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Editorial
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Pilomatricoma Mimicking Myelomeningocele

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Editorial

A 13 year-old female presented with a cervical lesion suggestive of myelomeningocele with one year of evolution. It had rapid growth in the last two months and she also complained of local pain (Figure 1). At the physical neurological examination, the patient presented no deficits.

The hypothesis of medullar dysraphism was raised regarding the location and characteristics of the lesion. She underwent a MRI that showed that the lesion was restricted to the skin (Figure 2).

The patient underwent complete tumor excision - "en bloc". No grafting was required. The histopathology and immunohistochemical exams confirmed the diagnosis of a conventional pilomatricoma.

Pilomatricoma is a benign skin tumor originating from the matrix cells of the hair follicles [1,2]. Diagnosis can be challenged specially in the cervical region, where other pathologies can be thought of. The most common localization are head and neck [1-3]. It has a malignant variant that is known as Pilomatrix carcinoma [3].

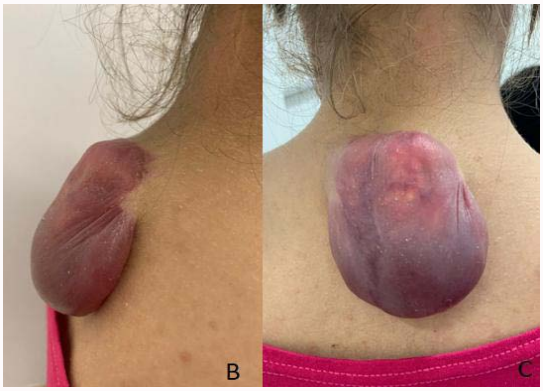

Figure 1: Macroscopic view of the lesion.

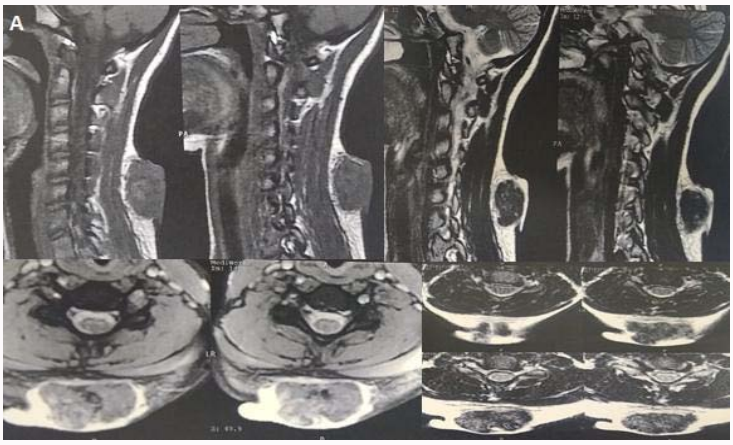

Figure 2: MRI showing that the lesion is restrict to the skin.

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Pilomatricoma usually occurs predominantly in female and it has a bimodal distribution occurs from 0 to 20 years and 50 to 60 years [1,3]. Clinically, it presents as a firm, subcutaneous tumor, similar to a stone, well demarcated [1,2]. Different from our case in what concern the lesion had a cystic aspect around, mimicking a myelomeningocele. But it had a stone-like structure below the cyst. They may also present with normal skin overlying or with a reddish or bluish tinge [1], which is similar to our case.

It usually present as a unique lesion variating from 4 cm to 6 cm [1]. When it appears as multiple lesions, it is associated with Gardner syndrome, constitutional mismatch repair deficiency, Kabuki syndrome, Steiner's myotonic dystrophy, hypercalcemia, sarcoidosis and/or Turner syndrome [1,2]. The differential diagnosis includes dermoid cysts, branchial cleft remnants, pre-auricular sinuses, adenopathies, sebaceous cysts, hemangiomas or malignant soft tissue tumors [1].

Surgical excision remains the gold standard of treatment with very low recurrence rates. The authors don't have any conflict of interest.

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