

CASE REPORT

A Misdiagnosed Giant Sebaceous Epidermoid Cyst at Gluteal Region:
A Case ReportBharat Dulera¹, P.B. Joshi², Y.R. Meghani³

HOW TO CITE THIS ARTICLE:

Bharat Dulera, P.B. Joshi, Y.R. Meghani. A Misdiagnosed Giant Sebaceous Epidermoid Cyst at Gluteal Region: A Case Report. Ind J Anct Med Yoga. 2025; 18(3): 140-144.

ABSTRACT

A sebaceous cyst is a subcutaneous lesion that arises due to the obstruction of the pilosebaceous ductal entrance. In the absence of infection, the cyst presents as a soft, cystic, and fluctuant swelling, typically asymptomatic. The most commonly affected areas include the neck, face, and scalp. In Ayurvedic medicine, sebaceous cysts are often correlated with *Medoja Granthi* or *Medoja Arbuda* due to their similar characteristics. Ayurvedic texts recommend two primary treatment modalities: *Chedhana* (excision) and *Bhedhana* (incision). Conventional treatment approaches for these epidermal inclusion cysts typically involve techniques such as elliptical excision, minimal excision, and punch incision with drainage. This case report describes a 60-year-old female patient who presented to the Shalya Tantra OPD with complaints of a spherical swelling located in the left gluteal region. The lesion had been previously misdiagnosed as Lipoma. The patient was managed with conventional elliptical excision, which resulted in a minimally noticeable scar.

KEYWORDS

• Gluteal region • *Medoj granthi* or *Arbuda* • Sebaceous cyst

AUTHOR'S AFFILIATION:

¹ Ms Scholar, Department of Shalya Tantra, Institute of Teaching and Research in Ayurveda, Jamnagar, Gujarat, India.

² Reader, Department of Shalya Tantra, Institute of Teaching and Research in Ayurveda, Jamnagar, Gujarat, India.

³ Assistant Professor, Department of Shalya Tantra, Institute of Teaching and Research in Ayurveda, Jamnagar, Gujarat, India.

CORRESPONDING AUTHOR:

Bharat Dulera, Ms Scholar, Department of Shalya Tantra, Institute of Teaching and Research in Ayurveda, Jamnagar-361008, India.

E-mail: dulera1999@gmail.com

➤ Received: 01-05-2025 ➤ Accepted: 31-05-2025



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the Red Flower Publication and Open Access pages (<https://rfppl.co.in>)

INTRODUCTION

Sebaceous cysts, also referred to as epidermoid cysts, are benign, sebum-filled lumps that develop beneath the skin. These cysts are generally asymptomatic and painless unless they become infected. When the duct or opening of the sebaceous gland becomes obstructed, the gland becomes distended with its own secretion, leading to the formation of a sebaceous cyst. As a type of retention cyst, it is more accurately termed an "epidermoid cyst" due to the fact that the cyst is lined by superficial squamous epithelial cells.¹ Sebaceous cysts can develop anywhere on the body; however, they are most commonly found in regions with a high density of sebaceous glands, such as the face, neck, and scalp. These cysts account for approximately 85% to 90% of all excised cysts, making them the most prevalent type of benign skin lesion.²

Sebaceous cysts are typically hemispherical or spherical in shape, exhibiting a soft and putty-like consistency. They are generally fixed to the skin and often present with a central punctum, which is considered a pathognomonic feature of the cyst.³

The treatment of sebaceous cysts is determined by the clinical condition of the cyst. In cases where the cyst is inflamed or infected, initial management involves incision and drainage. Once the inflammation and induration have resolved, definitive excision is recommended. It is crucial to excise the cyst in its entirety, as incomplete removal often leads to recurrence.⁴

In Ayurveda, cysts are often compared to *Granthi*. *Granthi* is defined as a swelling that is spherical in shape, elevated from the skin's surface, and resembles a knot.⁵

Granthi is considered a *Kapha-pradhana Tridoshaja Vyadhi* in Ayurveda. According to Acharya Sushruta, when the *Vata dosha* vitiates the *Mamsa dhatu*, it results in a *Saruja Granthi* (painful swelling), whereas when *Vata dosha* vitiates the *Meda dhatu*, an *Alparuja Granthi* (less painful swelling) occurs.⁶

As per Ayurvedic treatment guidelines, *Chedhana* (excision) is recommended for *Kaphaja Granthi*, while *Bhedhana* (incision) is advised for *Vataja*, *Pithaja*, and *Medoja Granthi*.⁷

Acharya Vagbhata noted that *Arbuda* is relatively bigger than *Granthi*.⁸

The classic symptoms of benign growth are *Vrittam* (round), *Sthiram* (immovable), *Manda ruja* (slightly uncomfortable), *Mahant* (large size), *Unalpa-moolam* (deep seated), *Chiroruddhi* (slowly expanding), and *Apakam* (non-suppurating).⁹

CASE DESCRIPTION

A 60-year-old female presented to the Shalya Tantra Outpatient Department (OPD) with a painless swelling in the left gluteal region, persisting for 12 months. The onset of the swelling was insidious, and it demonstrated gradual progression over time. The swelling has progressively increased in size, and there is no reported history of similar swellings in other parts of the body.

ON EXAMINATION

On inspection, there was an 8×8 cm spherical shaped swelling on the left gluteal region.

On palpation, it was firm, fluctuating and tender on palpation. Temperature was normal. The surface was smooth and even. The margins were regular and well defined. The skin overlying the swelling was normal. Sign of moulding and sign of indentation was found to be negative. The rest of area and right gluteal side were within normal contour. A provisional diagnosis of dermoid/ epidermoid or sebaceous cyst was made.

Pre-operative image of the patients' condition is shown in Figure 1.



Figure 1: Pre-operative image

INVESTIGATIONS

Ultrasound showed a well-defined, oval, hypoechoic cystic lesion in the left gluteal

region, subcutaneous tissue plane with low level internal echoes. No communicating tracts seen. Perilesional tissue was normal. Features were suggestive of the lipoma. Haematological, biochemical investigations found within normal limits and serological investigations such as HIV, HBsAg, VDRL and HCV were found negative.

SURGICAL INTERVENTION

Under local anesthesia (Inj. Lignocaine 2%) and adhering to strict aseptic precautions, an elliptical incision was made over the left gluteal region. The incision was deepened, resulting in the rupture of the sebaceous cyst sac and the extrusion of thick, white, cheesy material. The cyst sac was meticulously separated from the surrounding healthy tissue and completely excised (Figures 2 and 3). The contents and the sac confirmed the diagnosis of a sebaceous

cyst. After ensuring adequate hemostasis, five vertical mattress sutures were placed using Ethilon 3-0 on the left gluteal region (Figure 4). Postoperatively, the patient was prescribed an oral antibiotic, Cefixime 200 mg (twice daily after meals), and an analgesic, Tab. Zerodol SP (as needed, after meals), for three days. Due to incomplete approximation of the wound edges, the sutures were removed, and the wound was allowed to heal by secondary intention. No signs of infection were observed during this period. Daily wound dressing was performed using *Jatyadi Taila* following cleansing with diluted betadine solution. The wound achieved complete healing within four weeks. Mild pain was reported at the operated site during the first five days, without any discharge. Following suture removal, the pain subsided. A follow-up examination conducted three months postoperatively revealed no recurrence of cystic swelling or collection.

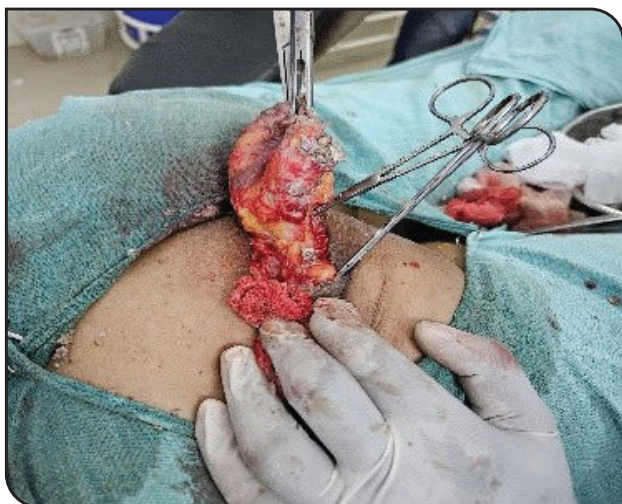


Figure 2: During operative



Figure 3: Giant Sebaceous cyst



Figure 4: After Complete excision



Figure 5: Post-operative



Figure 6: Post-operative

DISCUSSION

Sebaceous cysts, also known as epidermoid cysts, are a type of retention cyst characterized by the accumulation of sebum, keratin, and, in cases of infection, pus or blood. In this case, the patient presented with a giant sebaceous cyst in the left gluteal region. Subsequently, a distinct cystic swelling developed. Based on the clinical features, including its consistency, minimal pain, slow progression, and the presence of white, cheesy material observed during the operative phase, the condition was correlated with *Kaphaja Granthi*, as described in classical texts.^{7,10}

Epidermal cysts in the postauricular region require differentiation from lipomas and hemangiomas. Lipomas are benign tumors composed of adipose tissue, while hemangiomas, typically congenital, are benign vascular tumors originating from endothelial cells. Diagnostic tools such as fine-needle aspiration cytology (FNAC) can assist in distinguishing epidermoid cysts from other neoplasms. An epidermoid cyst must also be differentiated from conditions such as neurofibroma, eruptive vellus hair cyst, pilomatrixoma, dermatofibroma, sarcoma, lipoma, and trichilemmal cyst. In older individuals, differential diagnoses should include malignant conditions such as basal cell carcinoma, squamous cell carcinoma, and Bowen's disease.⁸ However, in this case, the diagnosis was established based on clinical examination and ultrasonographic findings.

A cyst related to gluteal region is commonly an inclusion dermoid and can be excised.⁹ One of the associated problems with large epidermal cysts is their ugly, unaesthetic appearance, so many patients go under the knife for cosmetic reasons, as more often than not epidermal cysts are asymptomatic.

In this case, *Chedana Karma* (surgical excision) was chosen over conservative management. When removal of an epidermoid cyst is indicated, either for cosmetic reasons or due to complications, complete excision of both the cyst contents and its wall is the treatment of choice. Therefore, the excision of the entire sac was undertaken as the definitive line of treatment, followed by suturing. According to classical texts, a glandular swelling (*Kaphaja Granthi*) located on any part of the body, except for vital or vulnerable regions (*Marma*), and that does not resolve or absorb spontaneously, should be surgically incised, even in its non-suppurated stage, to remove the glands. After excision, the expert surgeon should ensure proper hemostasis and subsequently cauterize the wound. The wound is then managed following the principles of *Sadyo-Vrana Chikitsa* (management of acute wounds) to ensure optimal healing.¹⁰

Minimizing scar formation is a key consideration during the surgical removal of a sebaceous cyst. In this case, an elliptical incision, including the punctum, was selected due to its ability to reduce scar visibility and size. This type of incision provides enhanced access to deeper layers, reduces tension on the skin edges, and minimizes scar formation by aligning with natural skin tension lines. Complete removal of the cyst sac is essential to prevent recurrence. To achieve this, meticulous excision was performed using a combination of sharp and blunt dissection techniques, ensuring minimal risk of sac rupture. The entire sac was carefully distinguished from the surrounding healthy tissues and completely excised. As the wound was not infected, it was closed with five vertical mattress sutures. However, wound dehiscence occurred, likely due to reduced blood supply in the area, as the sac was firmly adhered to the skin, leaving only the skin layers intact after excision. The sutures were removed on the fifth postoperative day to allow for secondary healing, and the wound healed completely within four weeks.

CONCLUSION

Sebaceous cysts in the gluteal region are often misdiagnosed, yet they can be effectively managed with appropriate medical or surgical interventions. A thorough understanding of their characteristics, diagnostic approaches, and treatment options is essential for both patients and healthcare providers. In this case, a misdiagnosed sebaceous cyst in the gluteal region was successfully managed using 'Chedana Karma' (surgical excision) followed by proper wound care. Complete excision of the cyst along with its sac remains the definitive treatment to prevent recurrence and ensure optimal outcomes.

REFERENCES

1. Sushruta: Sushruta Samhita with commentary of Dalhana, edited by Vaidya Jadavaji Trikamji Acharya, Chowakhambasubhartiprakashan, Varanasi, reprint, Nidanasthana, 11th Chapter, Verse, 2014; 6: 824-311.
2. Sriram Bhat M: SRB's Manual of surgery, Jaypee Publications, 6th edition, reprint, 1E Chapter, 2019; 1223-75.
3. Gomi M, Naito K, Obayashi O. A large epidermoid cyst developing in the palm: a case report. *Int J Surg Case Rep.* 2013;4(9):773-777.
4. Farquharson.M, Hollingshead. J, Moran.B, Farquharson's Textbook of Operative General Surgery, Crc Press, Tenth Edition, Chapter 1, page 11.
5. Sushruta: Sushruta Samhita with commentary of Dalhana, edited by Vaidya Jadavaji Trikamji Acharya, Chowakhambasubhartiprakashan, Varanasi, reprint, Chikitsasthana, 12th Chapter, Verse, 2014; 3: 824-310
6. Sushruta: Sushruta Samhita with commentary of Dalhana, edited by Vaidya Jadavaji Trikamji Acharya, Chowakhambasubhartiprakashan, Varanasi, reprint, Nidanasthana, 11th Chapter, Verse, 2014; 6: 824-311.
7. Sriram Bhat M: SRB's Manual of surgery, Jaypee Publications, 6th edition, reprint, 1E Chapter, 2019; 1223-75.
8. Gomi M, Naito K, Obayashi O. A large epidermoid cyst developing in the palm: a case report. *Int J Surg Case Rep.* 2013;4(9):773-777.
9. Farquharson.M, Hollingshead. J, Moran.B, Farquharson's Textbook of Operative General Surgery, Crc Press, Tenth Edition, Chapter 1, page 11.
10. Sushruta: Sushruta Samhita with commentary of Dalhana, edited by Vaidya Jadavaji Trikamji Acharya, Chowakhambasubhartiprakashan, Varanasi, reprint, Chikitsasthana, 12th Chapter, Verse, 2014; 3: 824-310