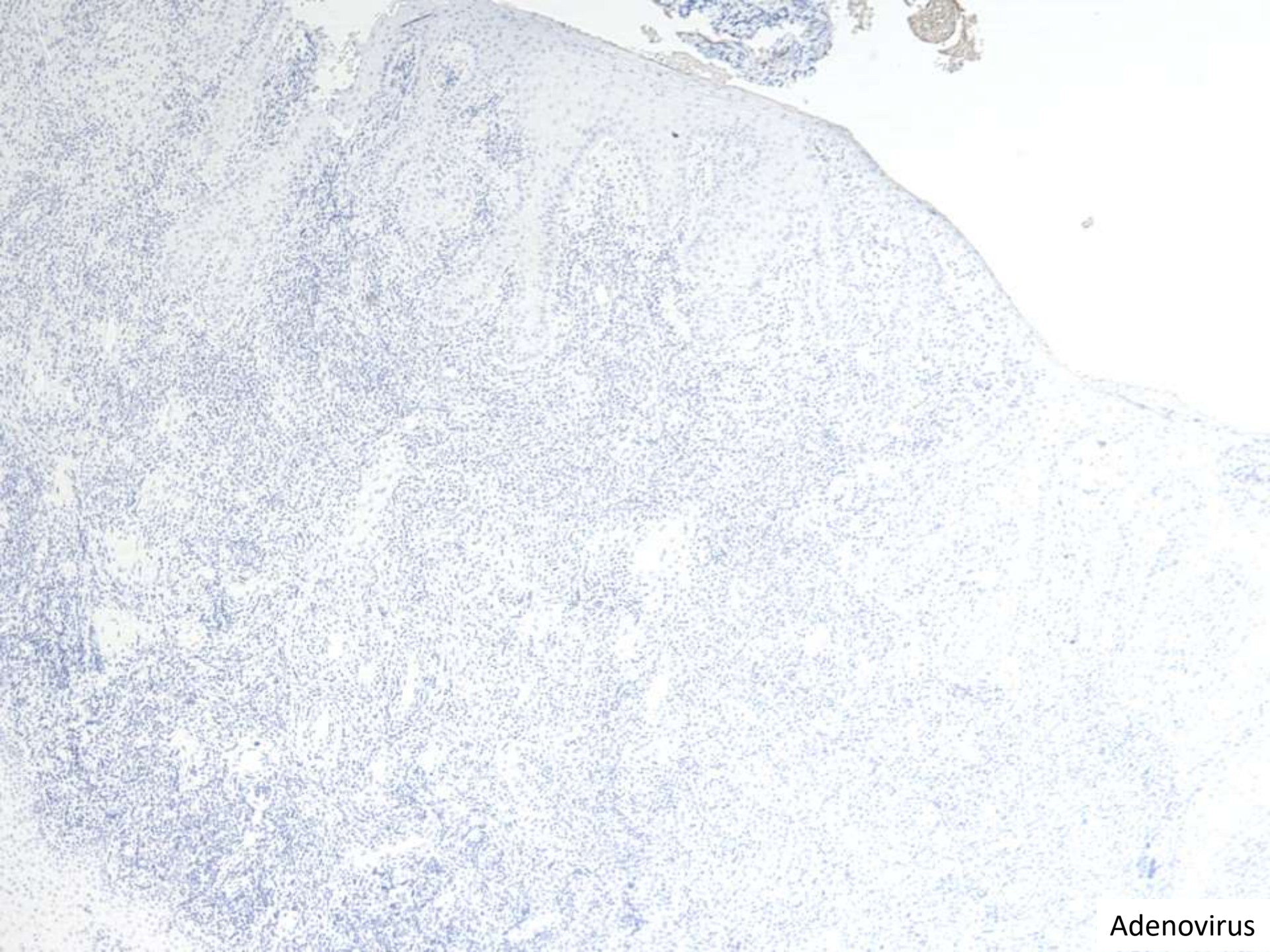
 - ">2 cm ulcer with exudates and heaped up edges"
 - "Clinically suspicious for malignancy"



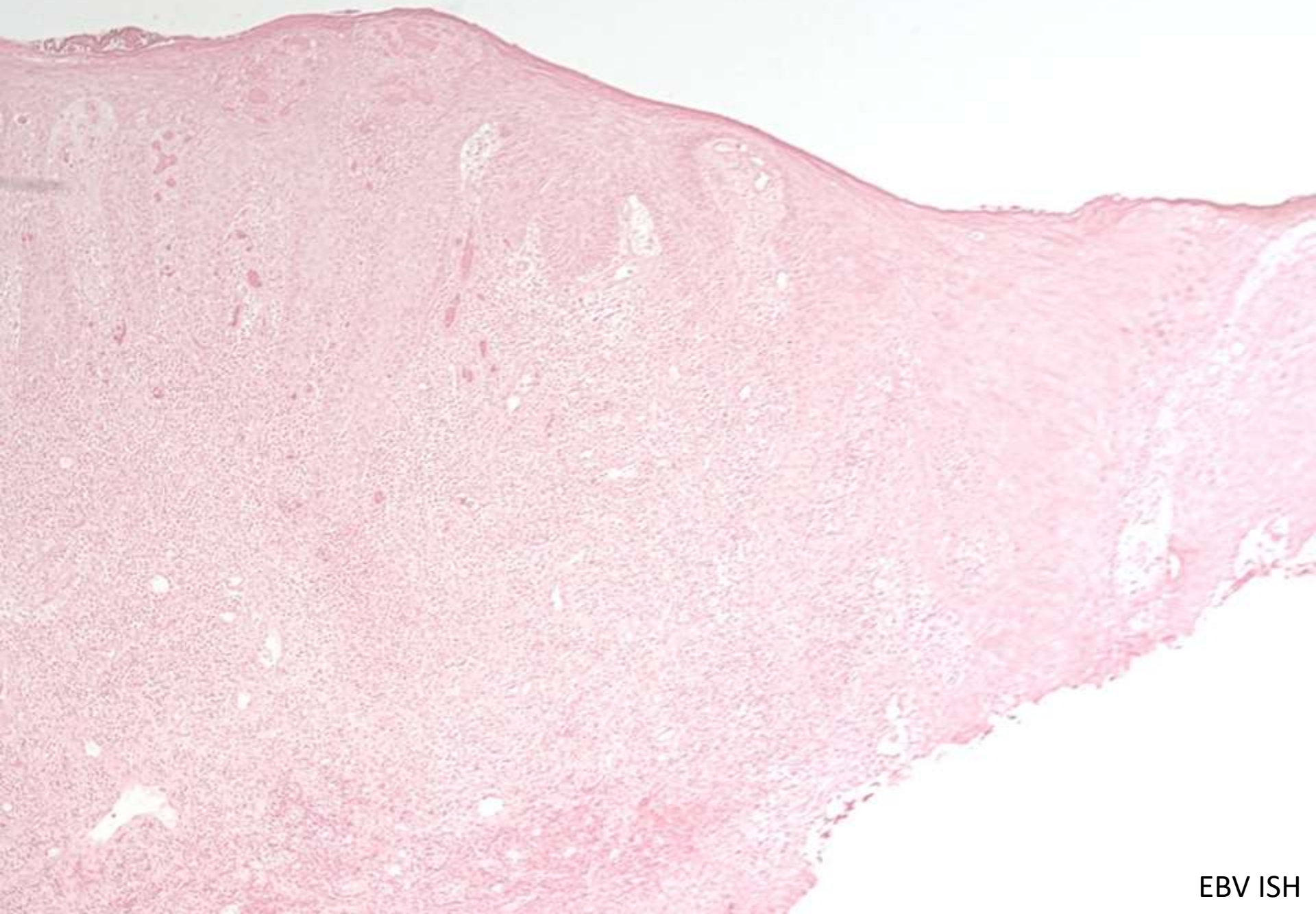




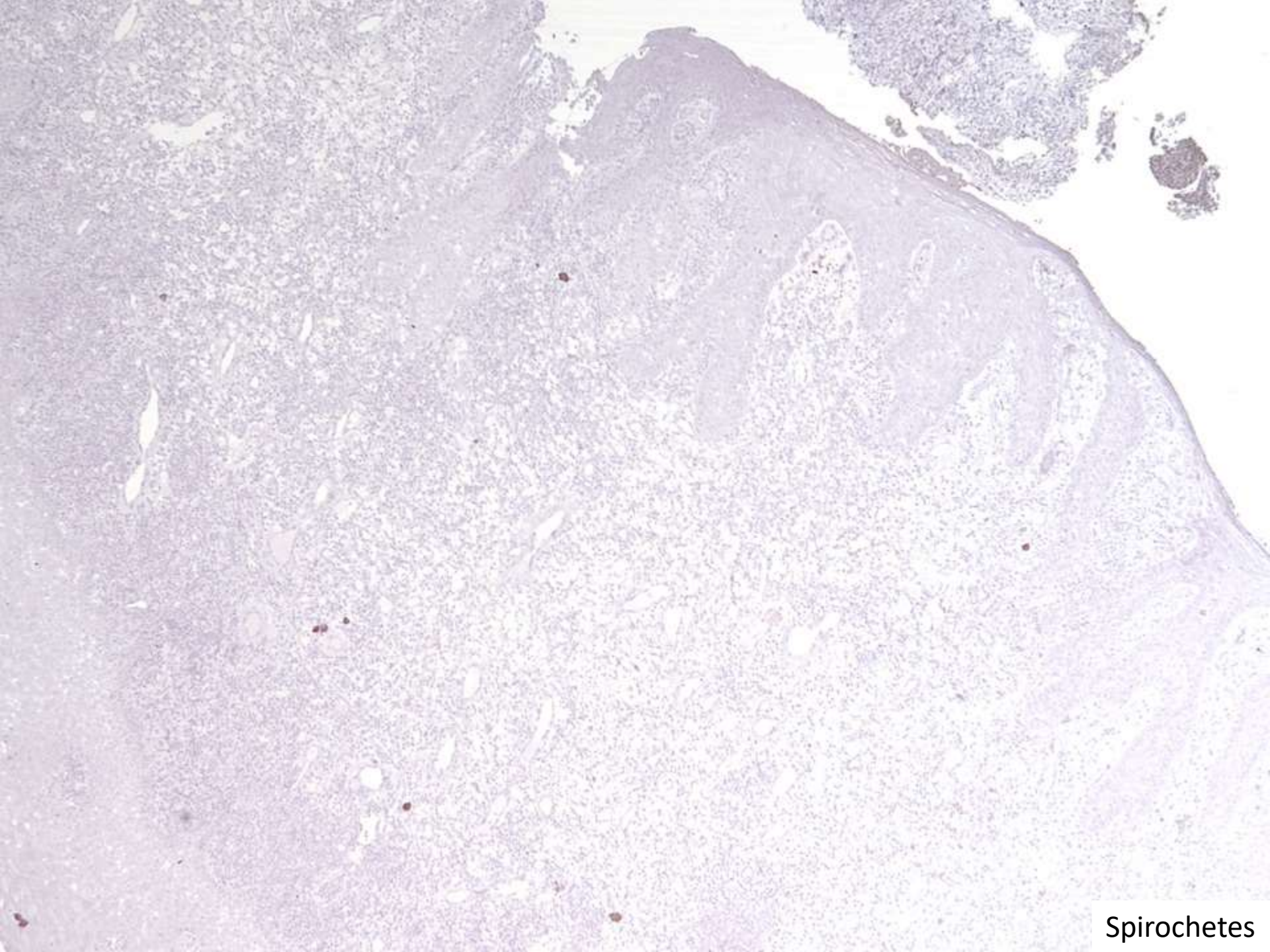




Adenovirus



EBV ISH



Spirochetes

Pathology Report

COMMENT:

We note, per EPIC, the patient's history of liver transplant and reported treatment with **mycophenolate**. A few case reports in the literature implicate mycophenolate in causing ulcerative stomatitis in transplant recipients, possibly by direct mycophenolate-induced cytotoxicity in oral mucosa. **We raise this as a possible etiology for the findings in the current biopsy and note that in the referenced case reports, decreasing mycophenolate dosing improved oral ulcerations.** Clinical correlation is recommended.

- 10/27/2017-ENT clinic
- Surgeon's assessment:
 - “Recommend to transplant team to consider decreasing CellCept per pathologist's suggestion to see if ulcers resolve”

Clinic follow up: 10/30/2017



Clinic follow up: 11/09/2017



Clinic follow up: 11/16/2017



Clinic follow up: 12/21/2017



Clinic follow up: 1/25/2018



Final Diagnosis:

LOWER LIP ULCER, BIOPSY

-- Mycophenolate Mofetil-Induced
Ulcerative Stomatitis

- A brief review of ulcerative stomatitis
("Aphthous Ulcers")

Ulcerative Stomatitis A.K.A “Aphthous Ulcers”

- Very common
- Etiology = unknown
 - Reported Triggers/Predisposing Factors
 - Allergies/hypersensitivity
 - Stress
 - Trauma
 - Nutritional deficiency
 - Hormones
 - Immunological factors
 - Hematological abnormalities
 - Genetic predisposition

Ulcerative Stomatitis “Aphthous Ulcers”

- 3 types
 - Minor : 3-10mm, 7-14 days
 - Major : 1-3cm, 2-6 weeks, +/- scar
 - Herpetiform : 1-3mm, 7-10 days, multiple & tend to occur in clusters, can be mistaken for intraoral HSV
- Minor is most common
 - Only occurs on non-keratinized mucosa
 - (not gingiva or hard palate)



- Diagnosis: Clinical

- Treatment:

- No treatment
- OTC anesthetic
- Topical corticosteroid
- Cauterization
- Systemic steroid (for multi-focal outbreak)

Rx: Fluocinonide Gel 0.05%
Disp: 15g
Sig: Apply a thin layer to
lesion 4 times per day
until resolved

If a patient presents w/ cc of multiple recurrences, r/o the following systemic conditions.....

| |
|------------------------------|
| Celiac Disease |
| Nutritional Deficiency |
| IBS/Chrohns |
| IgA Deficiency |
| Cyclic Neutropenia |
| Immunocompromised Conditions |

Mycophenolate Mofetil-Induced Ulcerative Stomatitis in Transplant Recipients

- First case described in the English literature in 2007
- Not well recognized until late 2015
- Initial step is to exclude infectious origin
 - HSV and CMV infections are most common culprits
- Exclude underlying dermatological or systemic diseases associated with oral ulceration

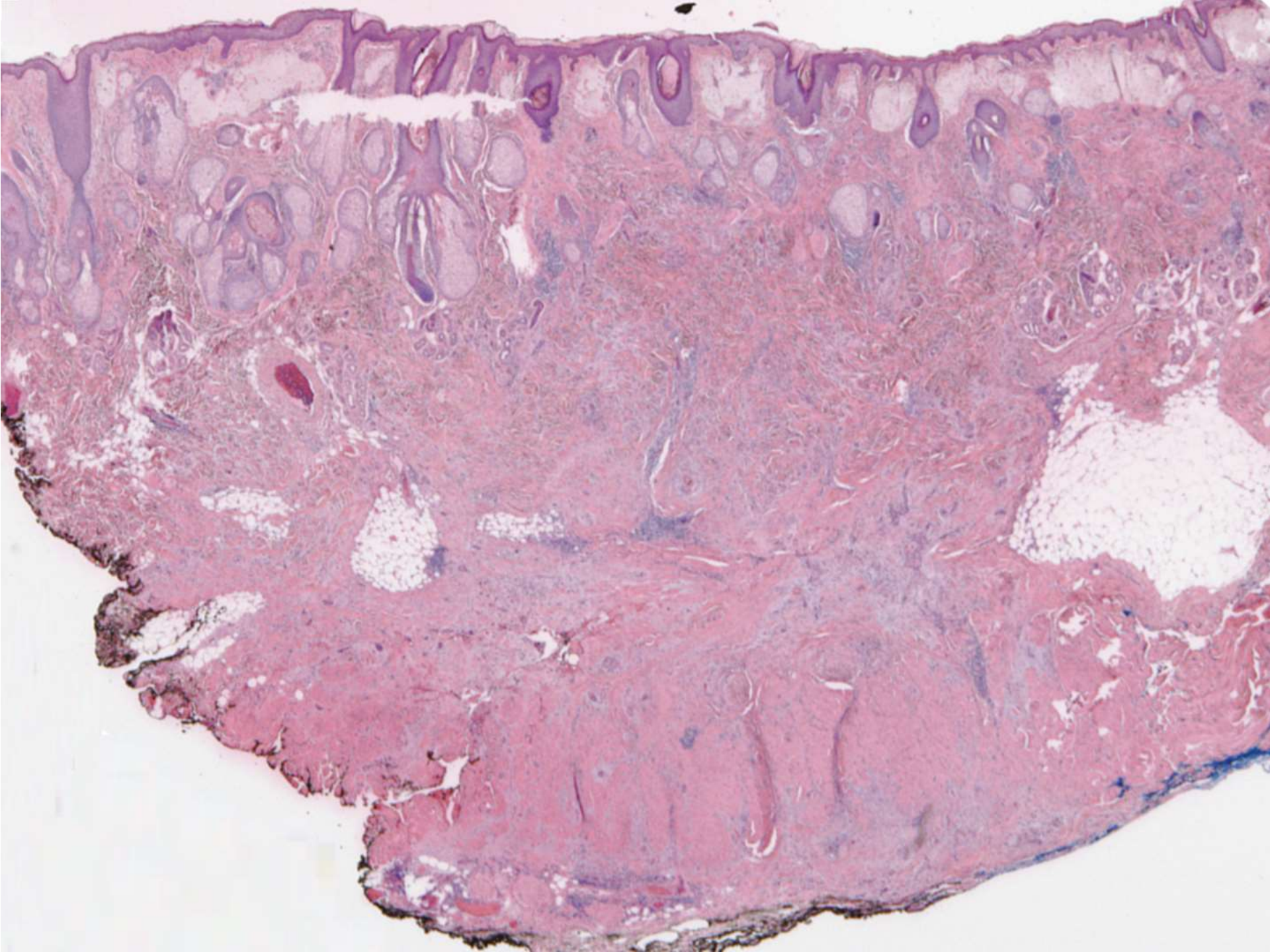
Mycophenolate Mofetil-Induced Ulcerative Stomatitis in Transplant Recipients

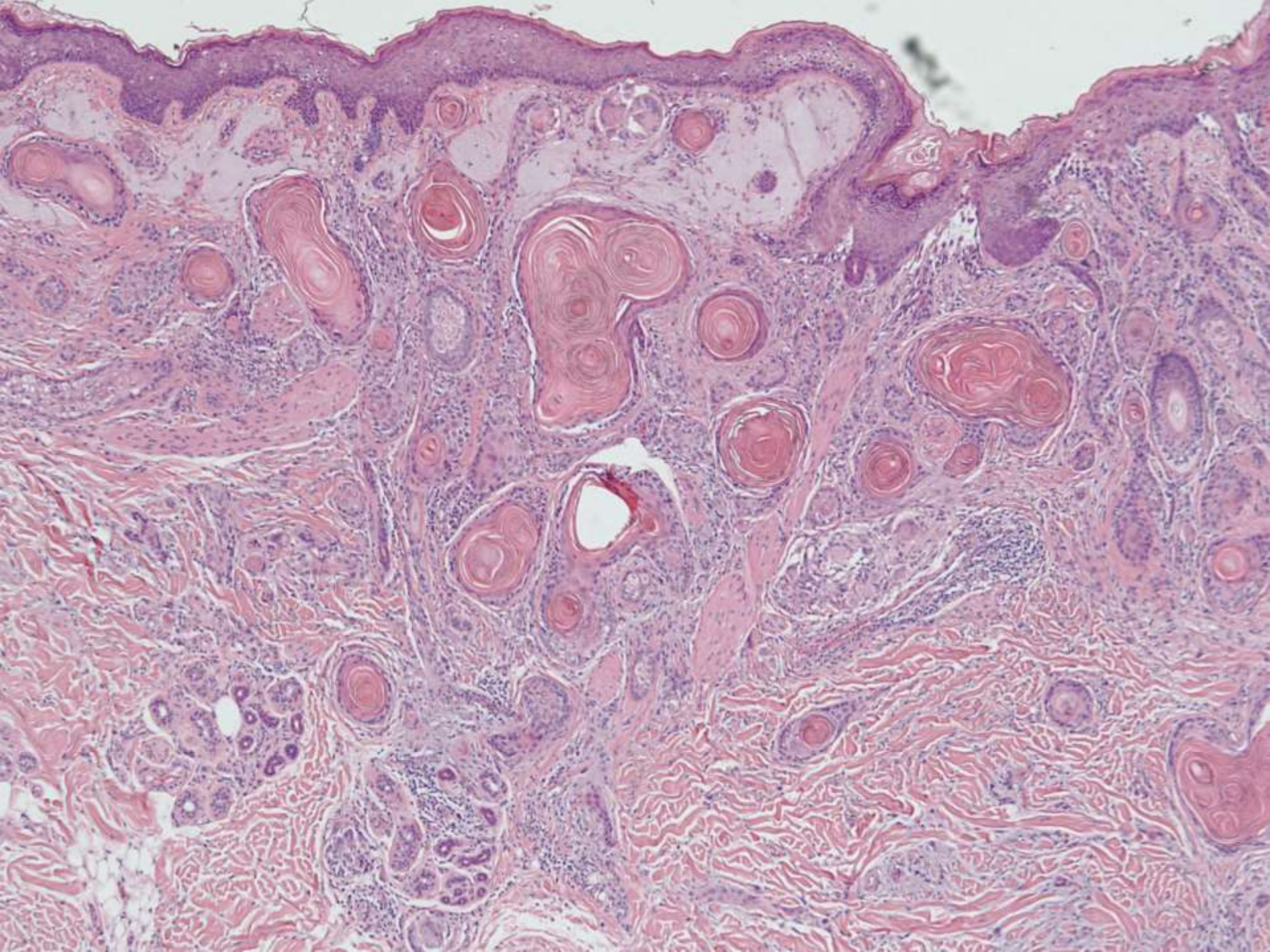
- Pathogenesis
 - Direct MMF-induced cytotoxicity in oral mucosa
 - Neutropenia-induced ulceration secondary to immunosuppression

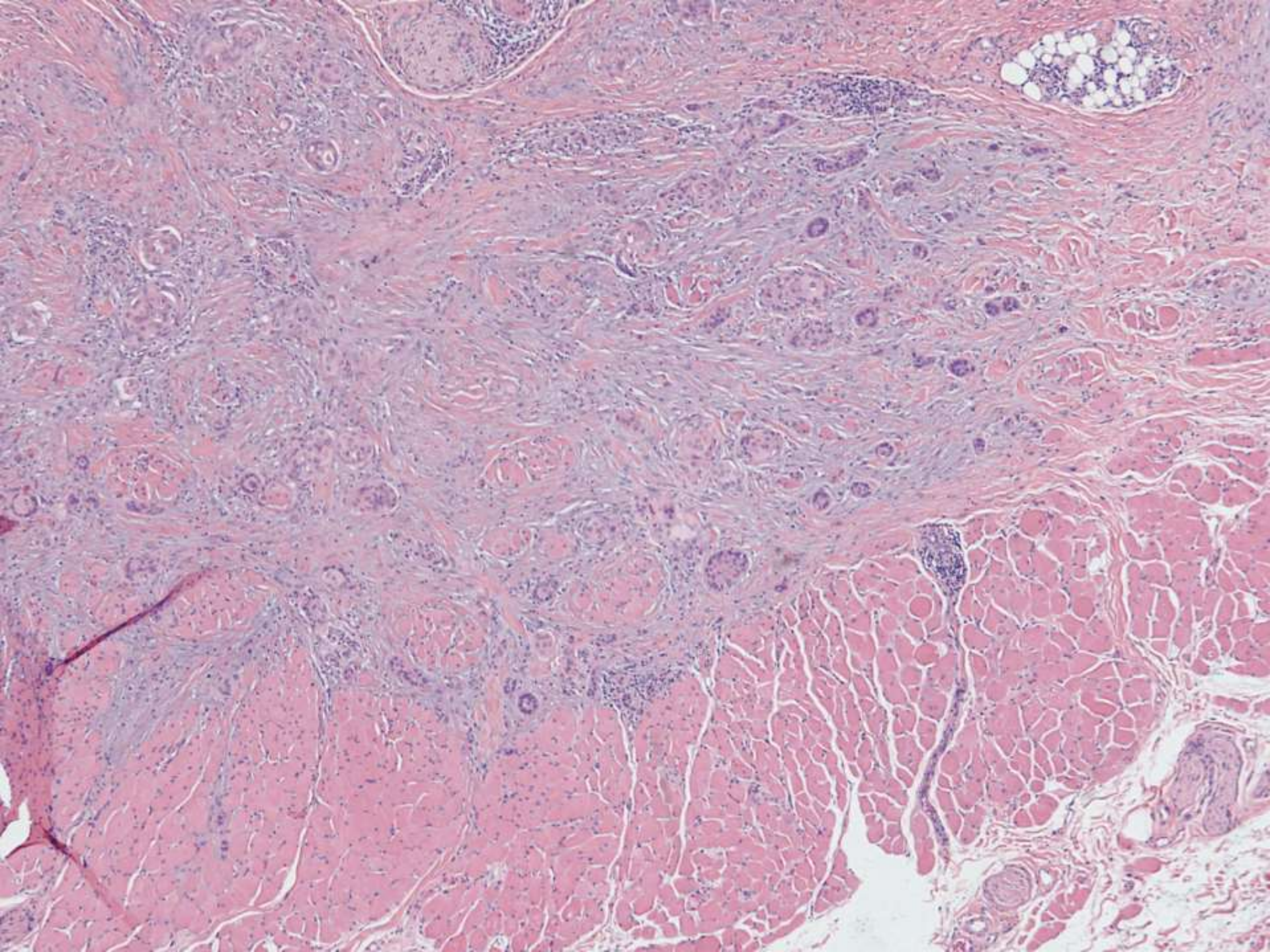
SB 6247

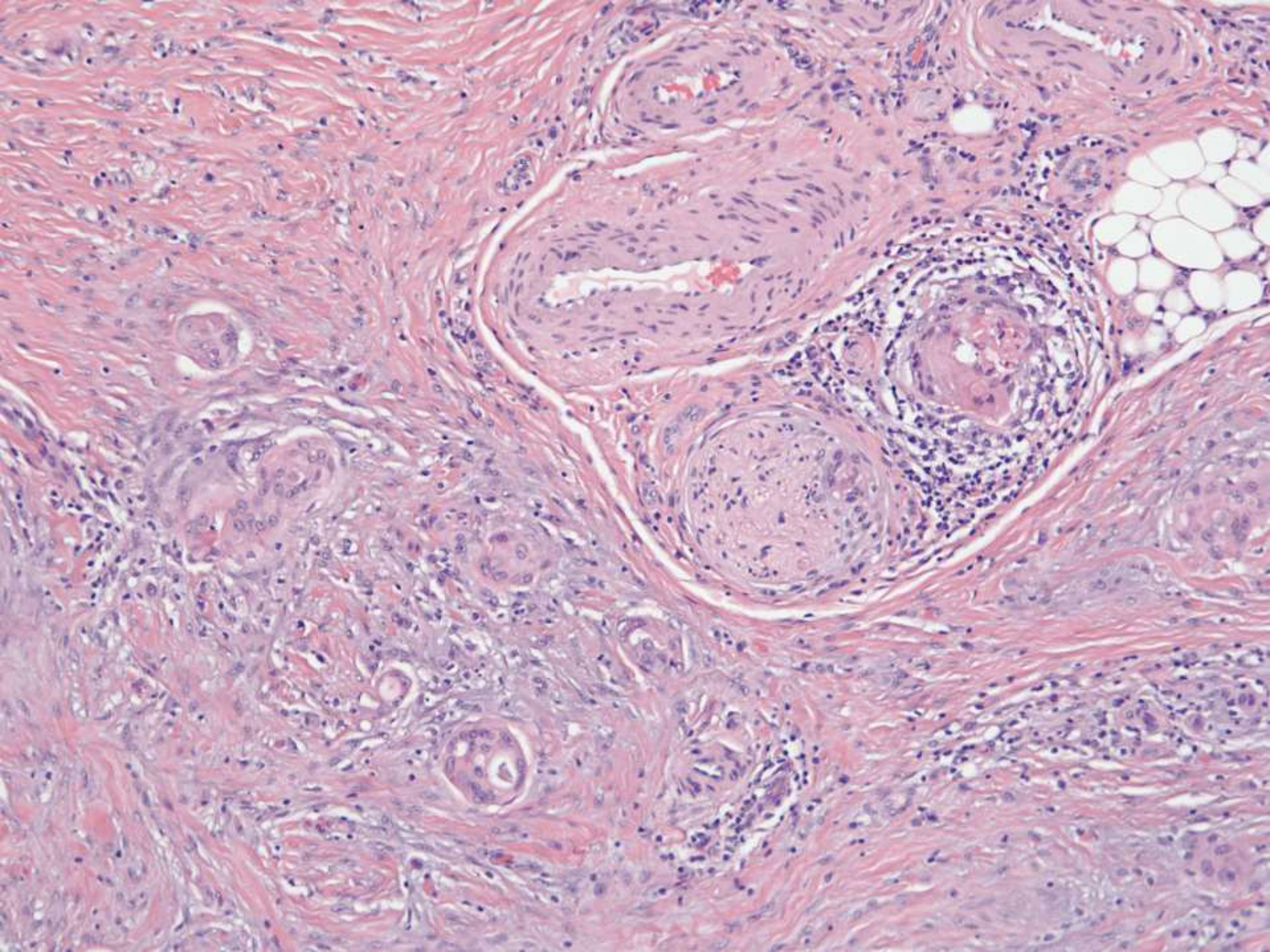
Kevin Ko/Christine Louie; Stanford/Palo Alto VA

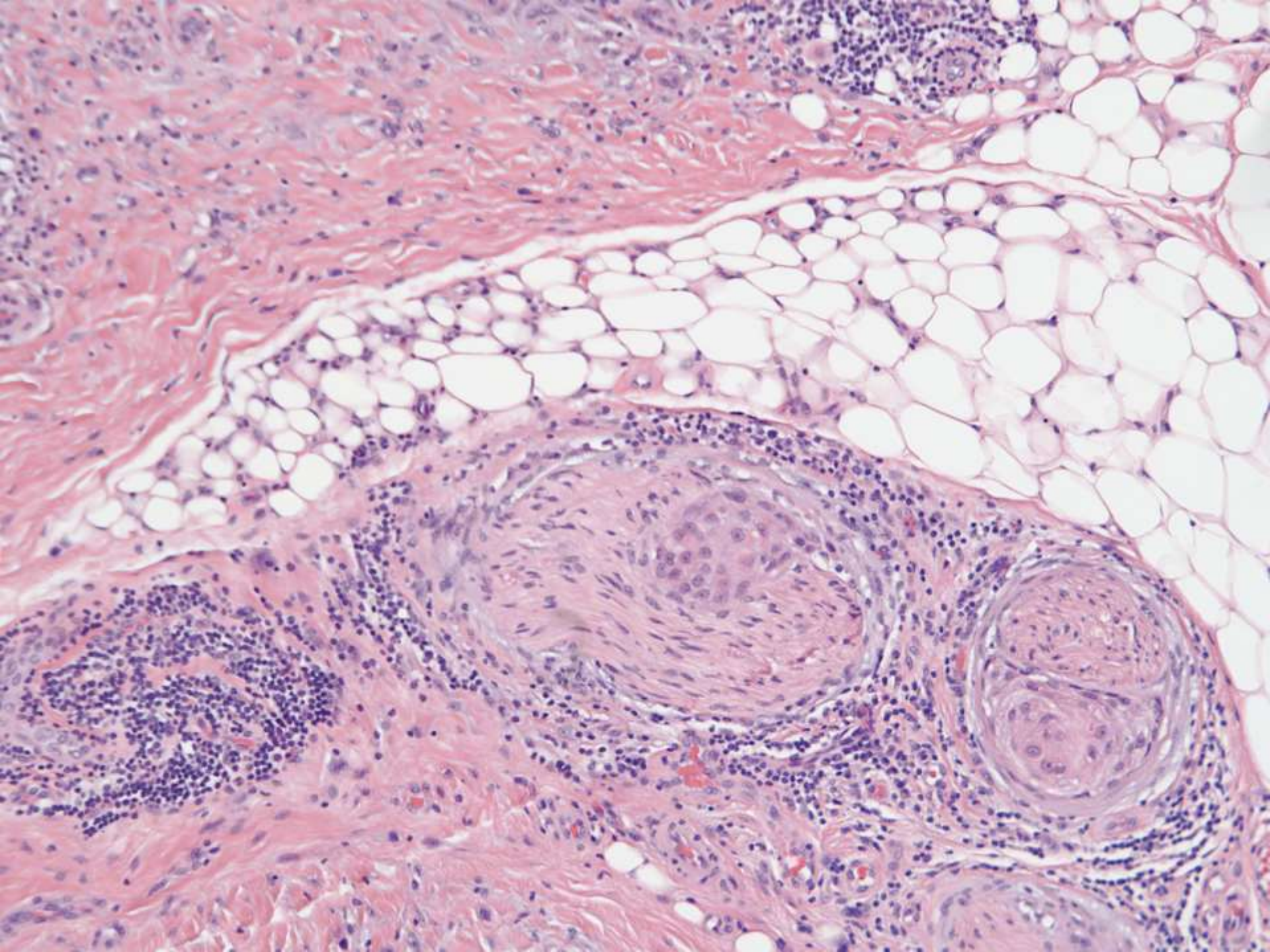
70-year-old male with depressed plaque on left forehead. Initial shave biopsy read as “squamous cell carcinoma, transected at deep margin.”



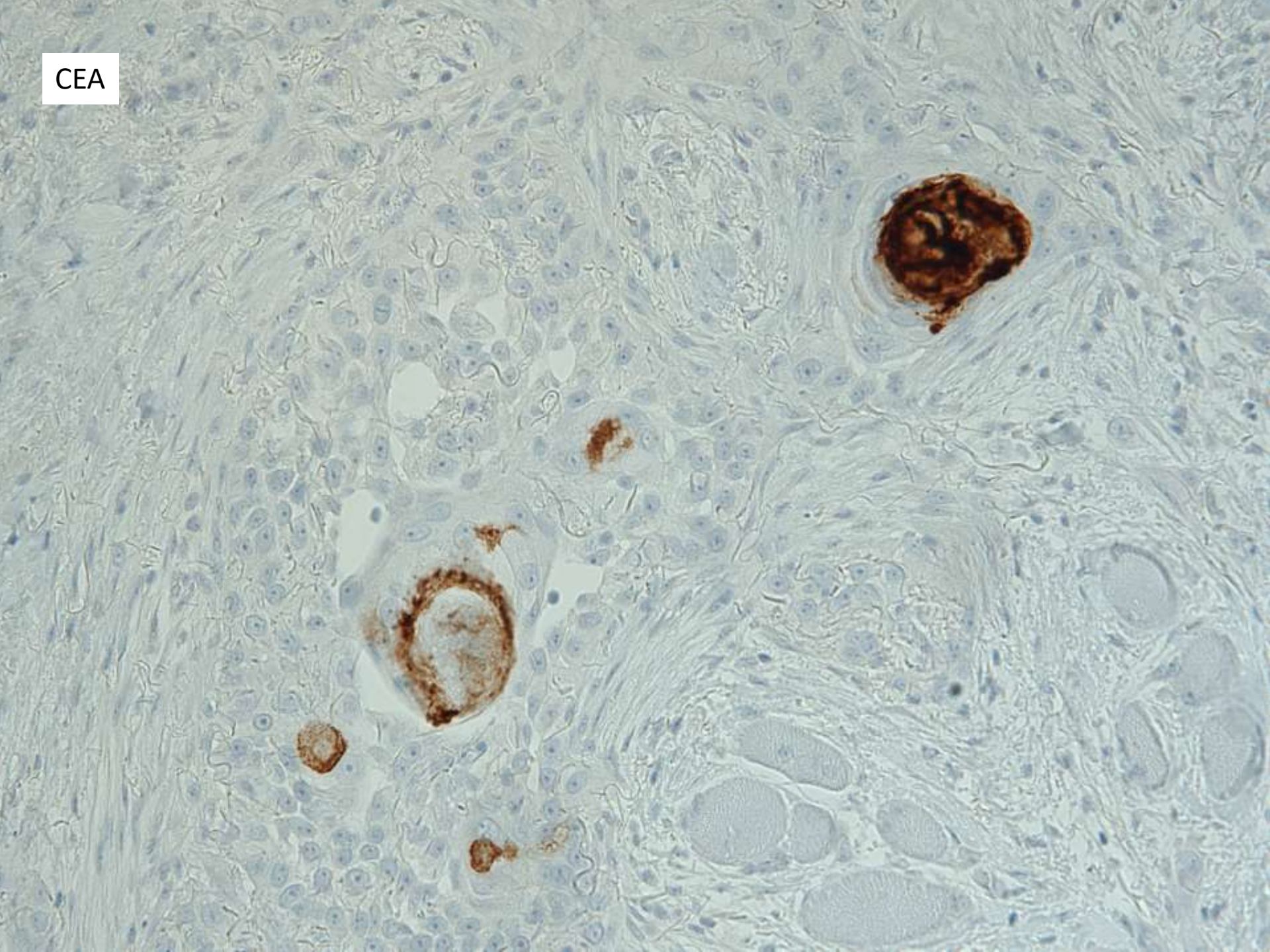




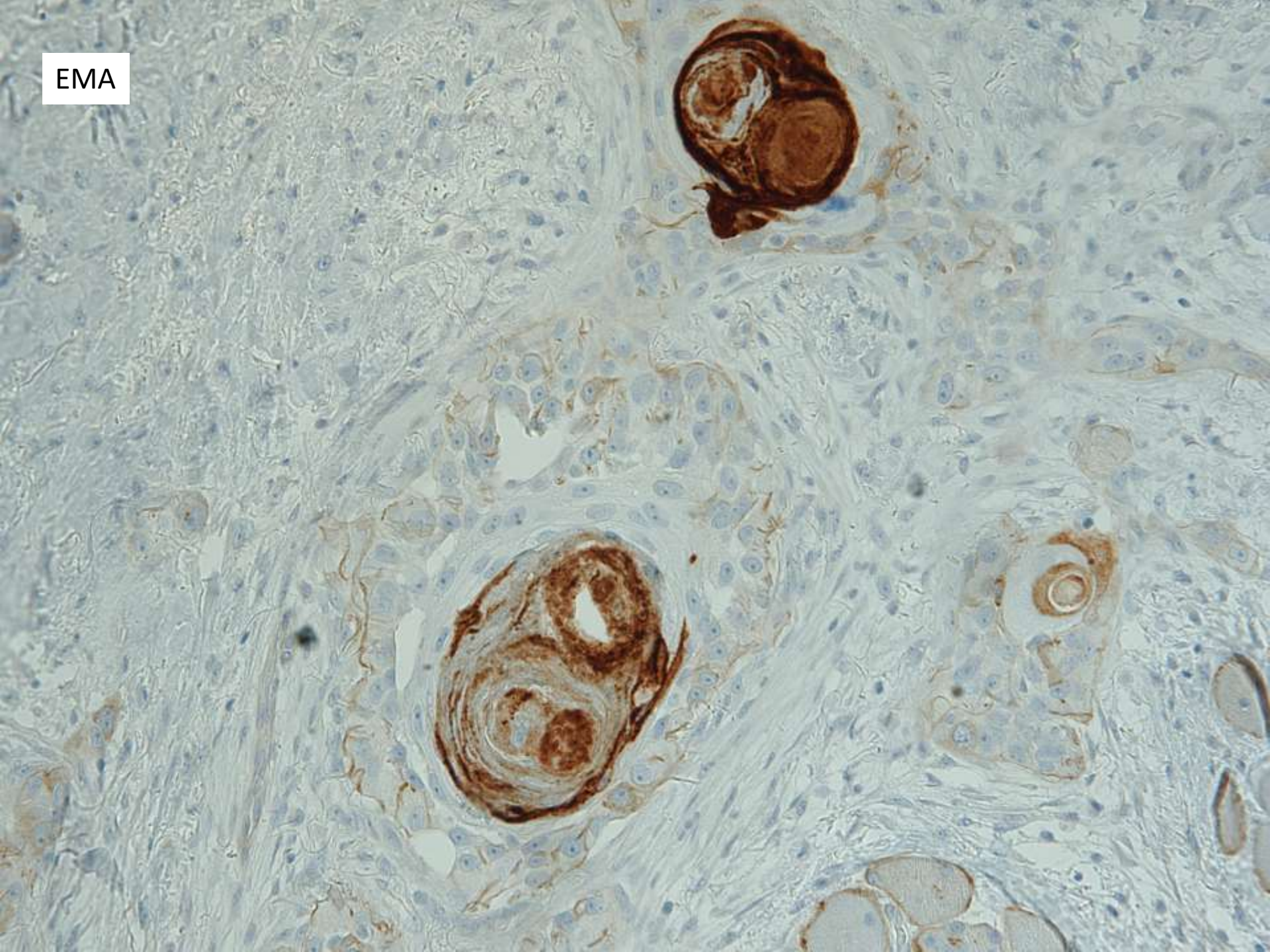




CEA



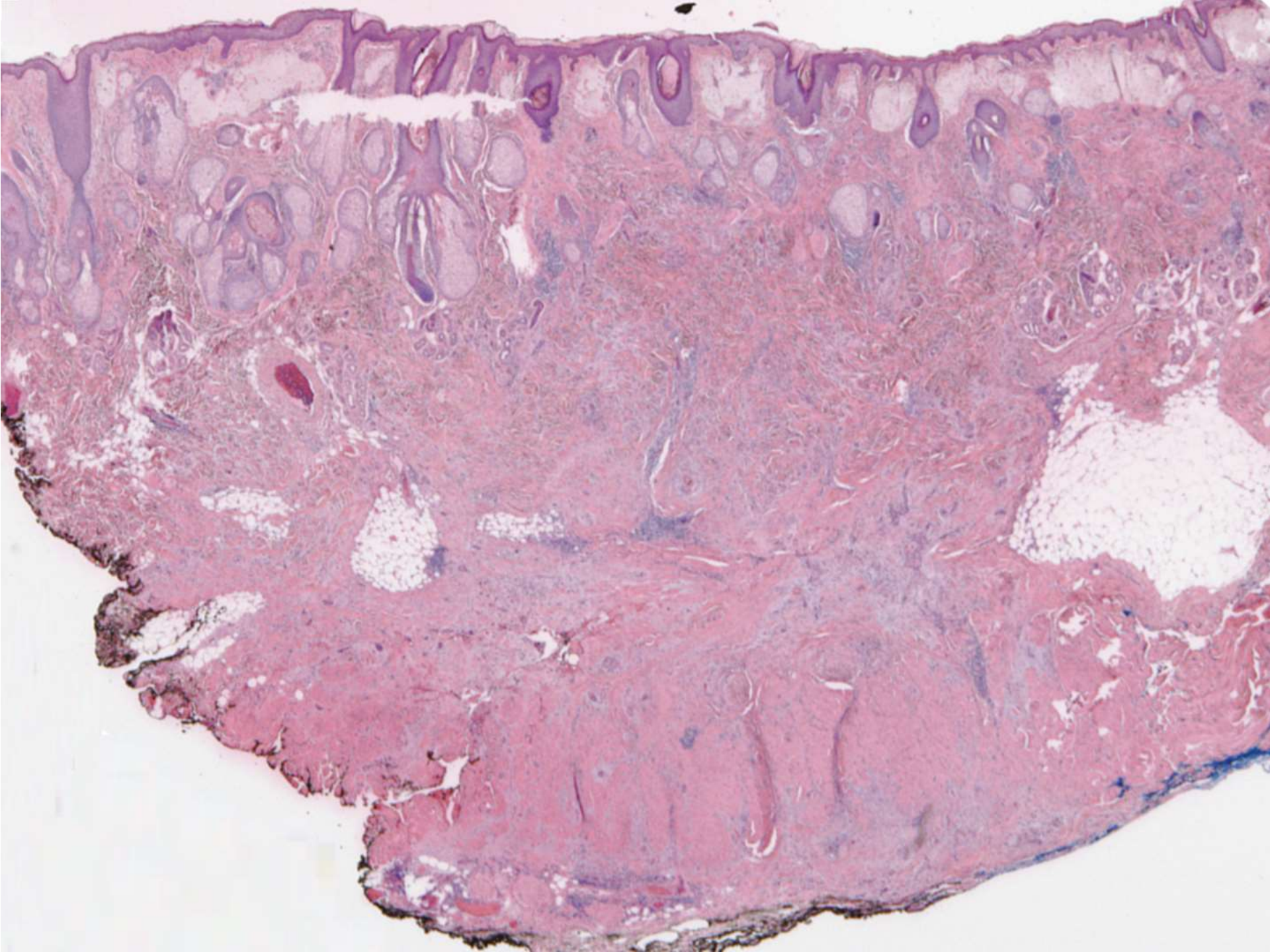
EMA

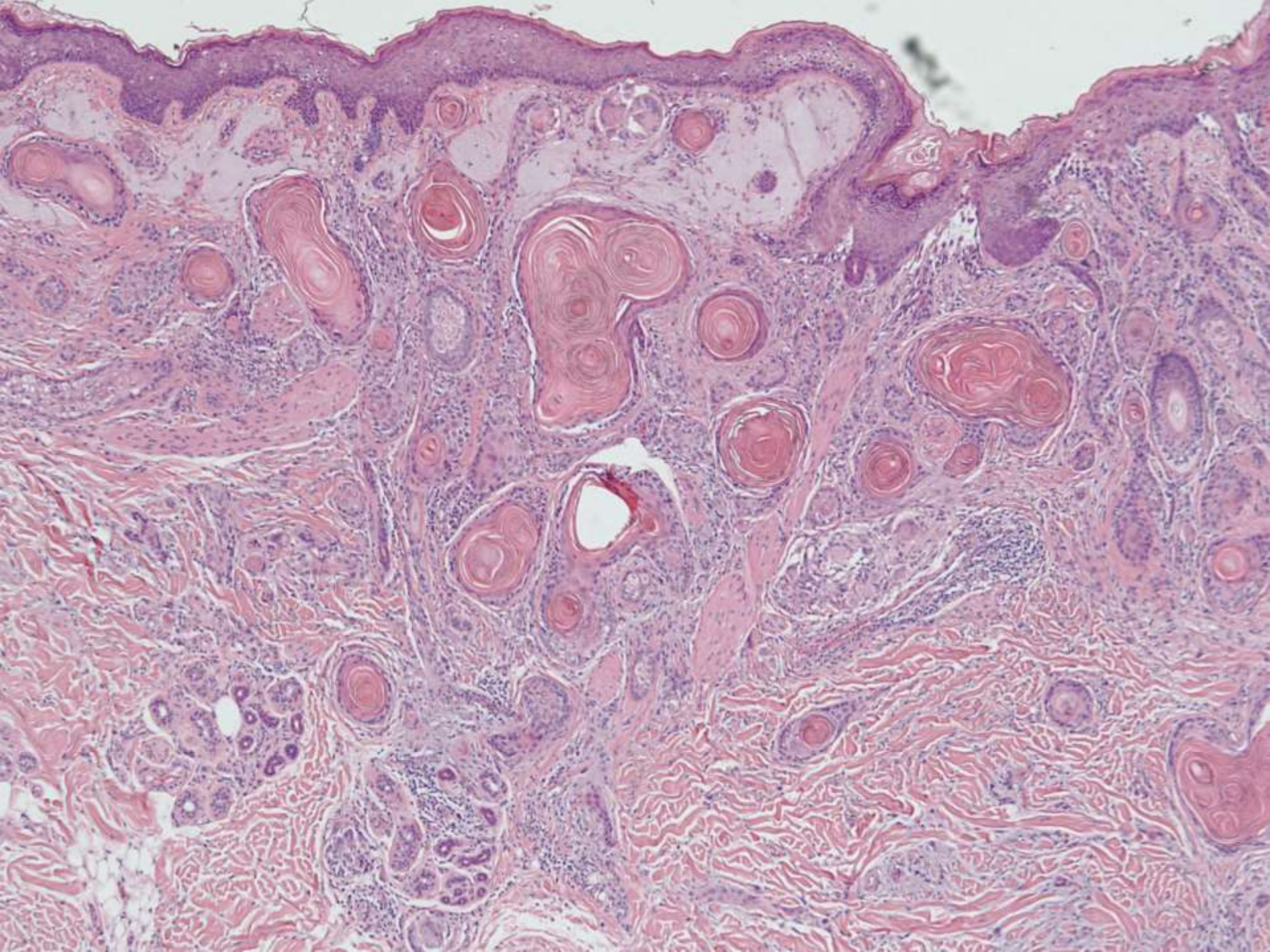


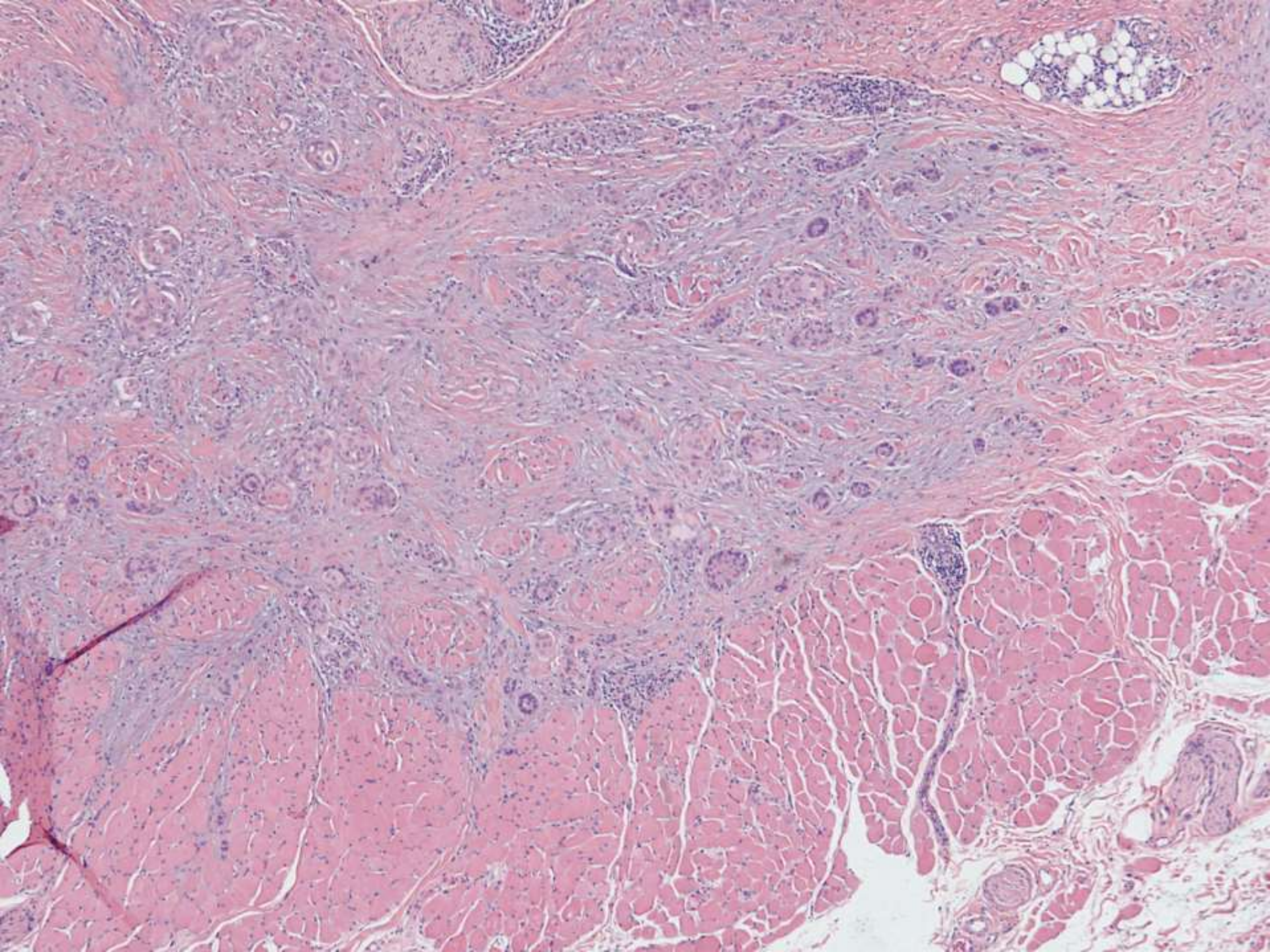
Kevin Ko/Christine Louie; Stanford; Palo Alto VA

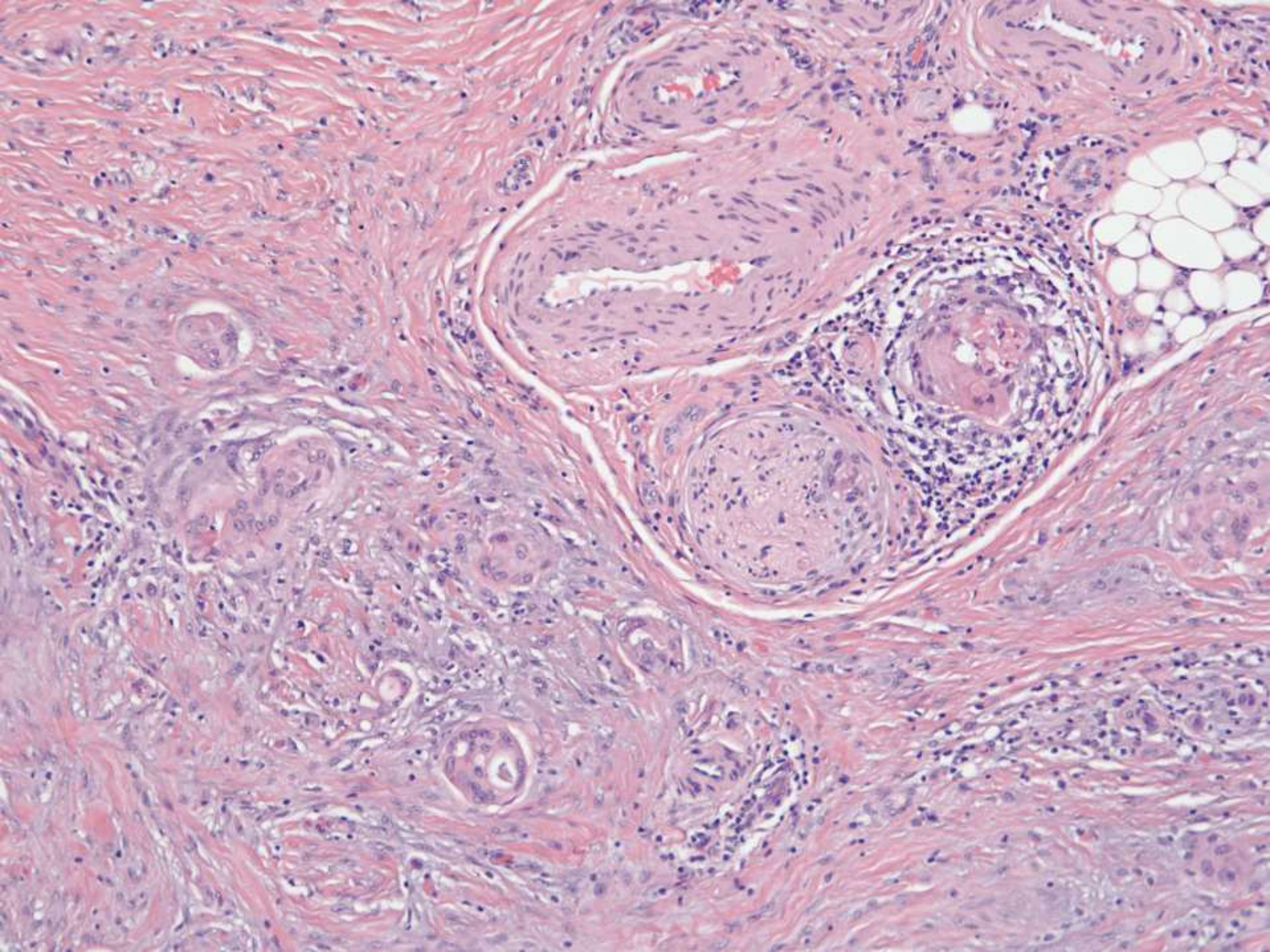
70-year-old man with depressed plaque on the left forehead.

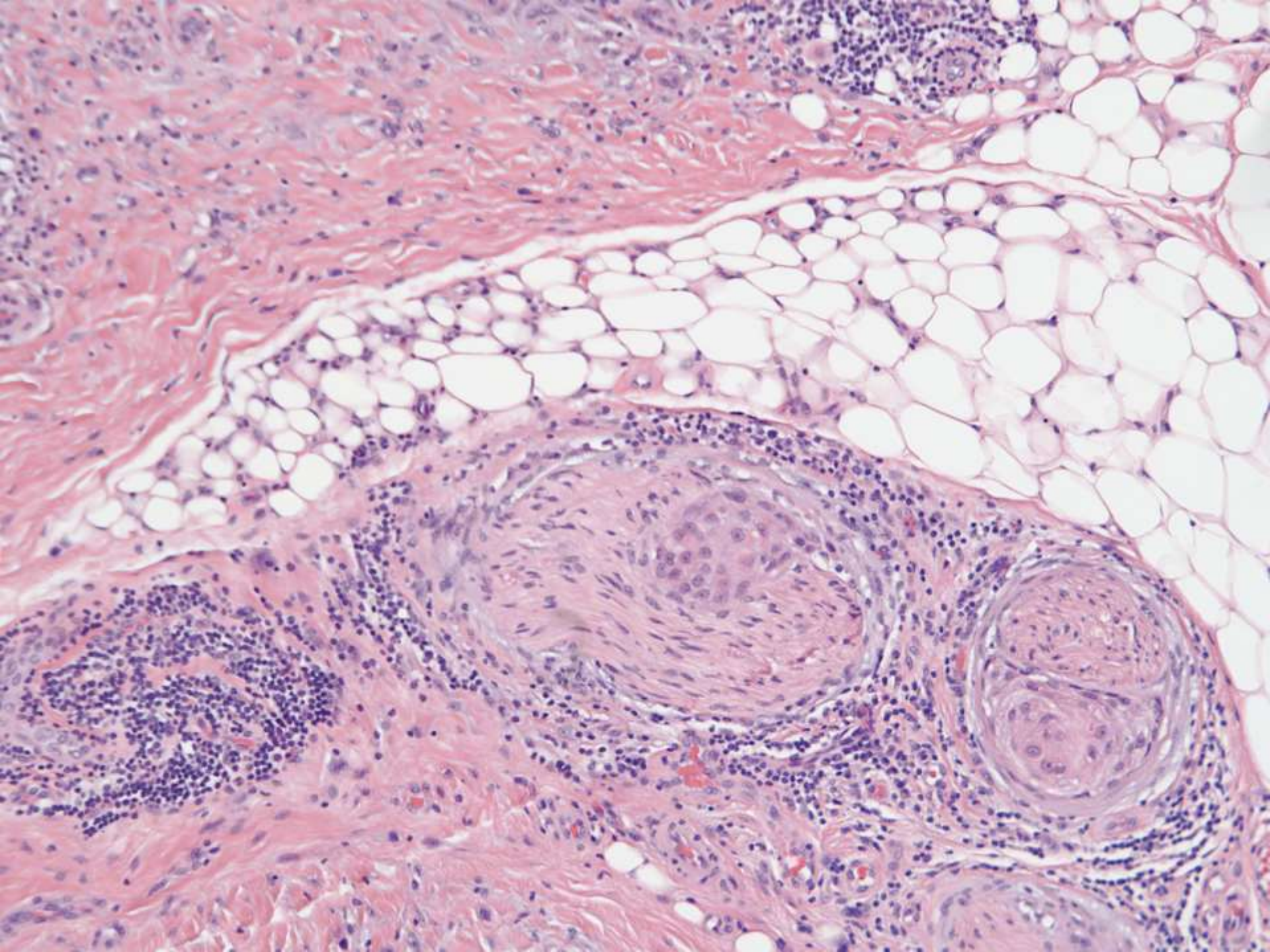
Initial shave biopsy read as “squamous cell carcinoma,
transected at deep margin”



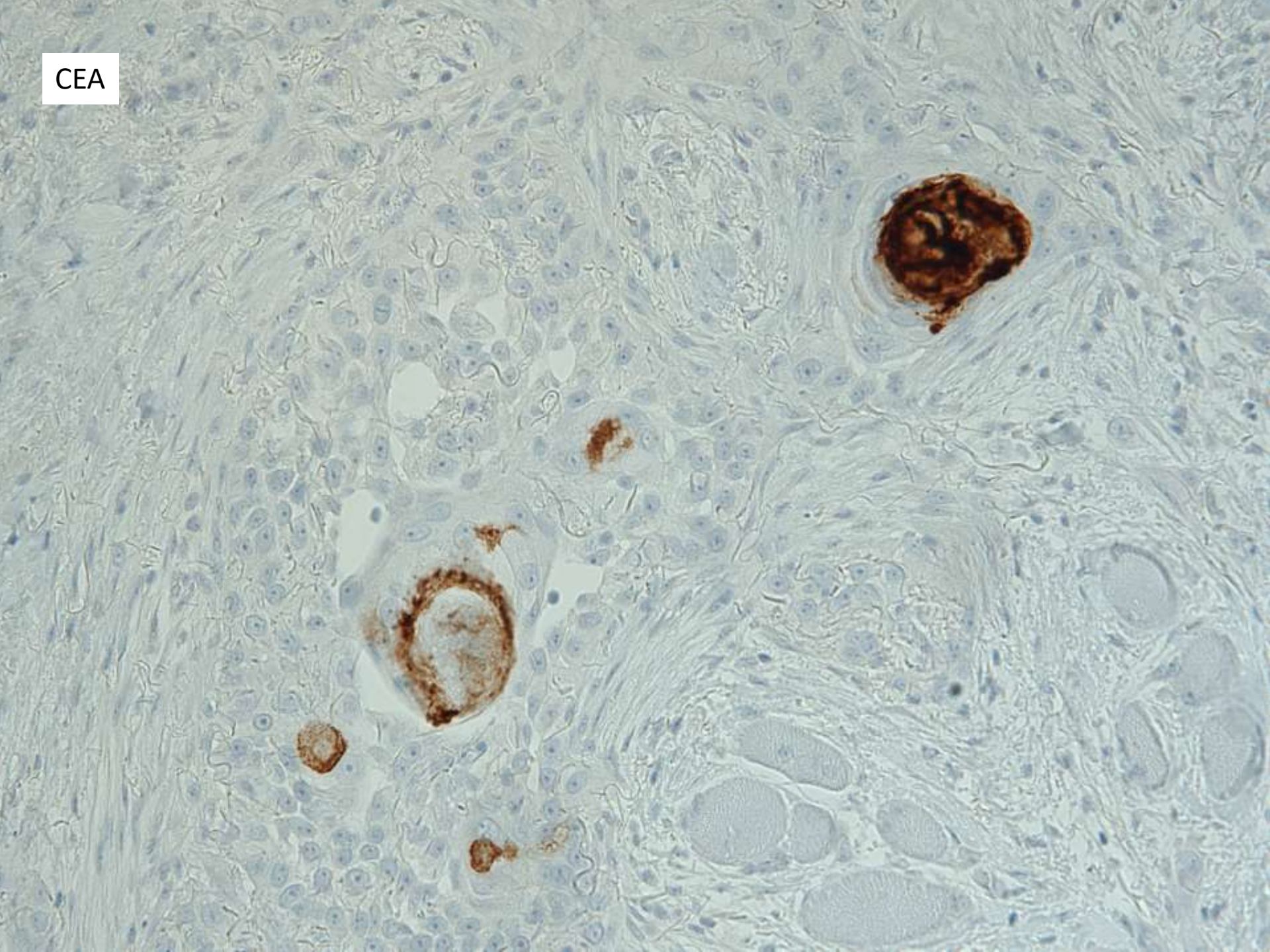




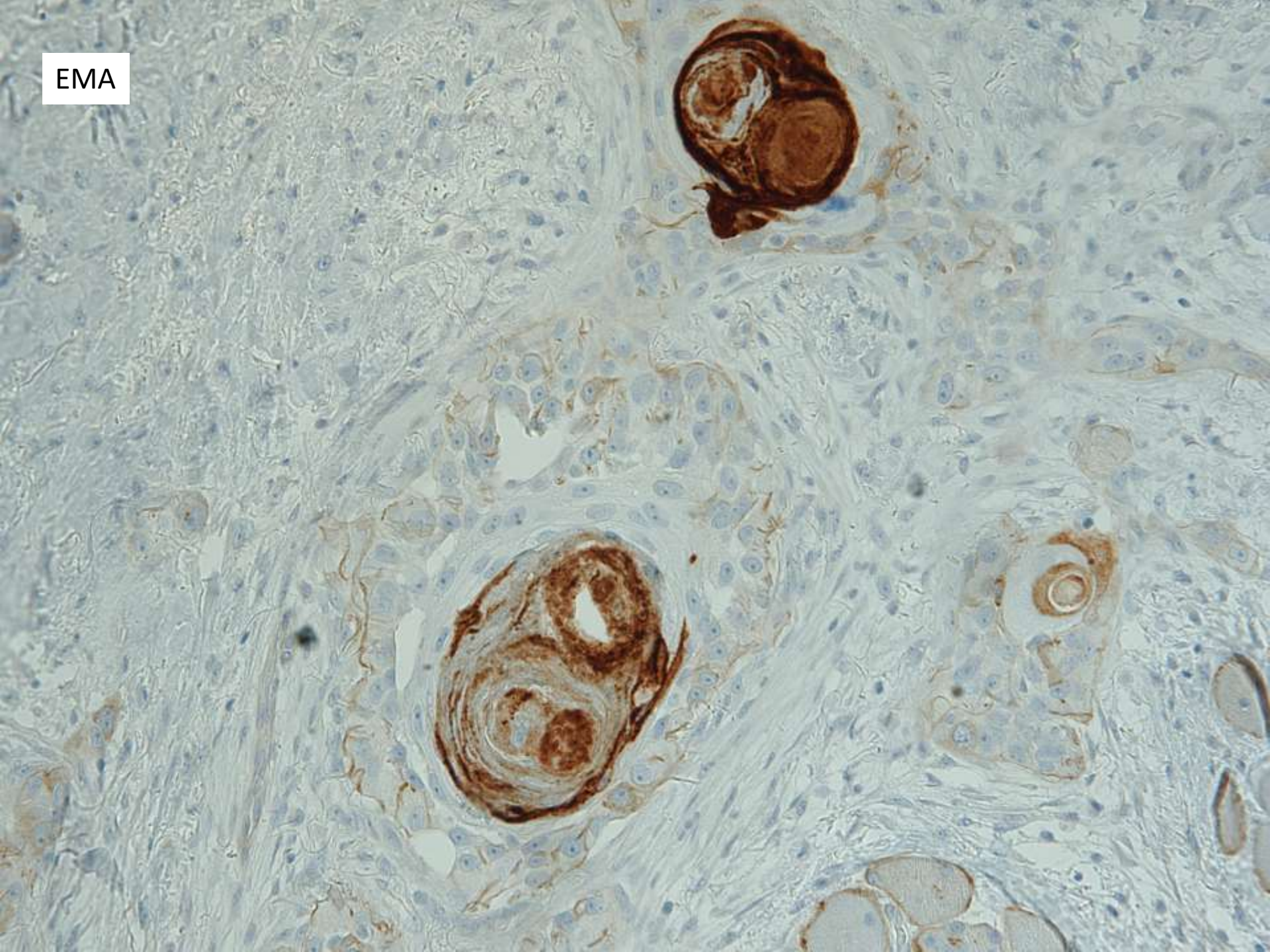




CEA



EMA



Diagnosis

- Microcystic Adnexal Carcinoma

Microcystic Adnexal Carcinoma

- Key features
 - Infiltrative adnexal neoplasm with eccrine and follicular differentiation
 - Clustering of bland-appearing, teardrop-shaped epithelial nests
 - Perineural invasion (often present in deeper areas)
 - Luminal cells: EMA+, CEA+
 - Low Ki-67

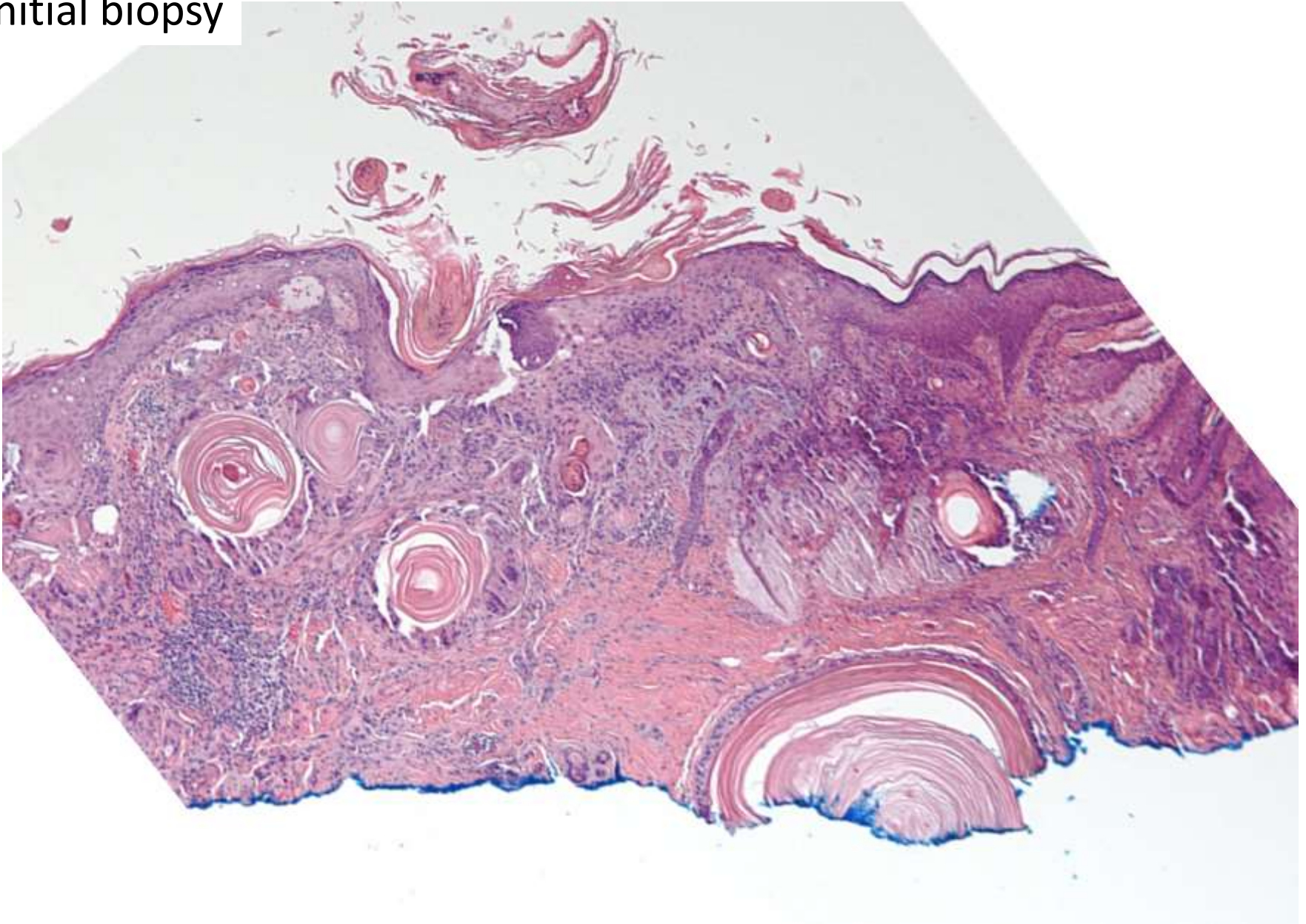
Microcystic Adnexal Carcinoma

- Differential diagnosis
 - Desmoplastic trichoepithelioma
 - Luminal cells EMA negative and CEA negative
 - Lacks perineural invasion
 - Syringoma
 - Lacks evidence of follicular differentiation
 - Desmoplastic basal cell carcinoma
 - Luminal cells EMA negative and CEA negative
 - High levels of Ki67

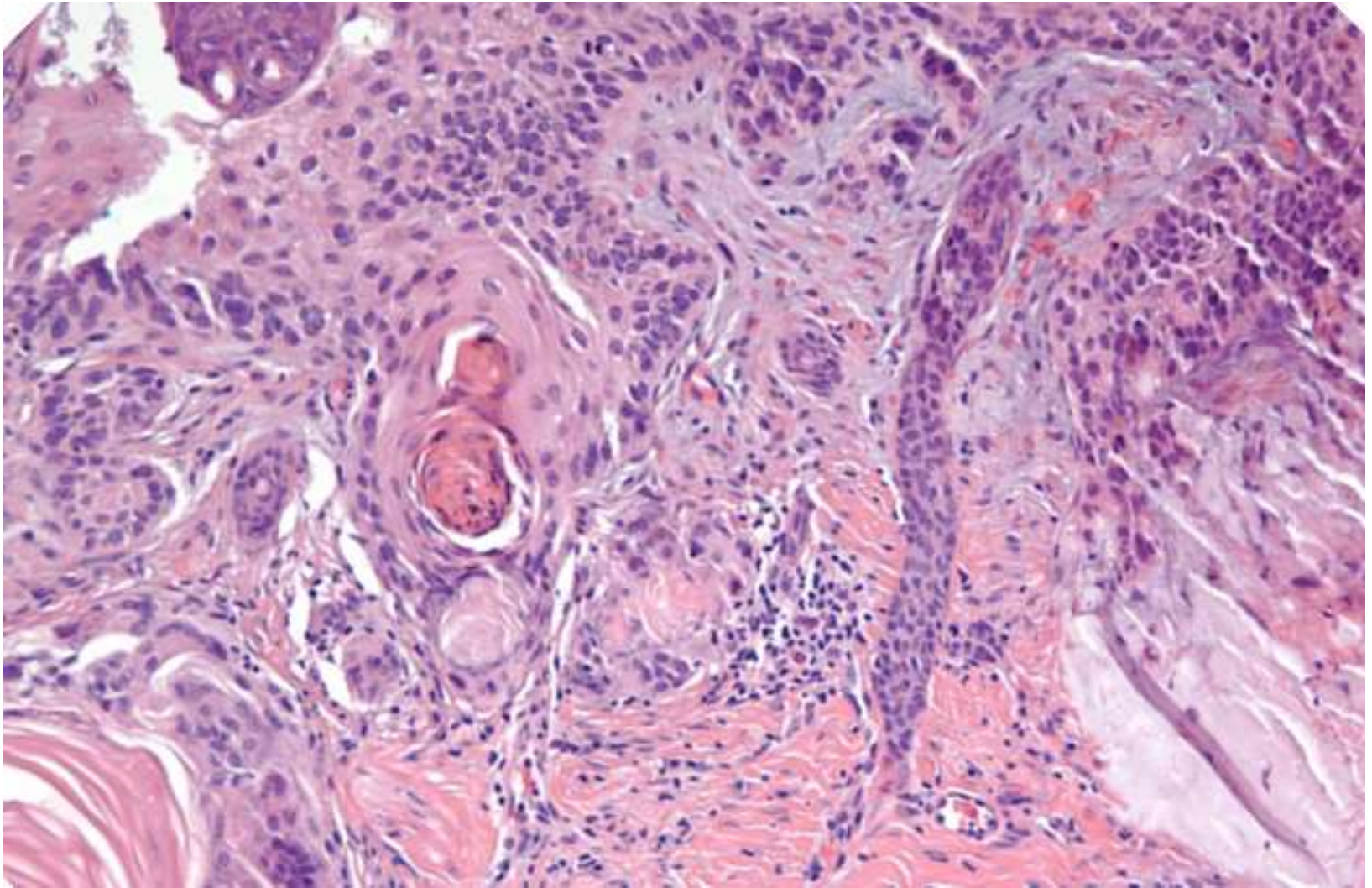
Microcystic Adnexal Carcinoma

- Incidence of 1.6 to 6.5 per 10,000,000 people
- Middle-aged to older adults
- Upper lip most common
- Treatment:
 - Complex excision with clear margins (Mohs)
- High incidence of local recurrence
- Rare metastases

Initial biopsy



Initial biopsy



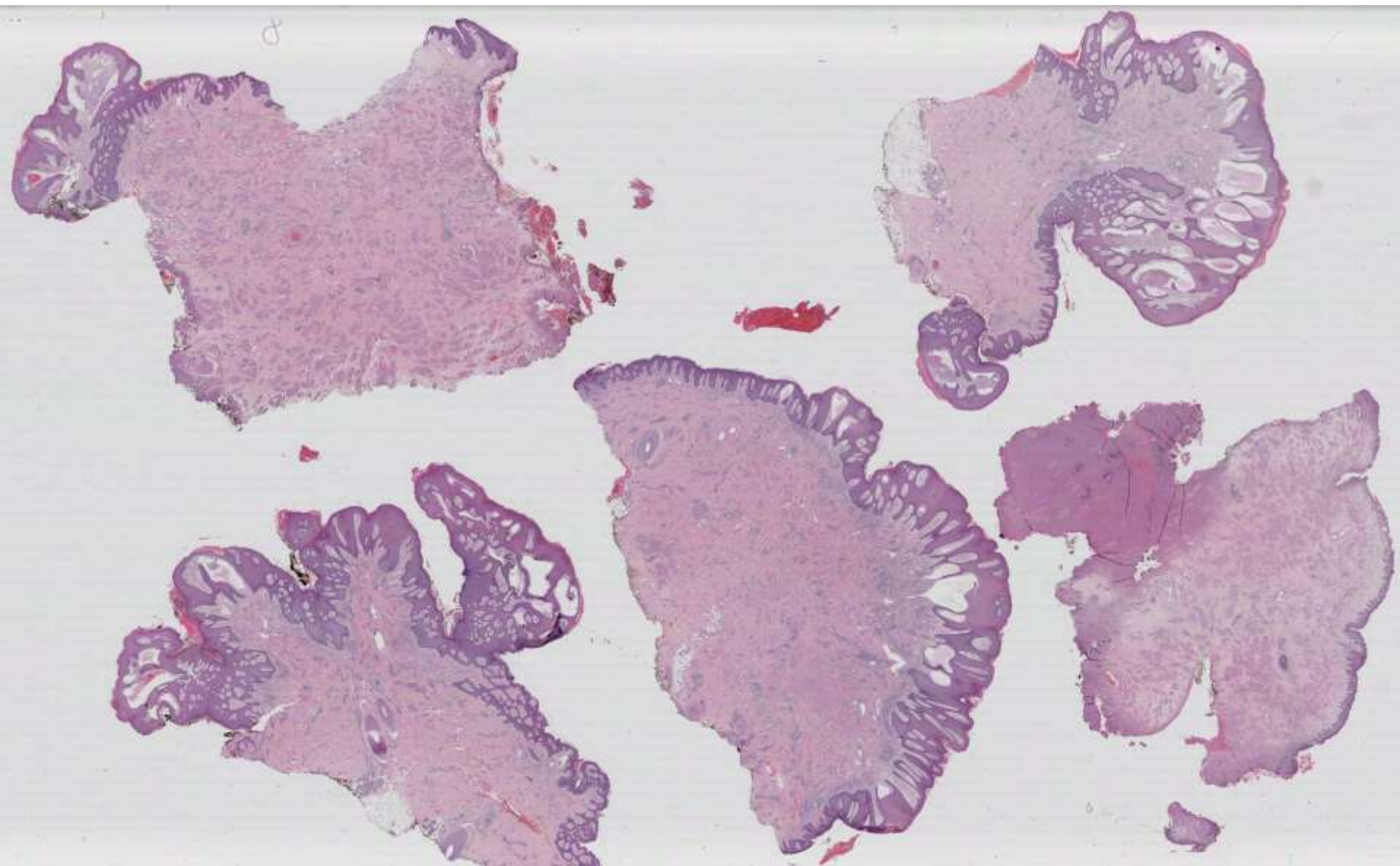
- “Inadequate biopsy techniques showing only the superficial component should be avoided”
- “A deep biopsy is mandatory for the correct diagnosis, and Mohs micrographic surgery provides the highest cure rate”

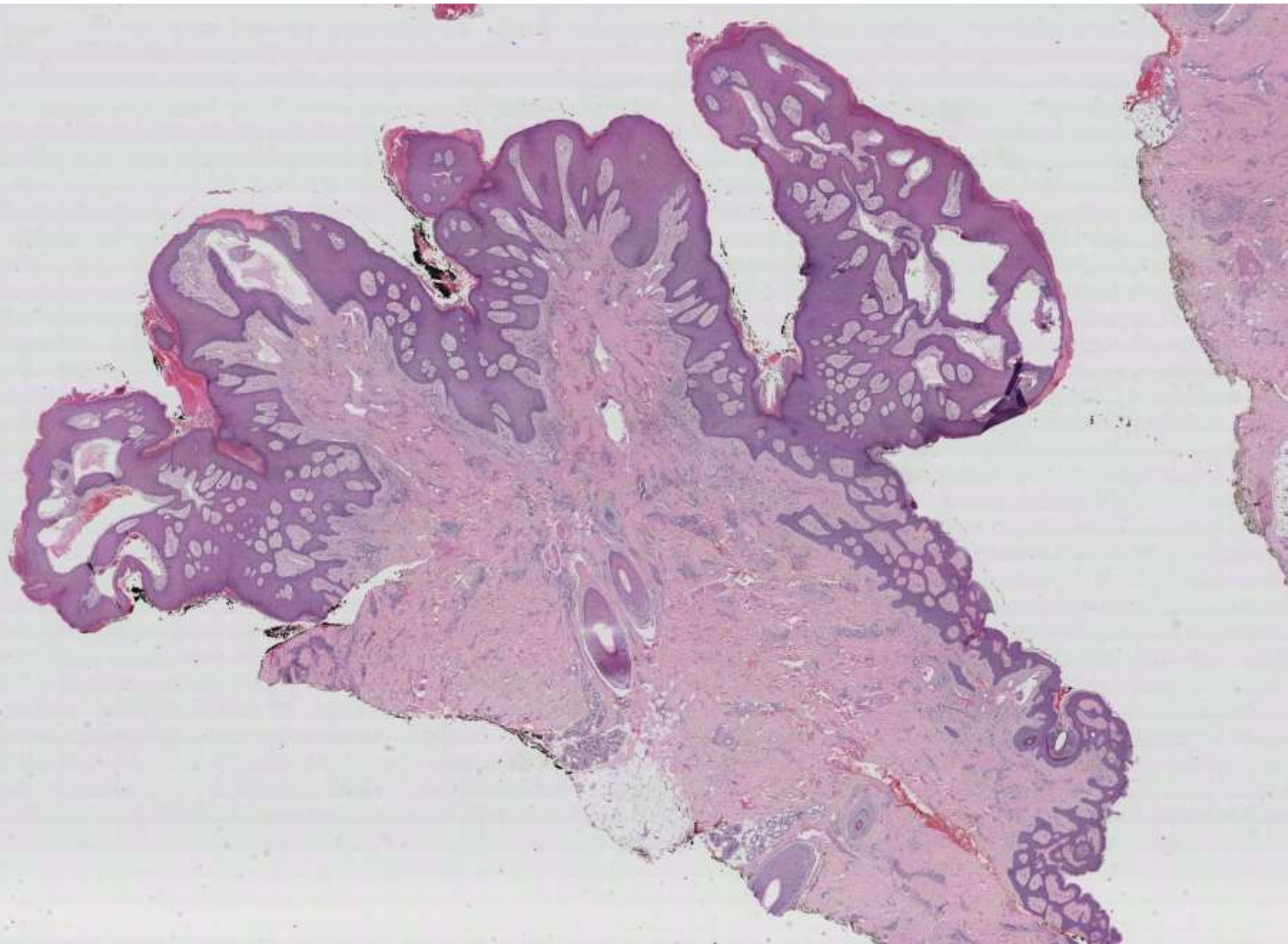
Gordon S, Fischer C, Martin A, Rosman IS, Council ML. Microcystic Adnexal Carcinoma: A Review of the Literature. *Dermatol Surg.* 2017 Aug;43(8):1012-1016

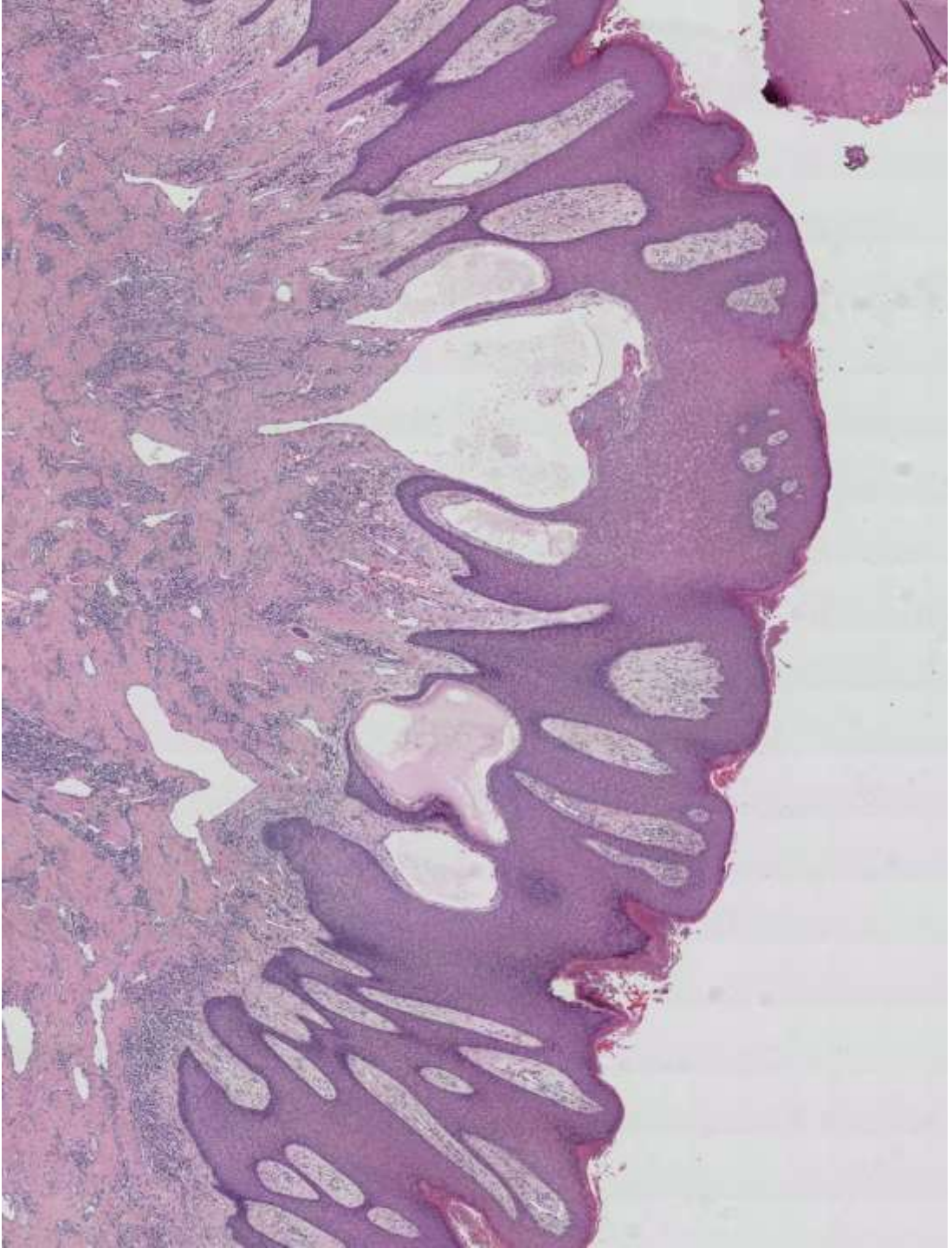
Ximena Calderón-Castrat, MD, Concepción Román-Curto, MD, PhD, Angel Santos-Briz, MD, PhD, and Emilia Fernández-López, MD, PhD. Microcystic adnexal carcinoma mimicking basal cell carcinoma. *JAAD Case Rep.* 2017 Nov; 3(6): 492–494.

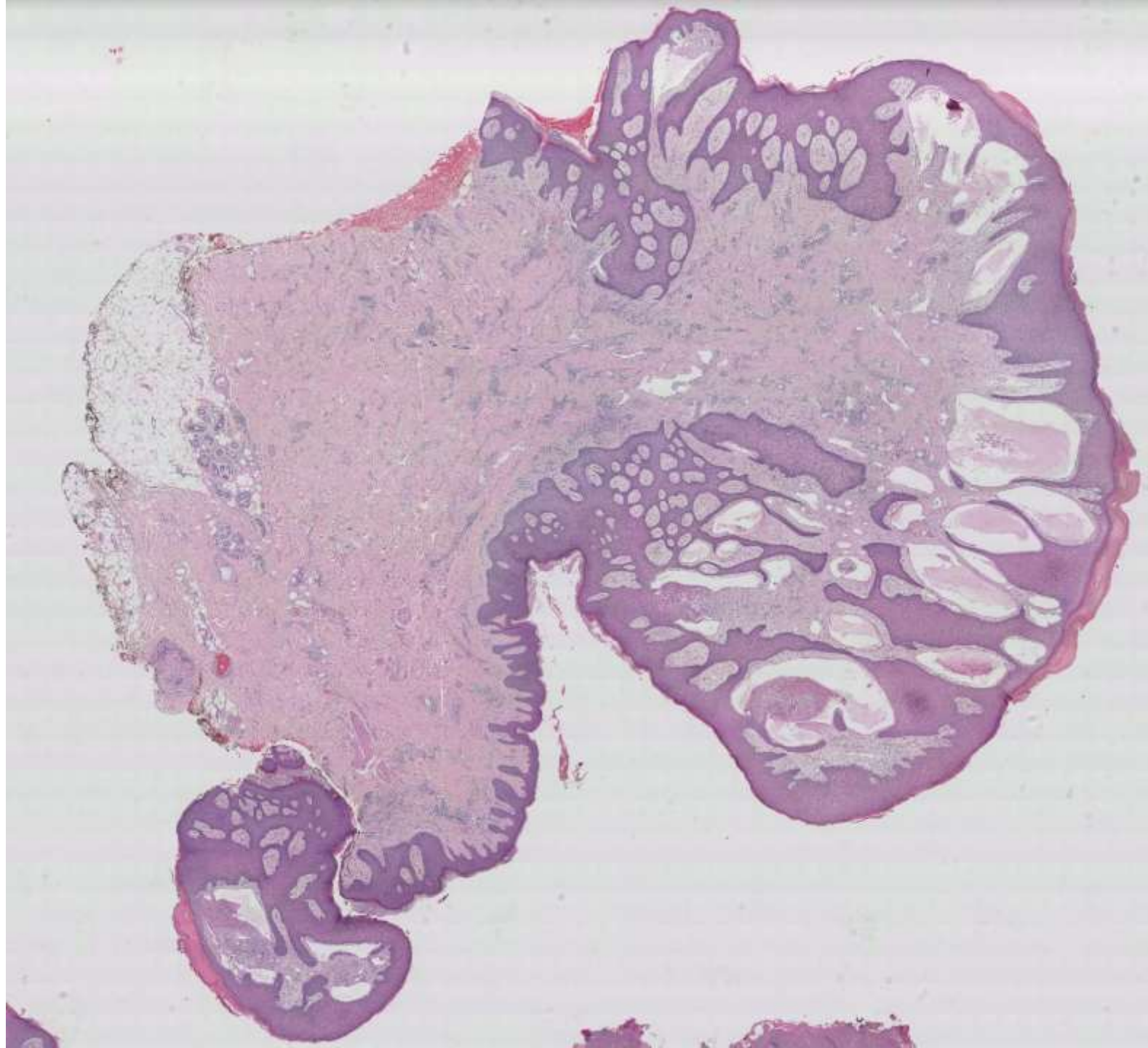
SB 6248
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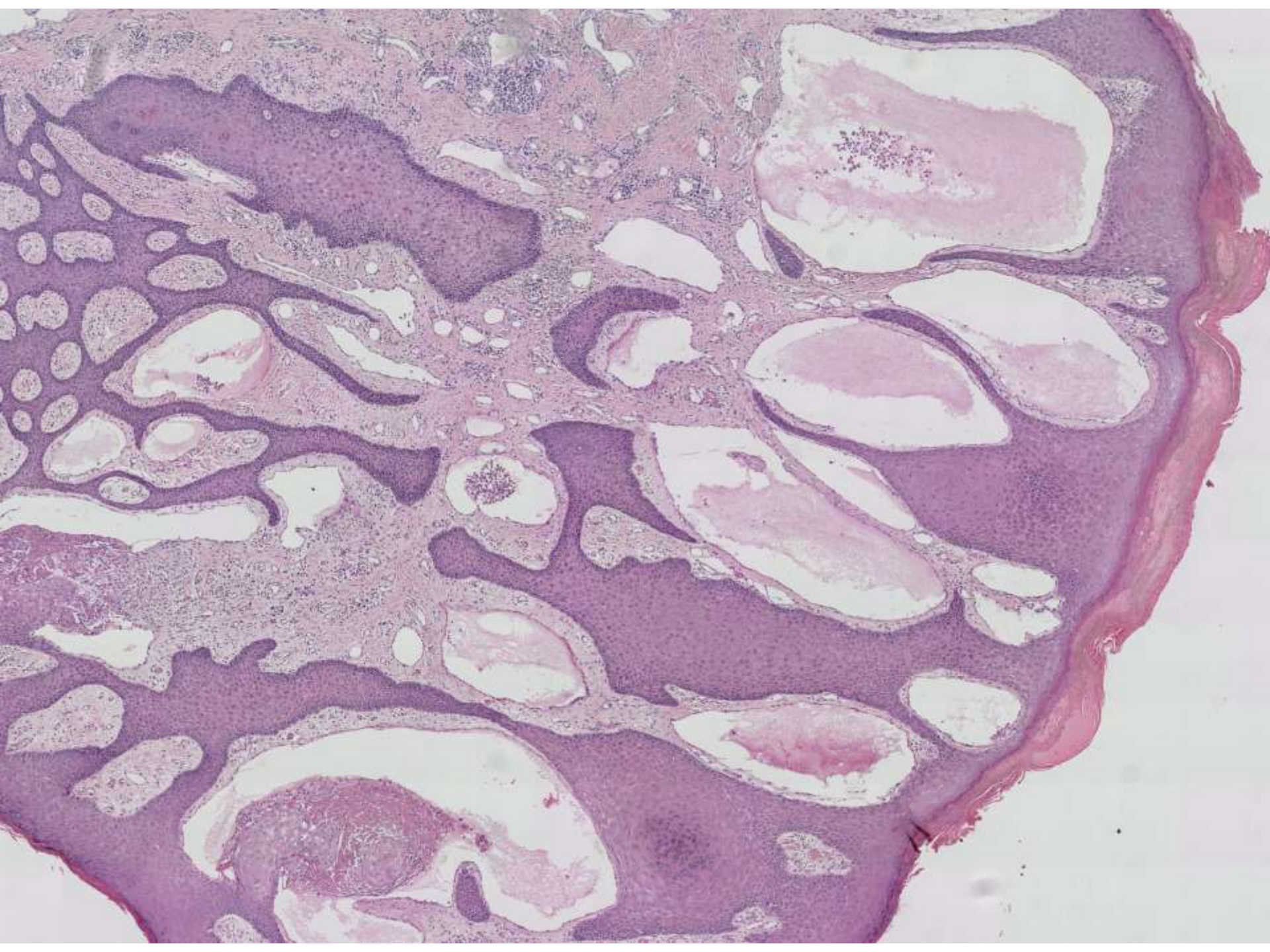
Ankur Sangoi; El Camino Hospital
54-year-old male with scrotal mass.

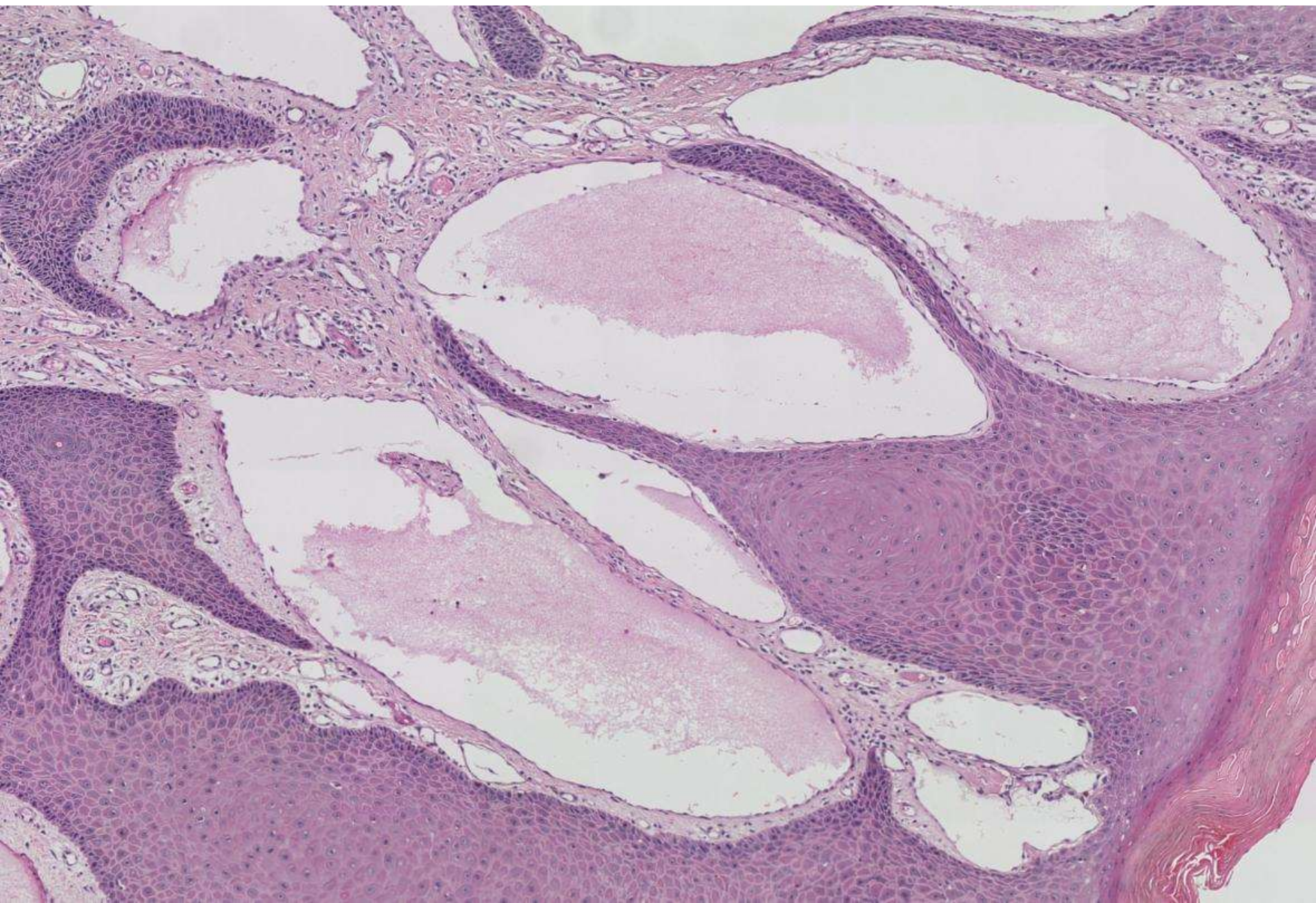


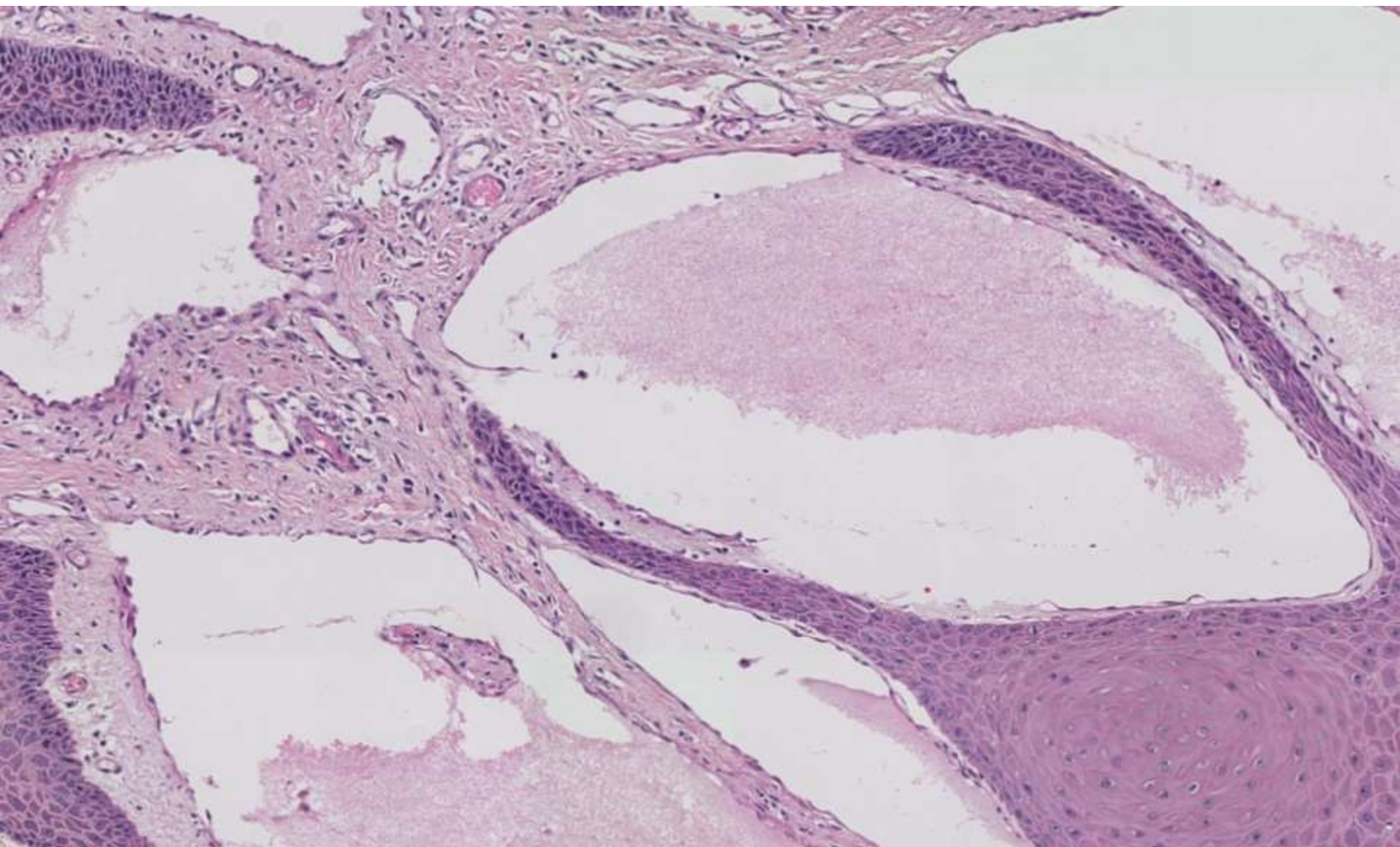


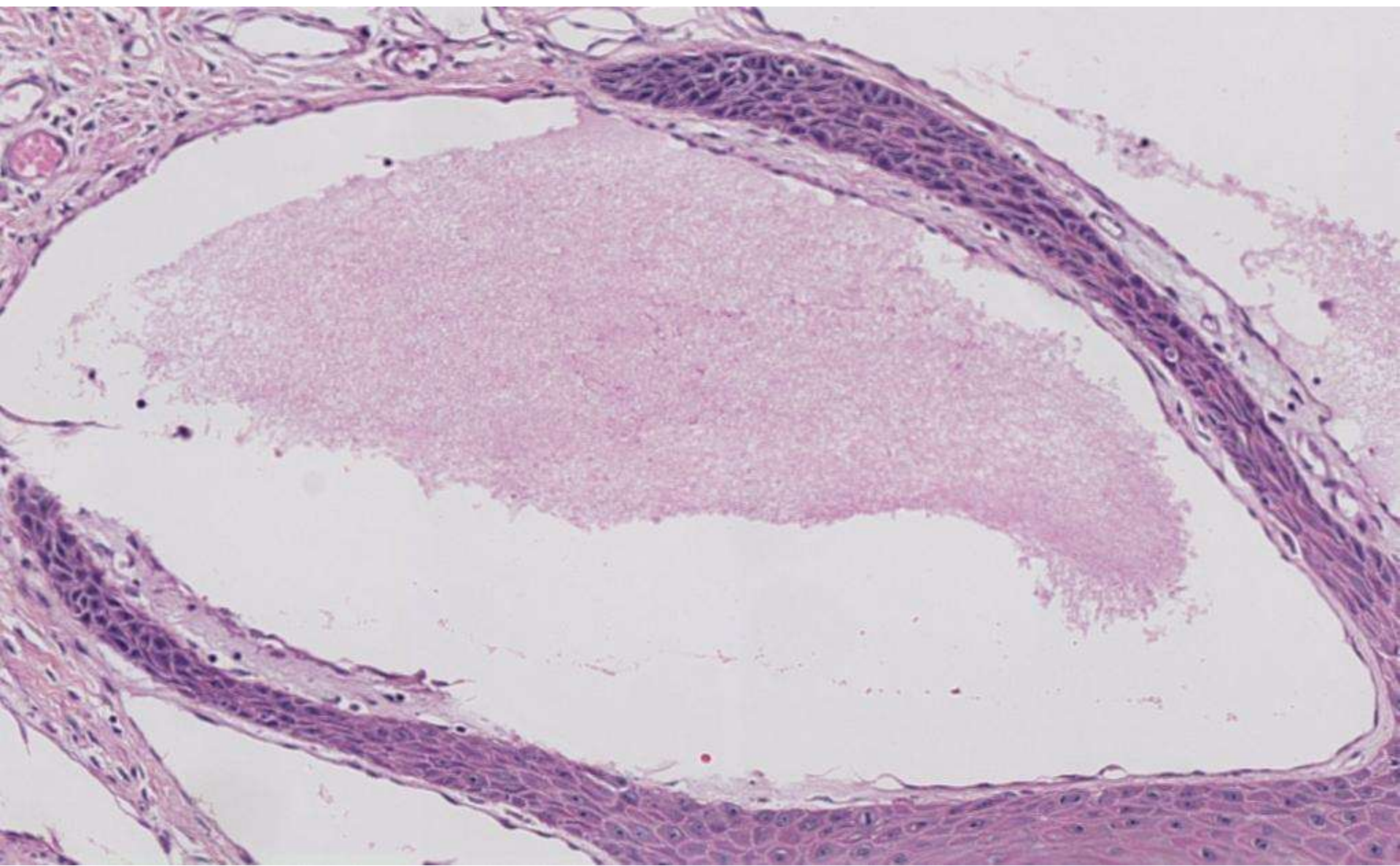






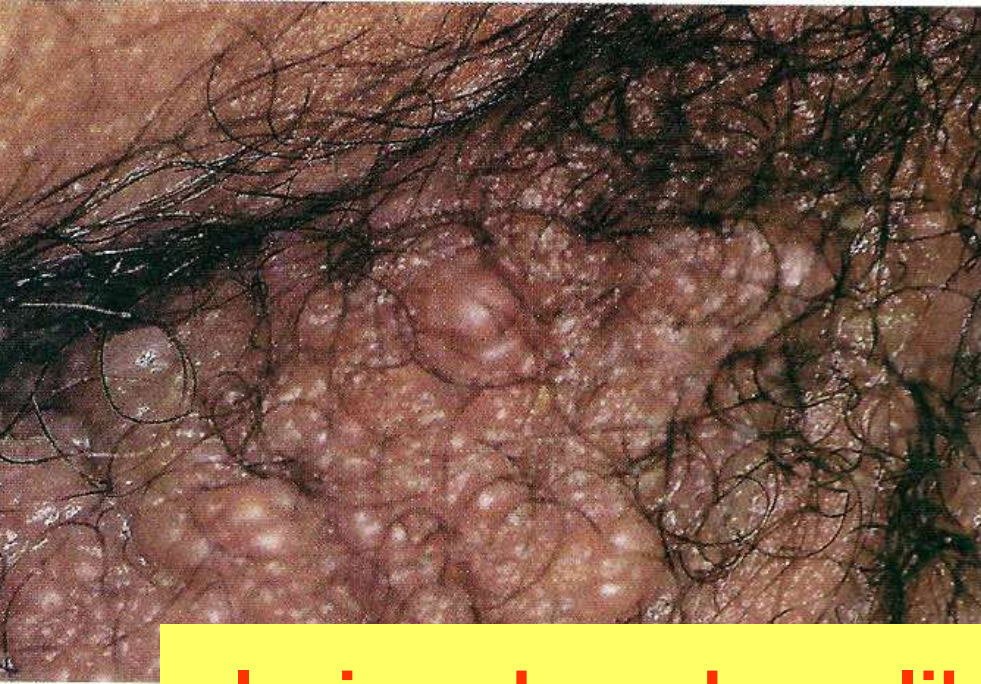






DDx

- **Lymphangioma circumscriptum**
- **Angiokeratoma**
- **Hemangioma**
- **Glomangioma**
- **Lymphangiosarcoma**



lesions have been likened to “frogspawn”

Google it



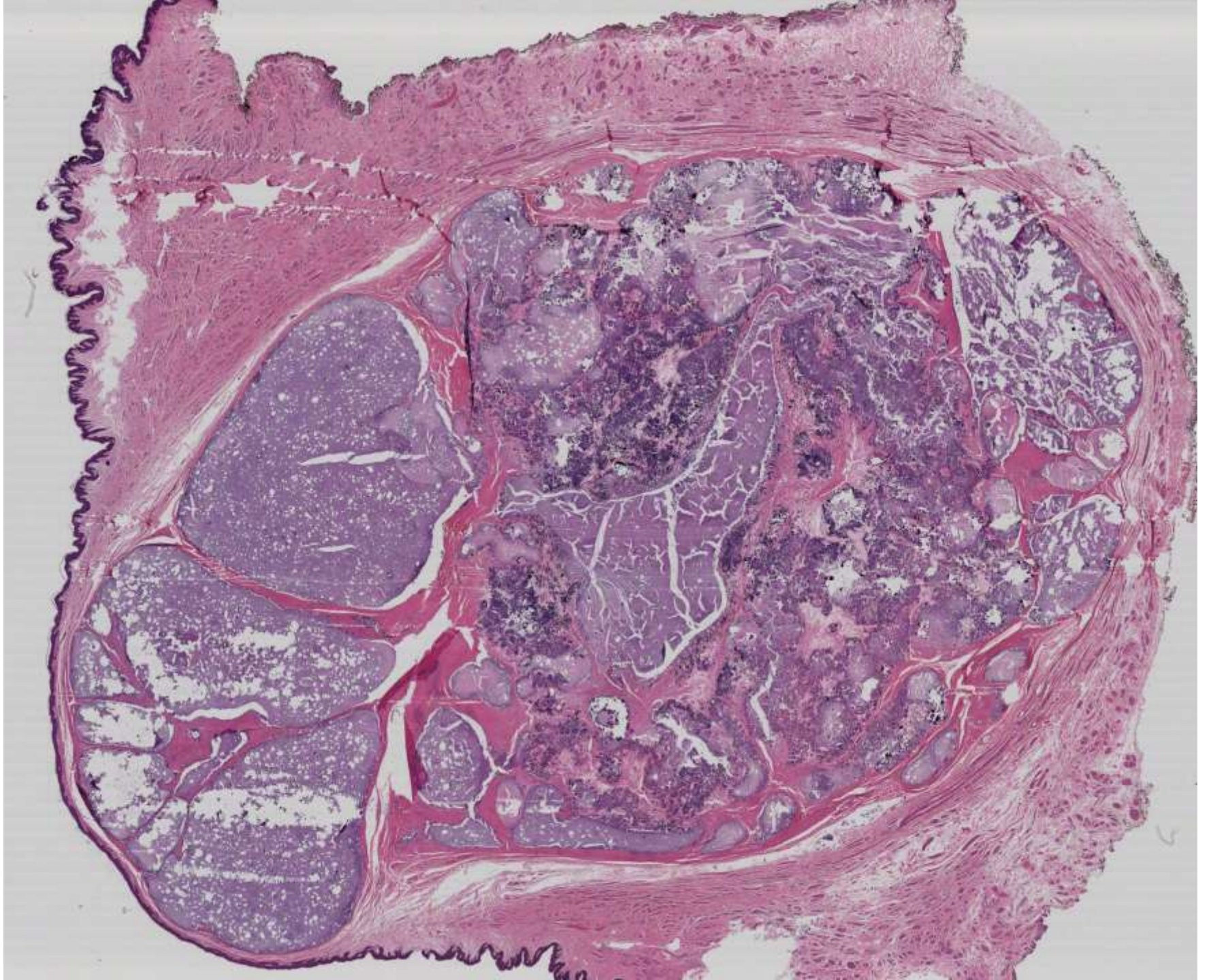
Lymphangioma circumscriptum

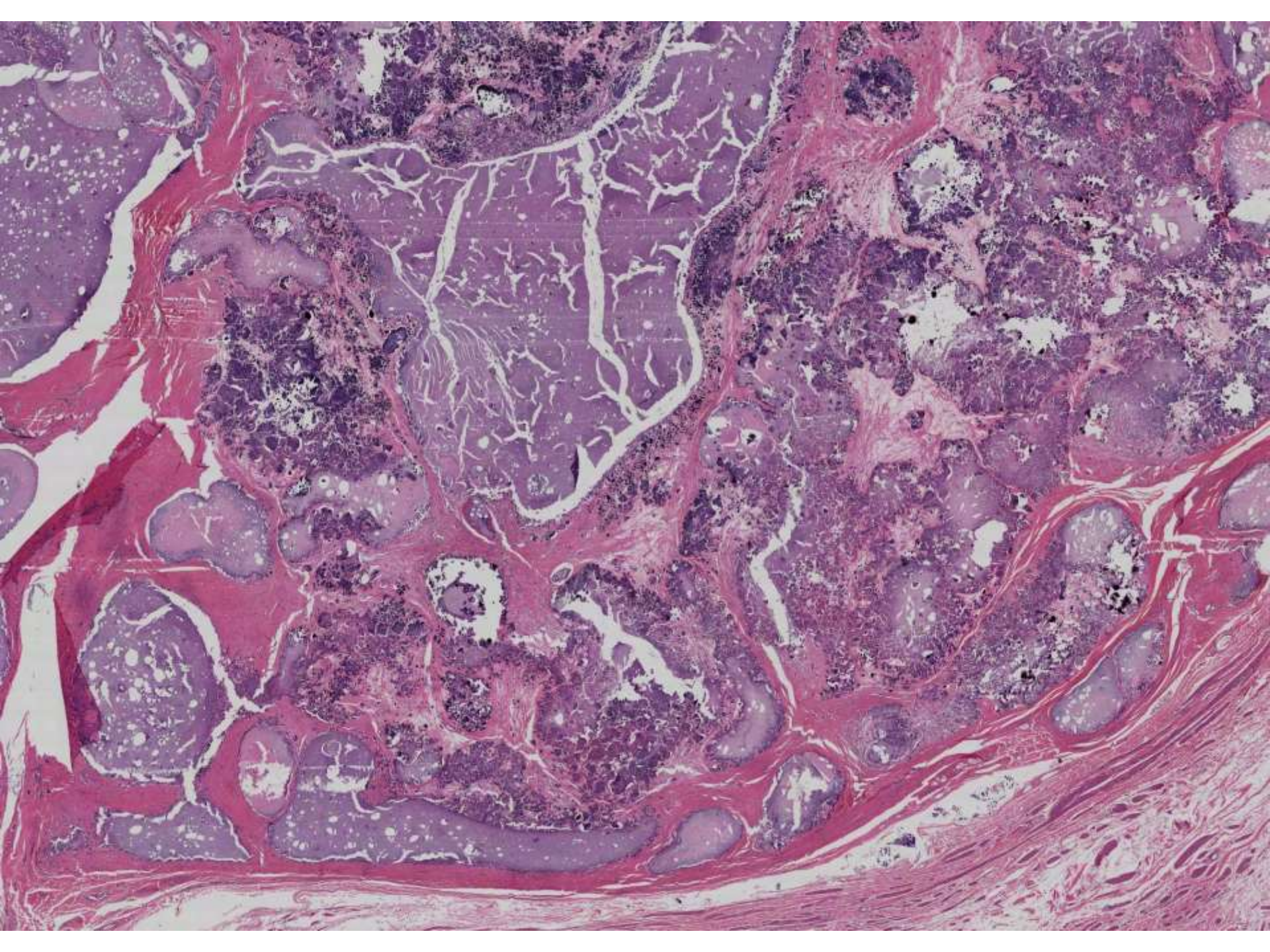
- **Uncommon grouped papulovesicles**
- **Usually multiple, usually congenital, sometimes arising later in childhood**
 - Rare in adulthood
- **Deep component can exist**
 - MRI often used to assess extent
- **Tendency to recur after superficial excision**
- **Rarely → to lymphangiosarcoma (after XRT)**

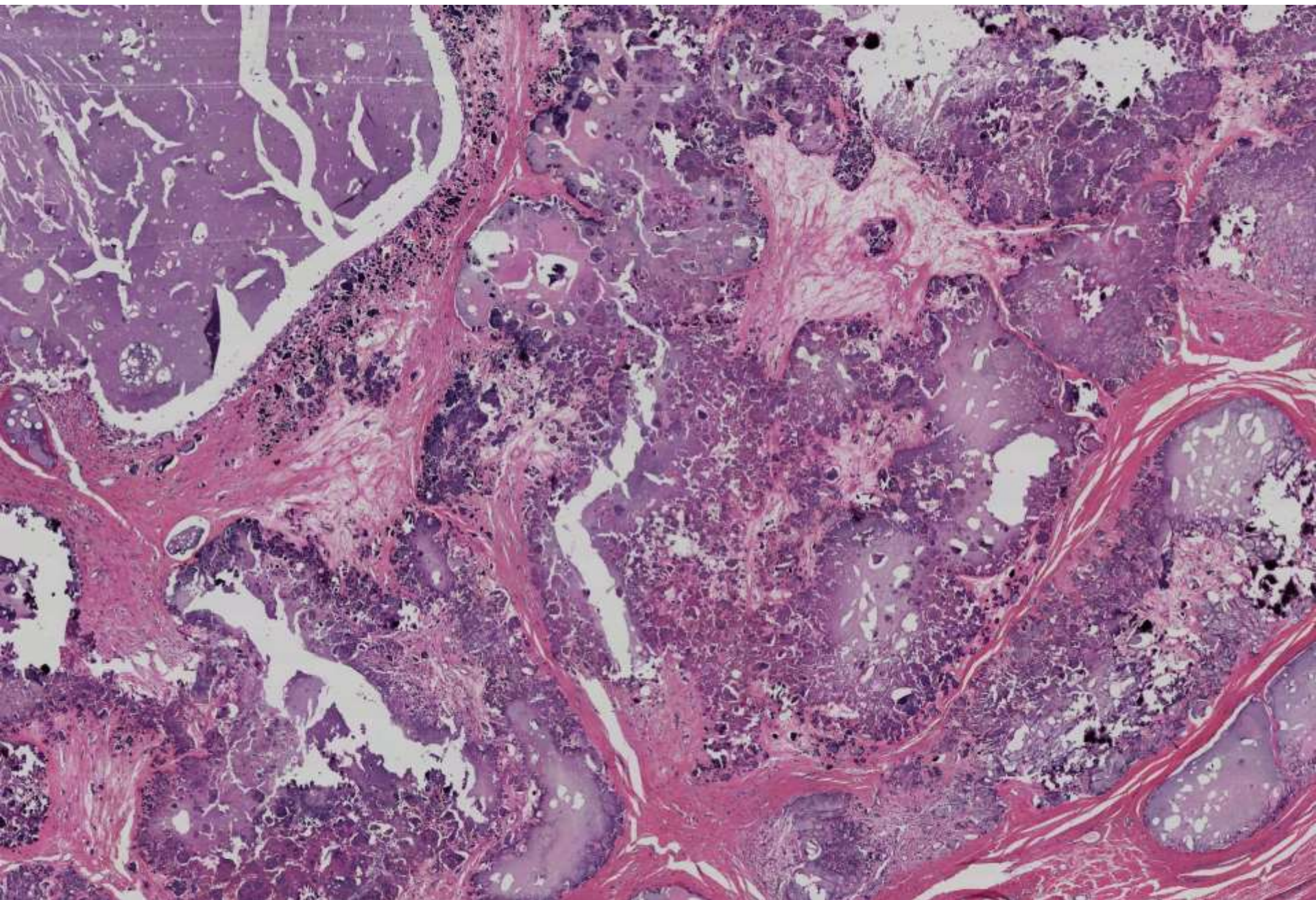
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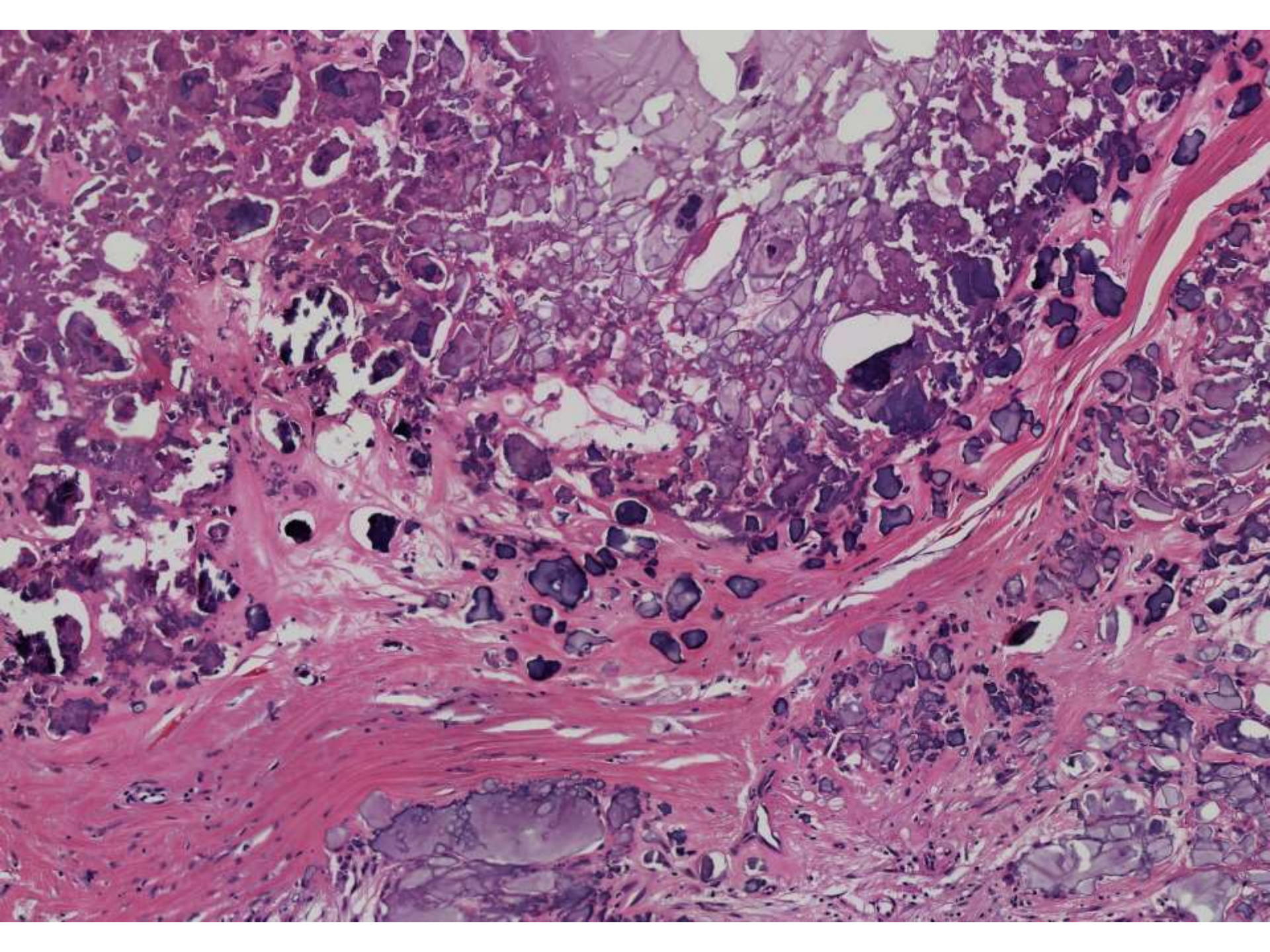
Ankur Sangoi; El Camino Hospital
47-year-old male with scrotal mass.

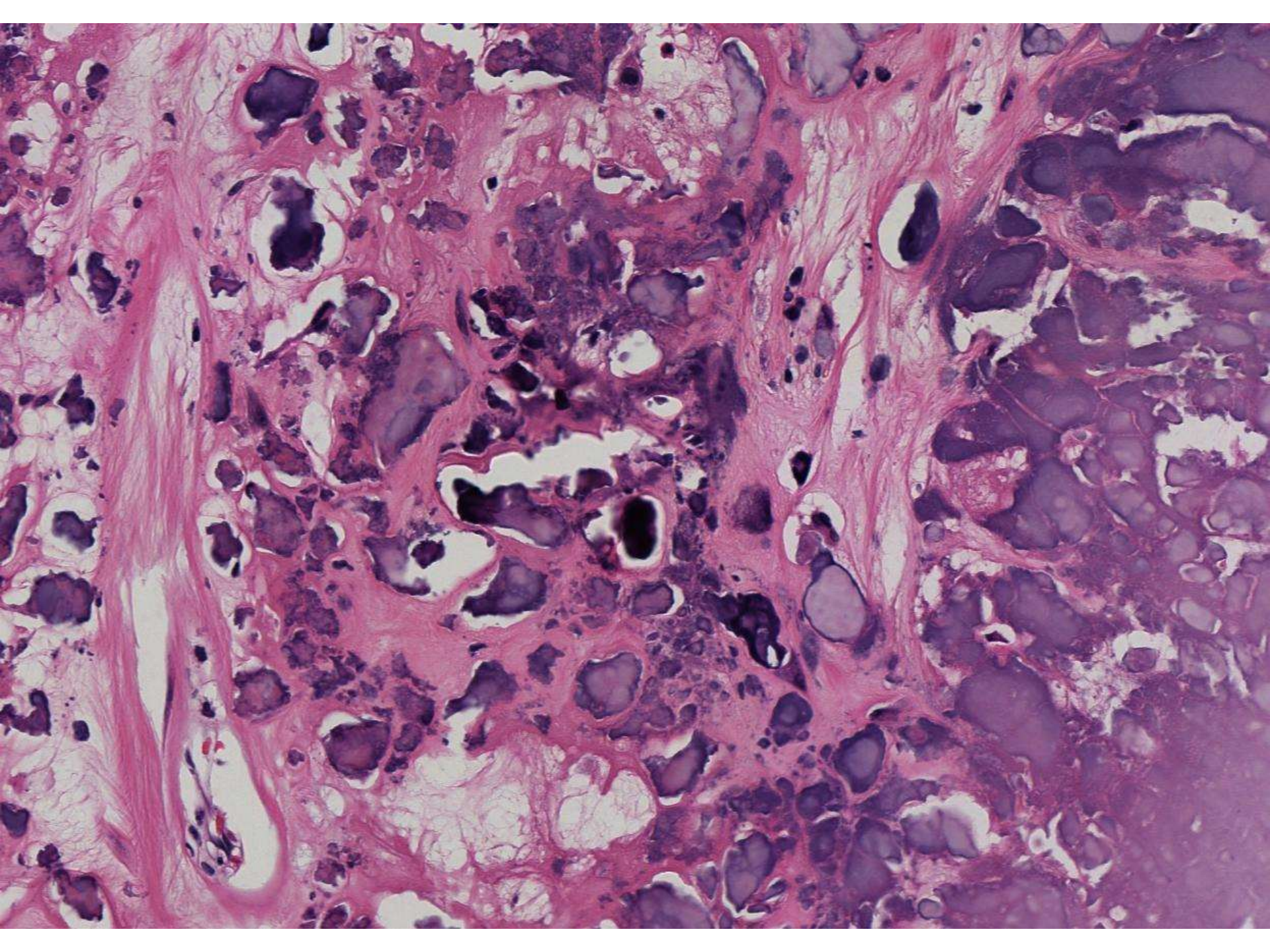












DDx?

- “this entity has a very distinctive appearance with almost NO histologic differential diagnosis”



DDx

- **Idiopathic scrotal calcinosis**
- **Dystrophic calcification**
 - Onchocerca volvulus
- **Nodular amyloidosis**

Dx:

idiopathic scrotal calcinosis

- **Uncommon growth of brown/yellow nodules in scrotal skin**
 - Ca deposits of various size + granulomatous rxn
- **Typically begin in adolescence or early adulthood**
 - Occurs in absence of abnormalities in Ca & PO₄ metabolism
- **Usually asymptomatic**
 - Can have pain and infection
- **Controversial risk of recurrence**
 - Surgery probably still curative

Possible pathogenesis: “idiopathic” scrotal calcinosis

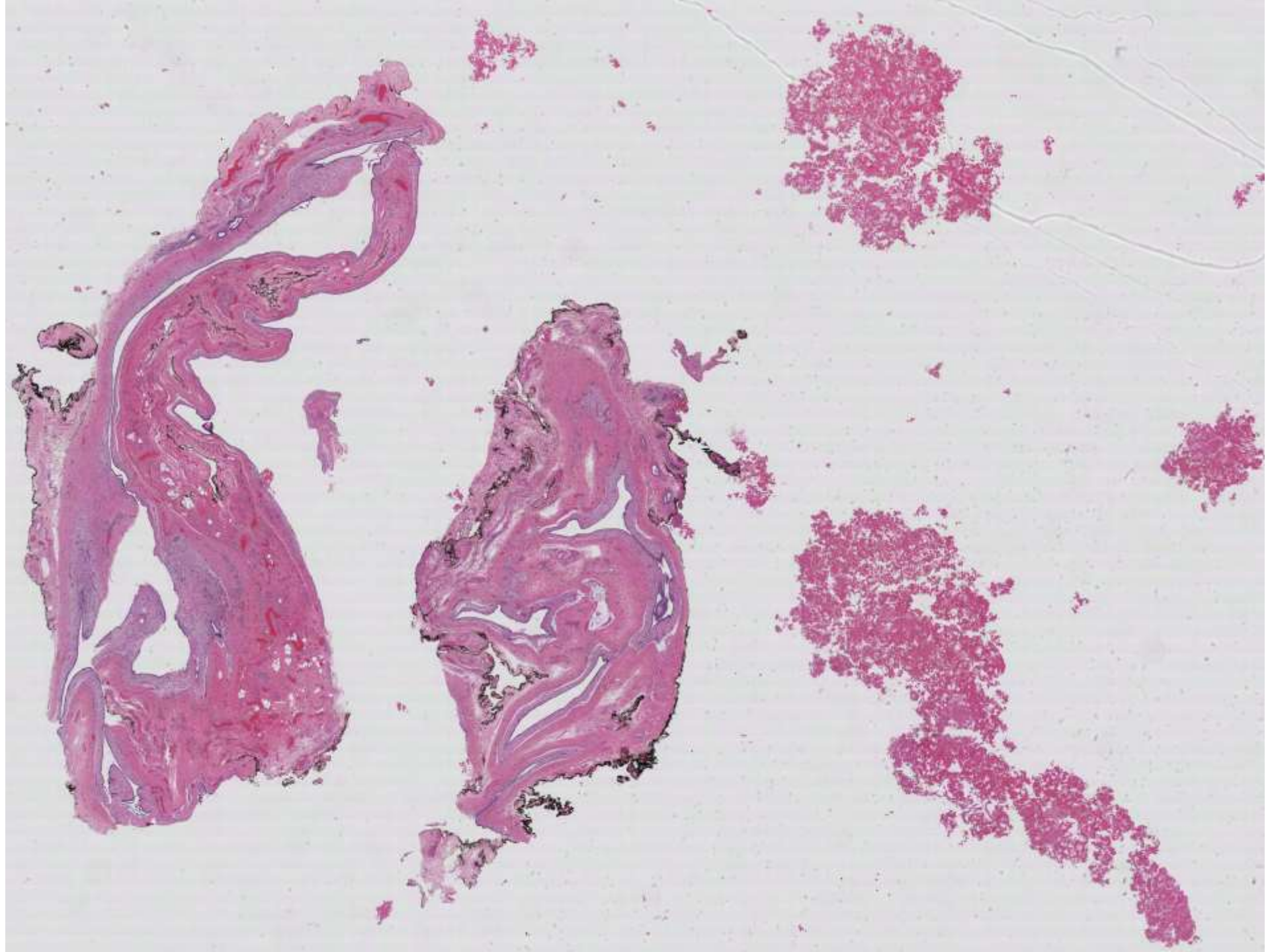
- **Calcific degeneration of epidermoid cysts or eccrine sweat ducts**
- **Dartos muscle necrosis → dystrophic calcification**
 - Similar to uterine leiomyoma calcification

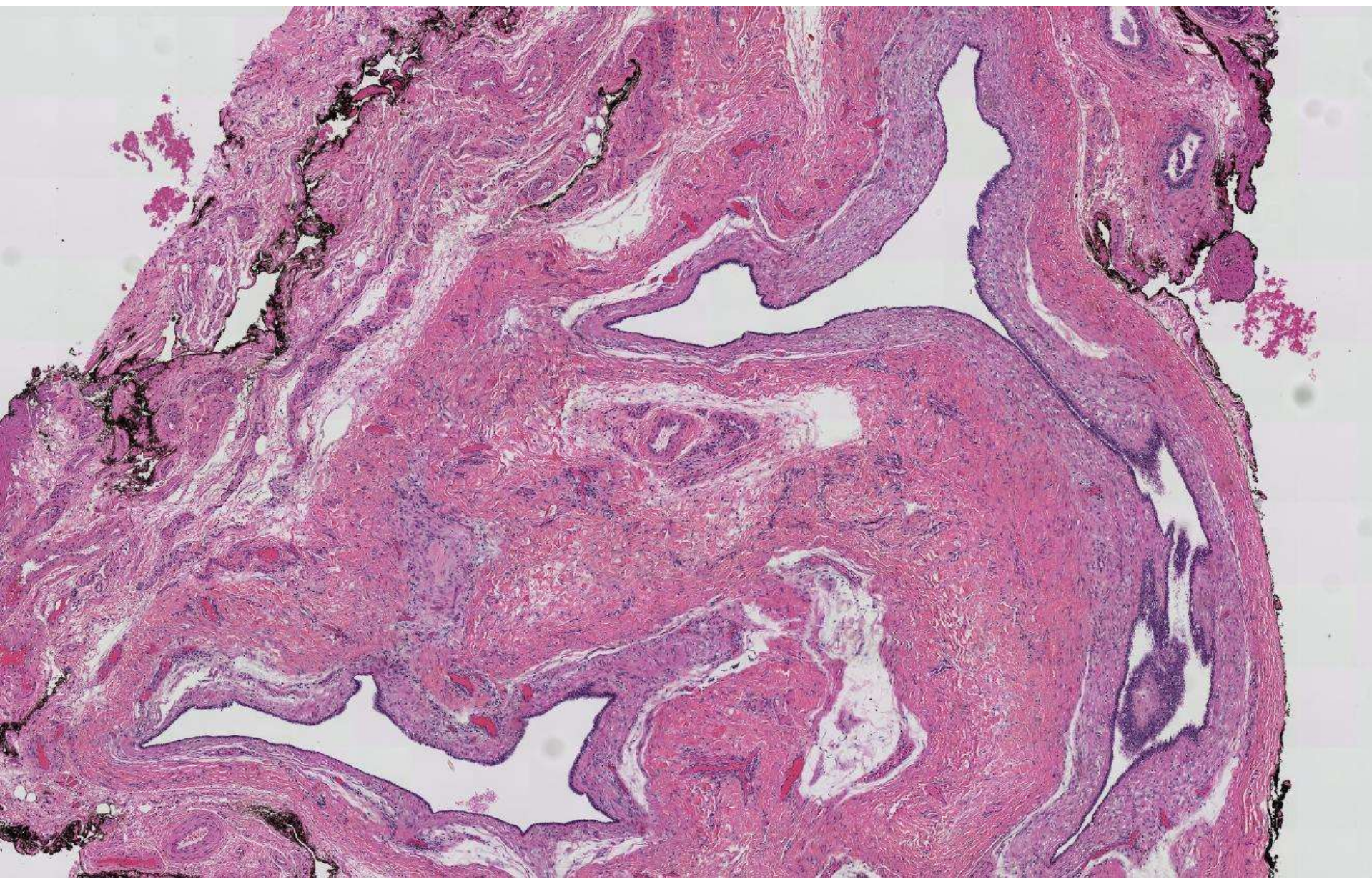
Cultural & Linguistic Competency References

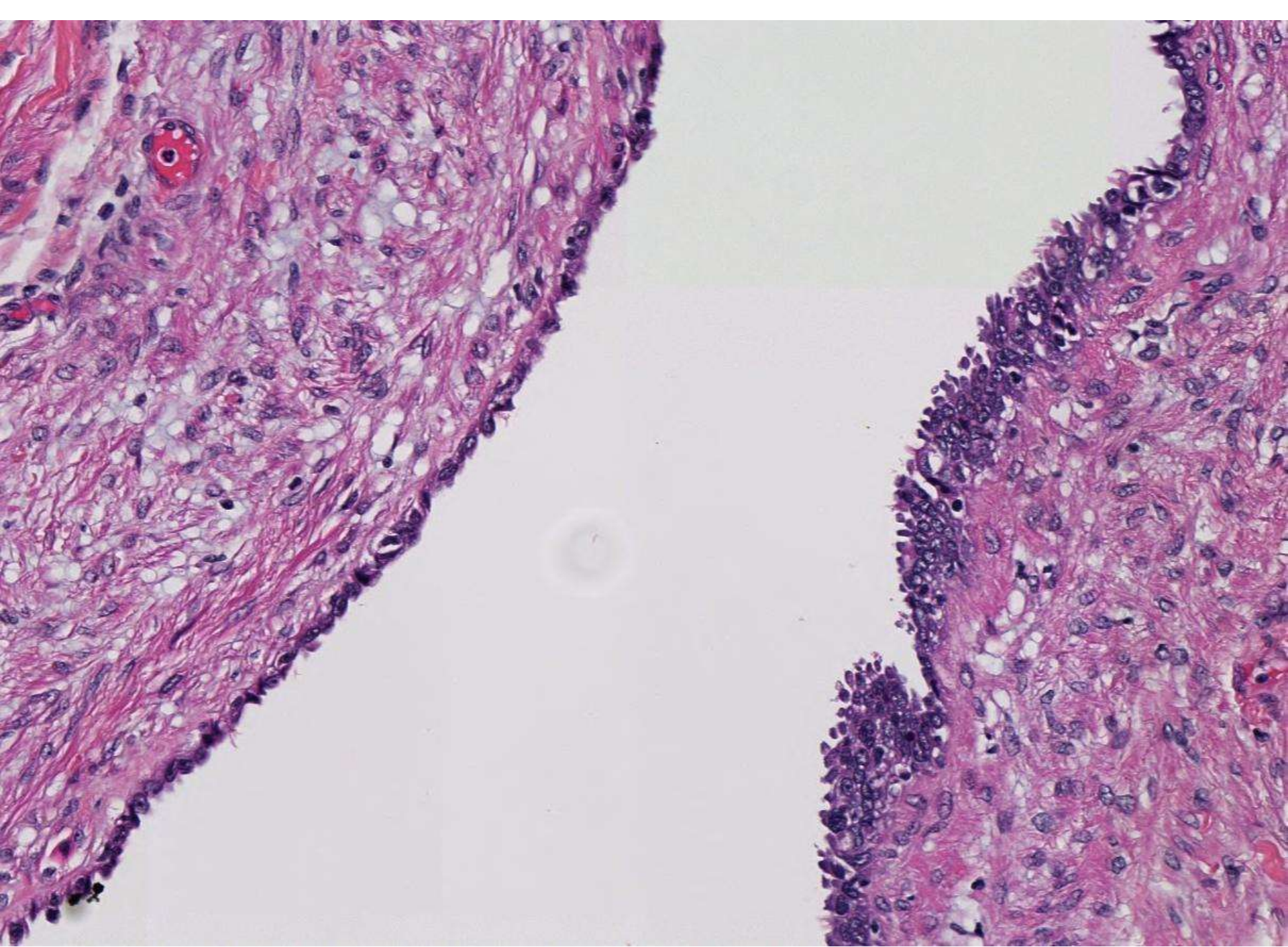
- Karaca M, Taylan G, Akan M, Eker G, Gideroglu K, Gul AE. Idiopathic scrotal calcinosis: surgical treatment and histopathologic evaluation of etiology. Urology. 2010 Dec;76(6):1493-5. doi: 10.1016/j.urology.2010.02.001. Epub 2010 Apr 9. PubMed PMID: 20381842.
- Dubey S, Sharma R, Maheshwari V. Scrotal calcinosis: idiopathic or dystrophic?
- Dermatol Online J. 2010 Feb 15;16(2):5. PubMed PMID: 20178701.

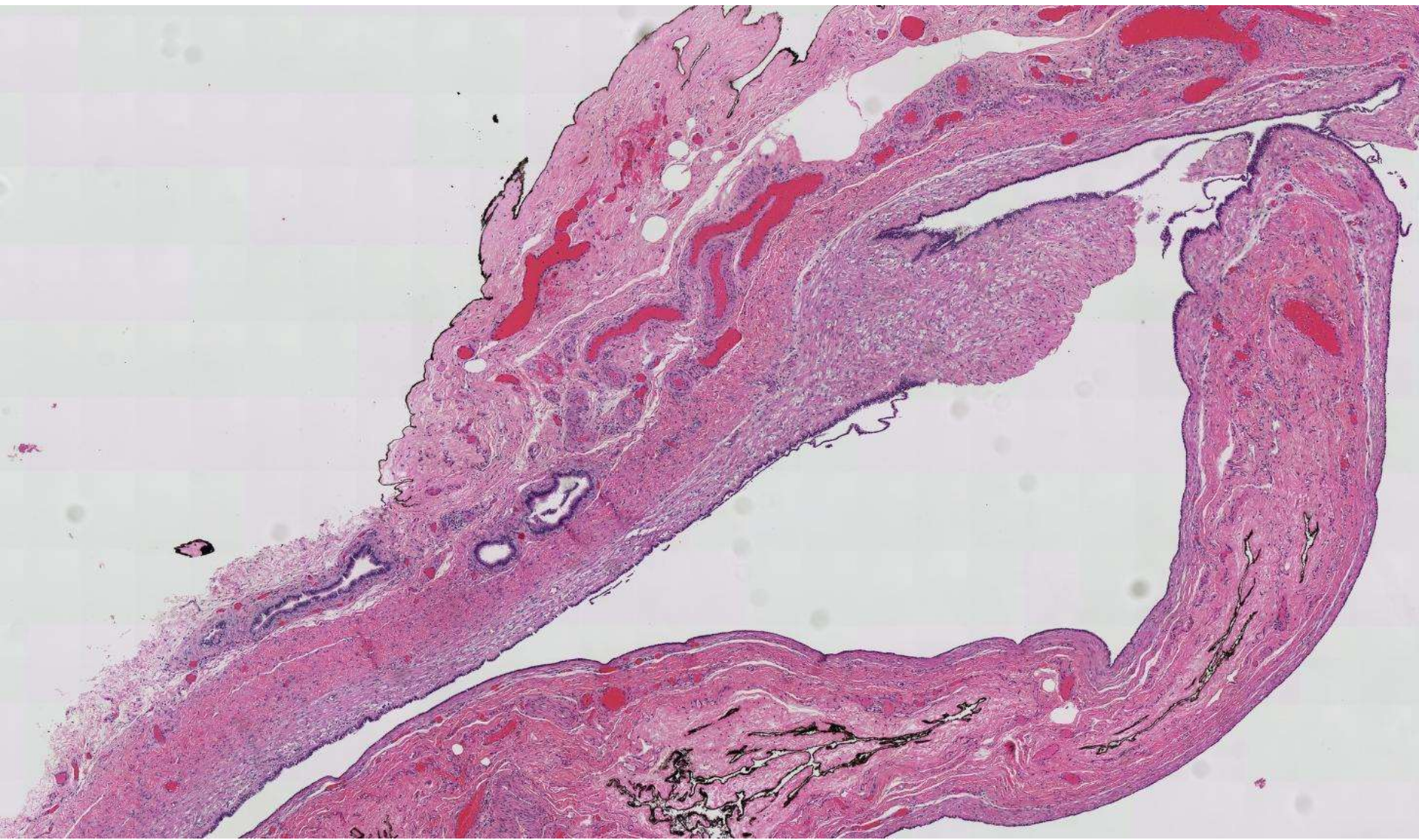
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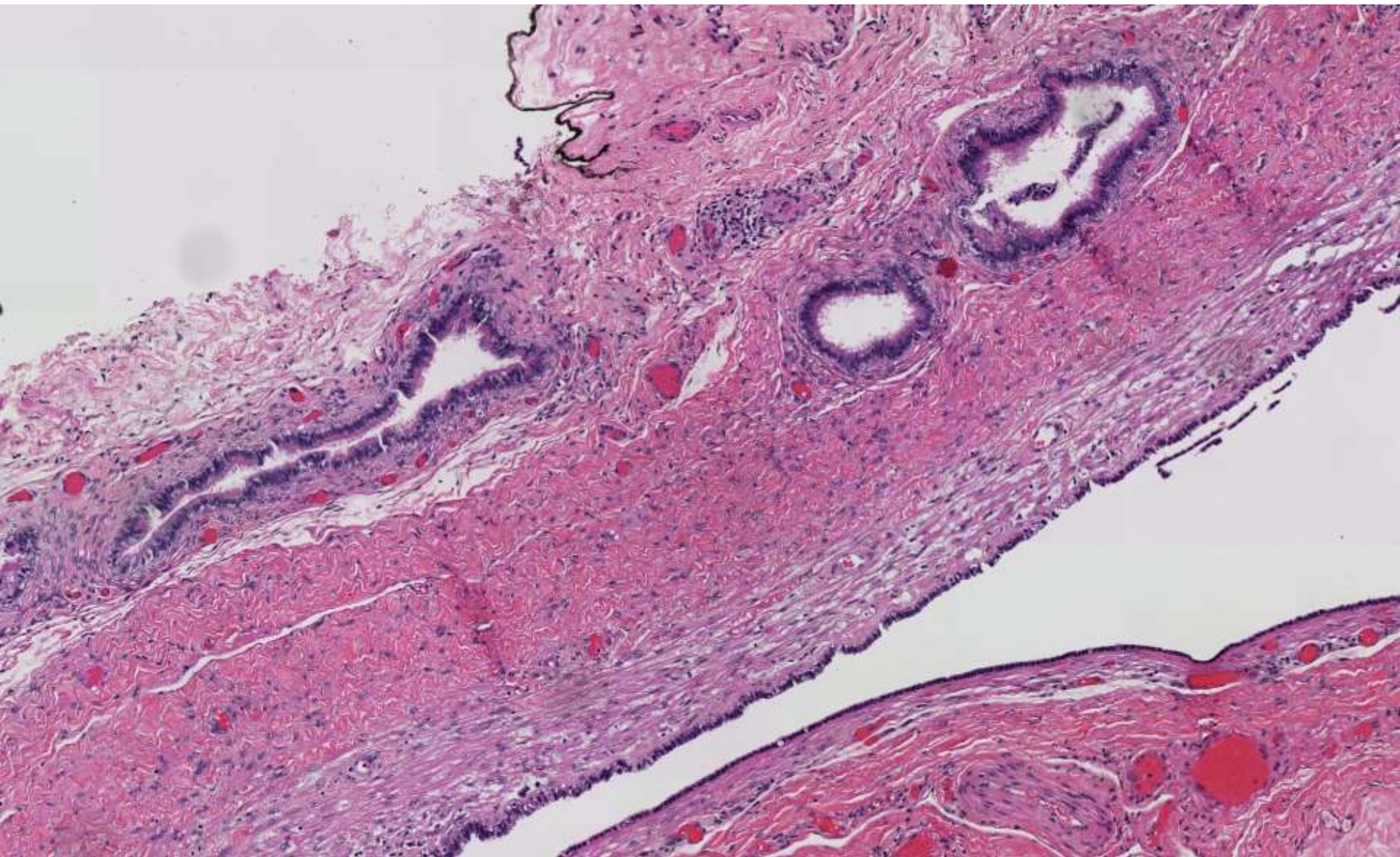
Ankur Sangoi; El Camino Hospital
24-year-old male with scrotal mass.

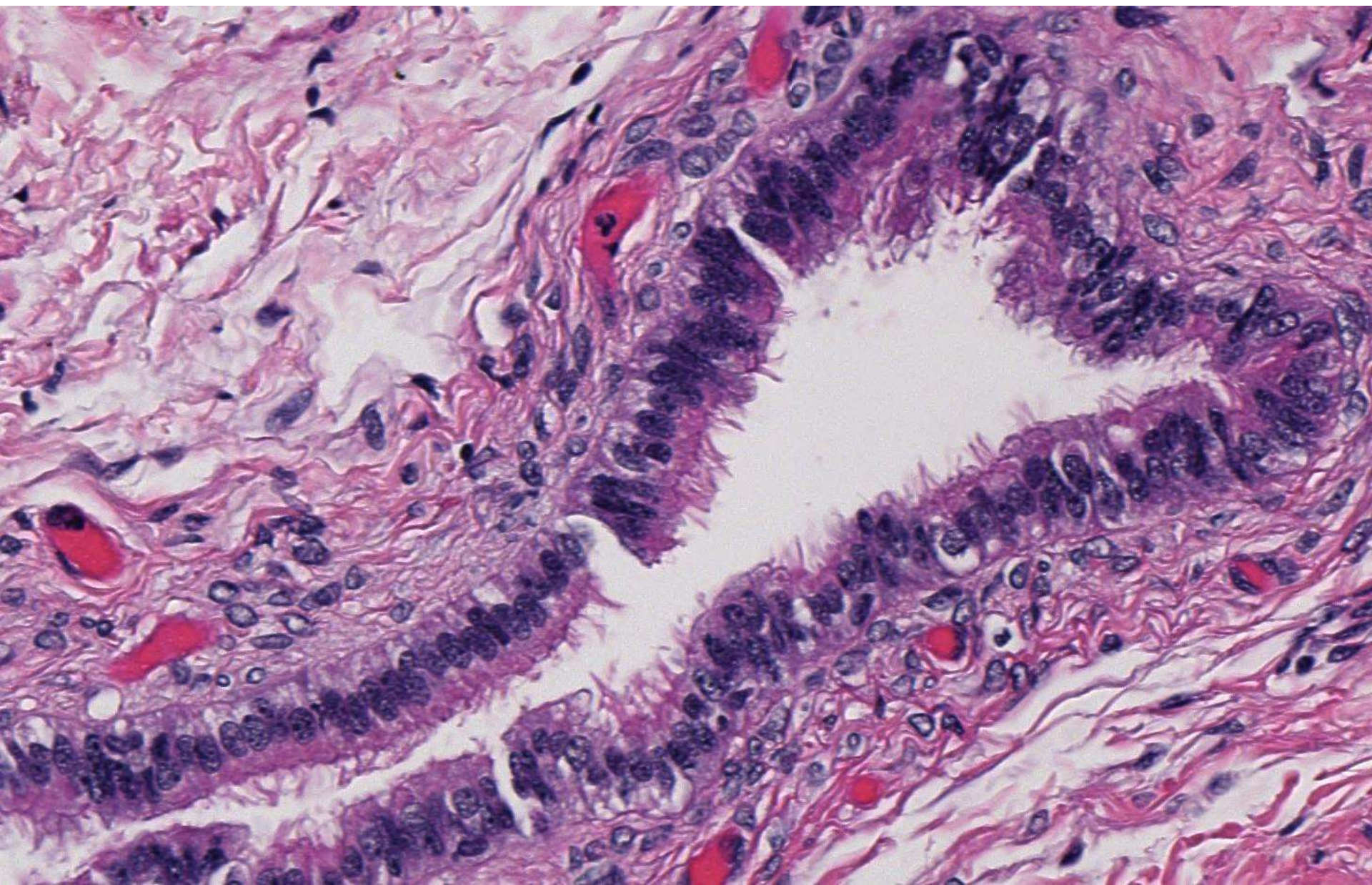


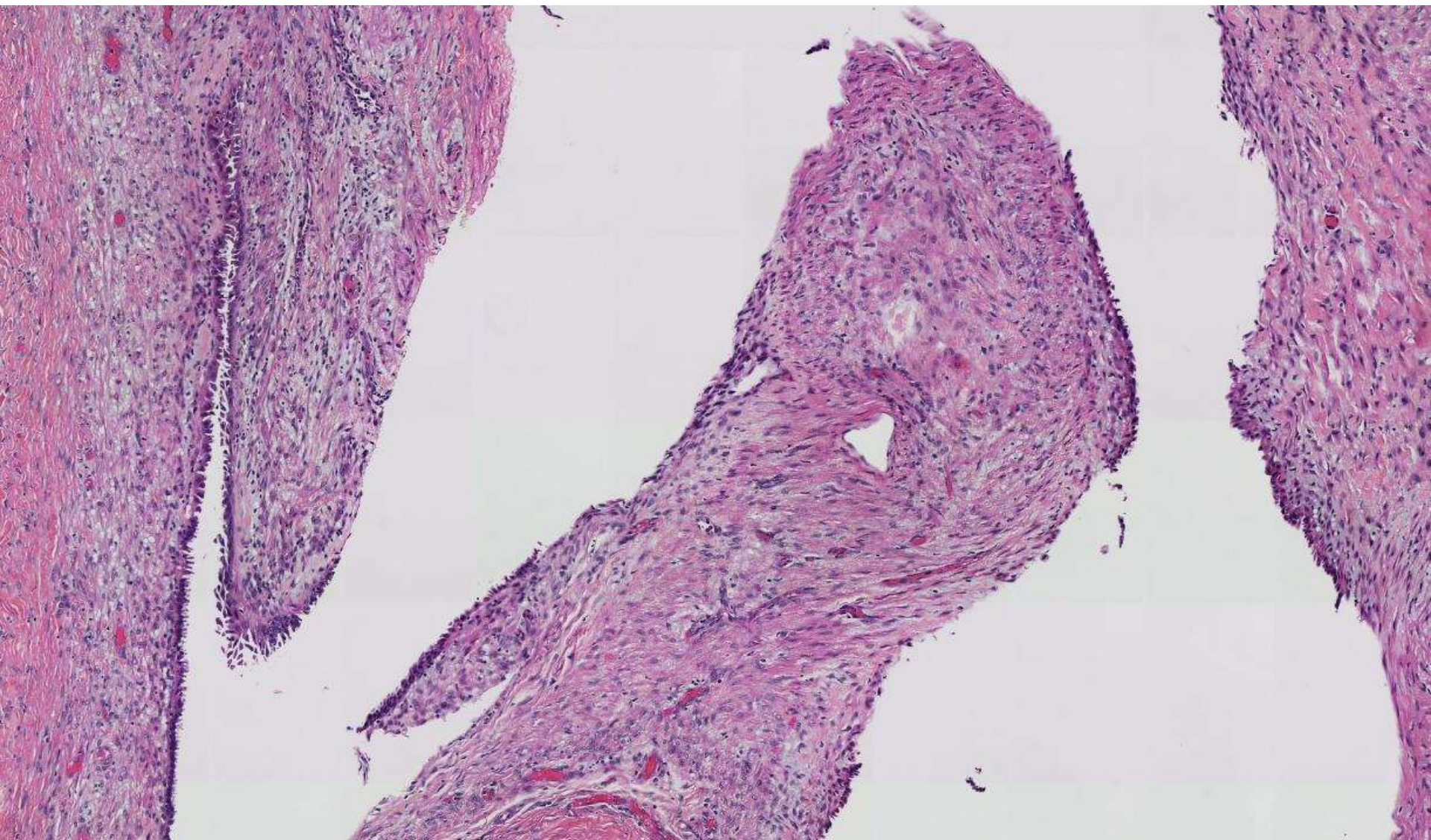


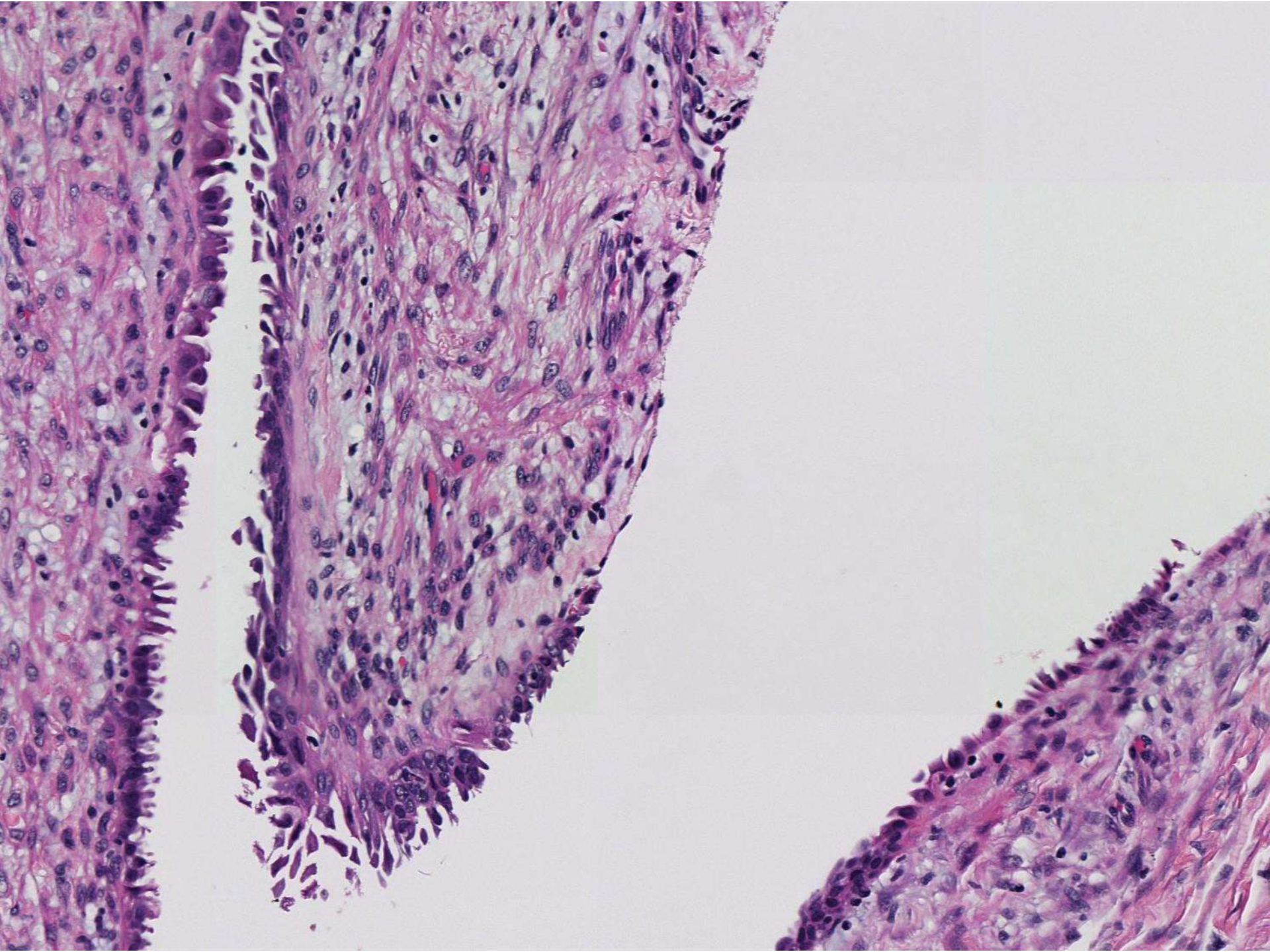


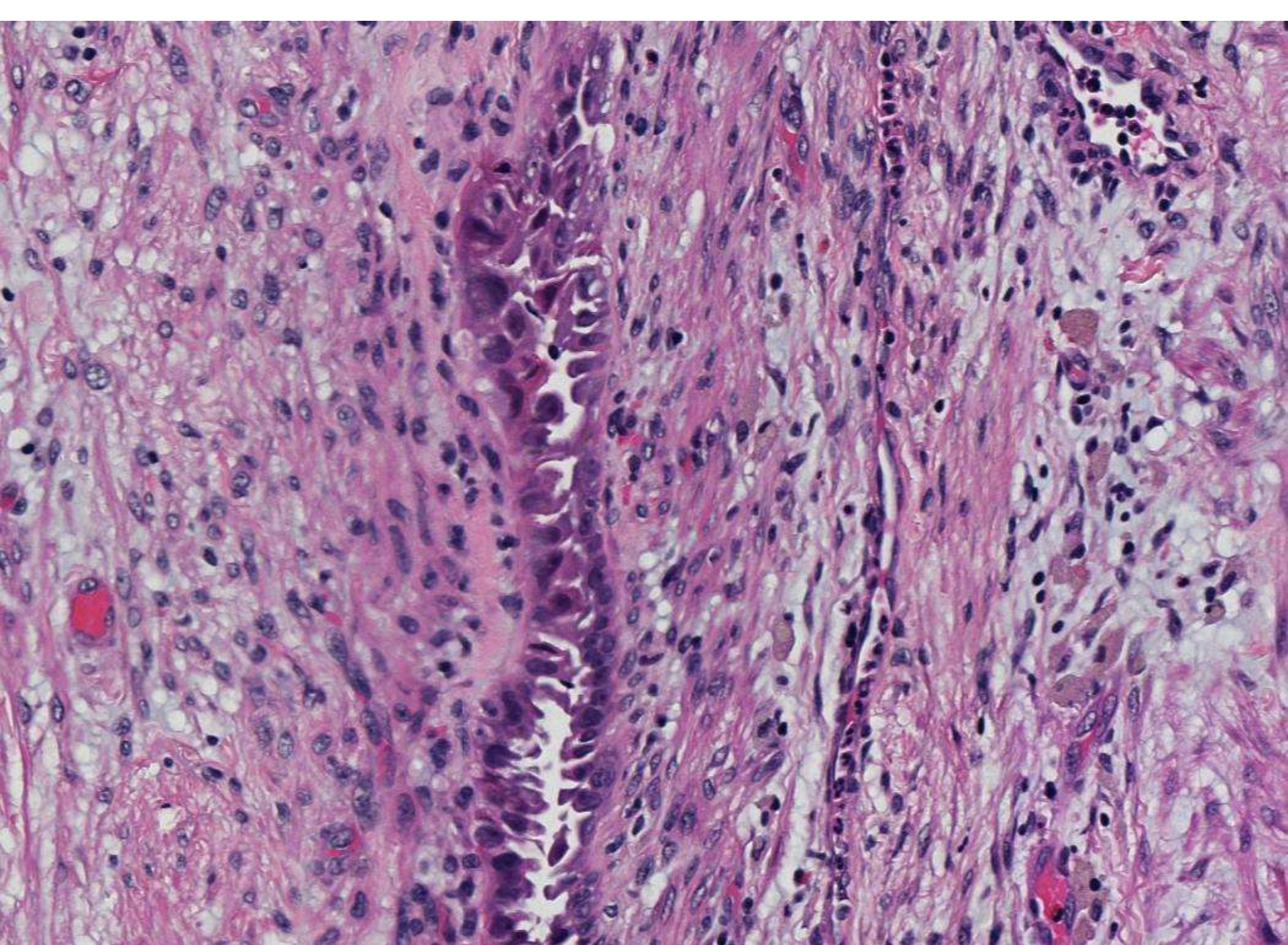












SCROTUM LESIONS

(Rapini's dermpath book)

- **Angiokeratoma**
- **Bowen's disease**
- **Contact dermatitis**
- **Candidiasis**
- **Calcinosis scroti**
- **Condyloma**
- **Elephantiasis**
- **Epidermoid cyst**
- **HSV**
- **Leiomyoma**
- **Lichen simplex chronicus**
- **Paget's disease**
- **Pediculosis pubis**
- **Sclerosing lipogranuloma**

Cutaneous cysts

- Hidrocystoma
- Bronchogenic cyst
- Cystadenoma
- Dermoid cyst
- Keratinous cyst
- Follicular cyst
- Steatocystoma
- Vellous hair cyst

Cutaneous cysts

- Hidrocystoma
- Bronchogenic cyst
- **Cystadenoma →**
- Dermoid cyst
- Keratinous cyst
- Follicular cyst
- Steatocystoma
- Vellous hair cyst

Cutaneous cysts

- Hidrocystoma
- Bronchogenic cyst
- **Cystadenoma →**
 - Cutaneous ciliated cyst
(cutaneous Muellarian cyst)
- Dermoid cyst
- Keratinous cyst
- Follicular cyst
- Steatocystoma
- Vellous hair cyst

Dx:

cutaneous Muellerian cyst

- **Usually extremity of teenage girls**
 - thigh>buttock>calf>foot
- Müllerian (paramesonephric) derivation, representing a migration abnormality of fetal development (heterotopia)
- Cysts arising at other sites and in males may represent metaplasia of lining of a pre-existent simple cyst of sweat duct derivation