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Preauricular pilomatricoma: An uncommon entity in a dental pediatric patient

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ABSTRACT

INTRODUCTION: Pilomatricomas are benign follicular skin appendage tumors, commonly occurring in children and young adults. Most patients admit to dermatologists to seek treatment and are well known by them; however, dental professionals, especially pediatric dentists are not familiar with these tumors.
PRESENTATION OF CASE: This report presents a 16-year-old female with preauricular pilomatricoma, located beneath the overlying skin of the temporomandibular region. Clinical examination revealed an asymptomatic lump, the overlying skin revealed no abnormalities. Patient was unaware of the lesion.
DISCUSSION: Pilomatricomas are commonly encountered in the maxillofacial region, although not considered in differential diagnosis by dental professionals. They usually present as, asymptomatic, subcutaneous masses; although symptomatic cases have been reported. In literature, common differential diagnosis for head and neck pilomatricoma includes sebaceous cyst, ossifying hematoma, giant cell tumor, chondroma, dermoid cyst, foreign body reaction, degenerating fibroxanthoma, metastatic bone formation, and osteoma cutis. We are of the opinion that temporomandibular joint disease should also be considered in differential diagnosis for preauricular pilomatricoma.
CONCLUSION: Pediatric dentists should be aware of the condition and consider it in the differential diagnosis of pediatric conditions involving the temporomandibular joint.

1. Introduction

Pilomatricomas are benign follicular skin appendage tumors, initially described in 1880 by Malherbe and Chenantais [1]. They can occur at any age, although children and young adults are mostly affected, 60% of cases are reported to occur within the first two decades of life [1,2]. They are most commonly reported in the head and neck region with preauricular region being one of the most frequent locations and have a wide variety of signs, which often causes misdiagnosis [2–4]. They present as solitary or seldom multiple lesions, which are commonly asymptomatic, superficial, subcutaneous hard masses demonstrating variable degrees of calcification, often attached to the skin but mostly mobile over the underlying tissues; as the tumor grows more superficial, a bluish color or ulceration of the overlying epidermis may be noted [1,2,5]. Treatment is by incision and curettage or by excision only [4].

In spite of high occurrence frequency, dental professionals have been rarely facing the lesion and pediatric dental literature publications are rare [1].

The aim of this paper is to present a case of preauricular pilomatricoma located in the maxillofacial region in a 16-year-old female, along with an analysis of literature in order to make a contribution to the pathogenesis, treatment and differential diagnosis of the lesion.

2. Presentation of case

Our case is reported in line with the SCARE criteria [6]. A 16-year-old female patient from the Society for Protection of Children was brought for dental care, to our pediatric outpatient clinic by her legal guardian. The patient's general medical history was unremarkable. Intra-oral examination revealed multiple caries lesions and radix relictea in all quadrants. A panoramic radiograph showed a calcified mass, which was superimposed to right mandibular

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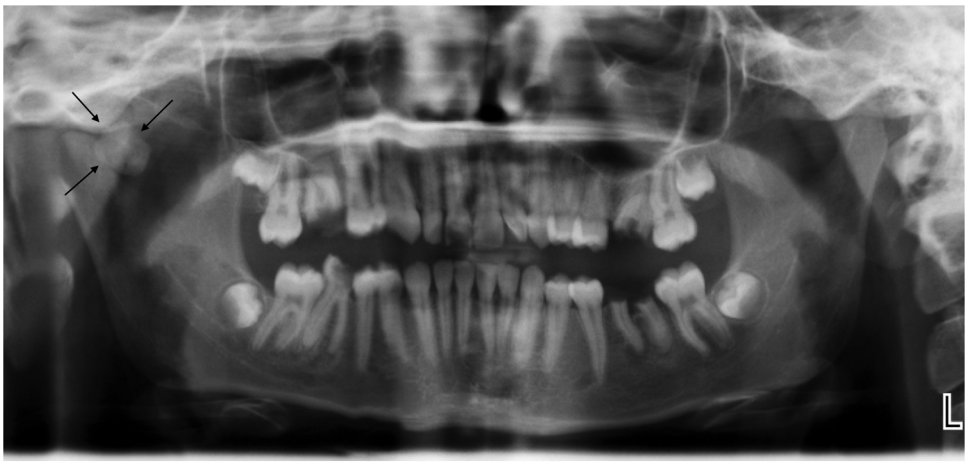

Fig. 1. Panoramic radiograph of the patient.

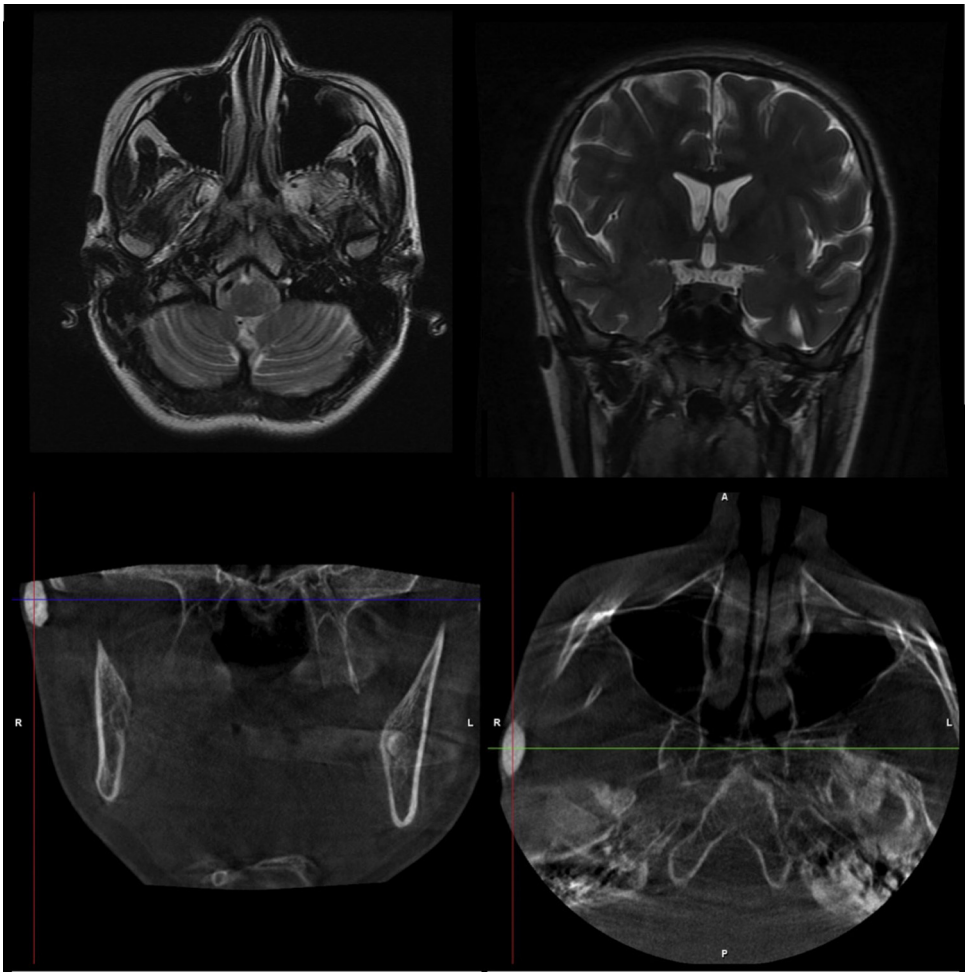

Fig. 2. Coronal and axial CBCT views and T1 axial and T2 coronal MRI views of the tumor.

condyle (Fig. 1). Patient was unaware of the lesion and had no complaints.

Head and neck examination revealed no evidence of adenopathy, paresthesia or motor nerve deficiency. However, physical examination revealed a hard, mobile mass measuring 1.5 × 1 cm, localized 1 cm anterior to the right crus of helix, in the overlying skin of the temporomandibular region. The skin covering the mass was normal.

In order to have a definition of the pathology and to minimize concerns of radiation to the child, initially, magnetic resonance imaging (MRI) was performed. MRI demonstrated signal void areas both on T1 and T2 images (Fig. 2a,b), which couldn't predict a differential diagnosis because of signal loss in the lesion. For this reason, it was decided to perform a cone beam computed tomography (CBCT) scan for obtaining a more precise location and definition of the pathologic features. CBCT demonstrated the calcified lesion lying