

EPIDERMAL CYSTS ASSOCIATED WITH REFRACTORY KELOID LESIONS: A THREE-CASE SERIES

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Running Title

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Word Count - 294 words

BACKGROUND

Refractory keloid lesions occasionally present with atypical clinical features such as recurrent inflammation, pain, pruritus, or discharge, raising suspicion of underlying pathology. This study aimed to describe the clinicopathologic characteristics of refractory keloid lesions in which epidermal cysts were identified after complete excision.

METHODS

Three patients with clinically diagnosed keloid lesions refractory to steroid-based treatment underwent complete excision and histopathologic evaluation. The first patient was a 57-year-old man who had undergone abdominal surgery for hepatocellular carcinoma 6 years earlier and subsequently developed an enlarged, pruritic postoperative lesion with purulent-like discharge after local steroid treatment. The second patient was a 29-year-old man with a rapidly enlarging anterior chest lesion that had developed after a deep abrasion and had not improved after intralesional steroid injection. The third patient was a 65-year-old woman who developed pain and recurrent discharge from a subumbilical lesion 5 years after laparoscopic gynecologic surgery. In all cases, the lesions were completely excised because of persistent symptoms, repeated inflammation, or poor response to conservative treatment.

RESULTS

Histopathologic examination revealed the coexistence of keloid tissue and epidermal cysts in all cases. Clinically, all lesions demonstrated treatment refractoriness and recurrent inflammatory symptoms, including pruritus, pain, discharge, or rapid growth. After surgical excision, keloid recurrence occurred in two patients; however, symptoms were effectively controlled with adjunctive steroid therapy. Notably, recurrent discharge and inflammatory episodes resolved completely following removal of the cystic component.

CONCLUSION

Refractory keloid lesions presenting with atypical features—such as recurrent inflammation, discharge, pain, pruritus, or rapid enlargement—may be associated with underlying epidermal cysts. In selected cases, complete excision with histopathologic evaluation may aid in definitive diagnosis and improve symptom control. Recognition of this association can guide management in keloid lesions with an unusual clinical course or poor response to steroid therapy.