A physical examination showed a huge tumoral lesion, oval in shape, situated in the central occipital area slightly to the left side with an irregular surface area. It was associated with ulceration as well as serous discharge but with no bleeding. The mass was solid in consistency, mobile, measuring about (21 cm × 17 cm × 12 cm), and was not covered by hair. The surrounding skin was intact. Further examination revealed no palpable lymph nodes.

A non-contrast-enhanced computed tomography scan of the head was performed to evaluate the un-
derlying extent (Fig. 2), which revealed a soft tissue swelling within the subcutaneous scalp tissue with no bone involvement but with possible pericranium involvement.

The surgical options depending on the pericranium involvement ranged from complete excision and skin grafting as a one stage procedure, excision and rotational flap application, or excision with primary dressing closure and burr holing later with a secondary procedure of skin graft coverage. These options were discussed with the patient who expressed a preference for a single-staged procedure and consented to any of these options depending on the surgeons’ intraoperative findings.

Intraoperatively, the mass was managed by complete excisional biopsy under general anesthesia in the prone position. Further exploration showed a completely intact pericranium with a clear plane. The excision was done with a 0.5 cm clearance area all around as a safety margin with preservation of the pericranium. The defect closure was performed by using a split-thickness skin graft as a coverage solution.

The excised mass was sent for proper histopathologic diagnosis. Hematoxylin and eosin-stained sections of the mass revealed the diagnosis of a proliferating trichilemmal tumor (Figs. 3, 4). The patient was followed closely afterward in the clinic for two consecutive years. Further examination showed good coverage of the defect with no evidence of recurrence either locally or at other sites (Fig. 5).

Management options of PTT generally vary depending on its malignant tendency. Adequate excision with careful assessment of the surgical margins of the tumor is important and required for decreasing the likelihood of recurrence of low-grade malignant PTTs. Also, Mohs micrographic surgery, which ensures precise lesion margin control, can be performed to reduce the recurrence and metastasis rate after tumor resection [4,5]. The morbidity and mortality associated with these tumors is represented by their tendency to recur, which was documented in the literature to be around 3.7%, their tendency to metastasize, the difficulty of differentiating them from squamous cell carcinoma, and the recommendations to deal with it as a low-grade malignant carcinoma [5].

This case is special due to its long duration (35 years), together with its location in the scalp with later associated changes including foul smell and ulceration supporting the presence of infection; there
was no malignant transformation at all, nor any local or distant metastasis. This case is the largest in size ever reported in the literature, measuring 21 cm×17 cm×12 cm. Although the radiological findings suggested the involvement of the pericranium, surgical exploration and the management plan favored simple excision with a free margin and skin graft coverage. During extended follow-up, no signs or symptoms of recurrence were noted. This case illustrates the importance of the knowledge of the patterns of recurrence and the malignant potential of such lesions together with their application to various presentations.

References

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Pyoderma gangrenosum is a rare destructive cutaneous disease characterized by a painful, progressive, and necrotizing wound. Pathologically, pyoderma gangrenosum is a noninfectious neutrophilic dermatitis that usually starts with a sterile pustule, which rapidly progresses to a large painful ulcer with undermined violaceous borders [1].

The treatment of pyoderma gangrenosum has been well reviewed but not established. Conservative management utilizing prolonged, high-dose systemic corticosteroids and other immunosuppressive agents, in addition to gentle local wound care, characterizes traditional treatment of pyoderma gangrenosum.