A novel and simple technique for treating pigmented follicular cysts

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Pigmented follicular cyst is a benign, asymptomatic and mostly solitary, recurrent intracutaneous (infundibular/terminal hair follicle) cyst of the mid dermis, and its wall is lined with stratified squamous epithelium and contains hair shafts [1–3]. It can be treated with excision biopsy. In case of multiple lesions, CO_2 laser and electrosurgery are useful, which provides a bloodless surgical field, precise ablation of lesions, and minimal scaring [4]. However, electrosurgery needs curettage of the cyst wall for avoiding recurrence. The laser is a better option for the pigmented follicular cyst, but it is a costlier device which

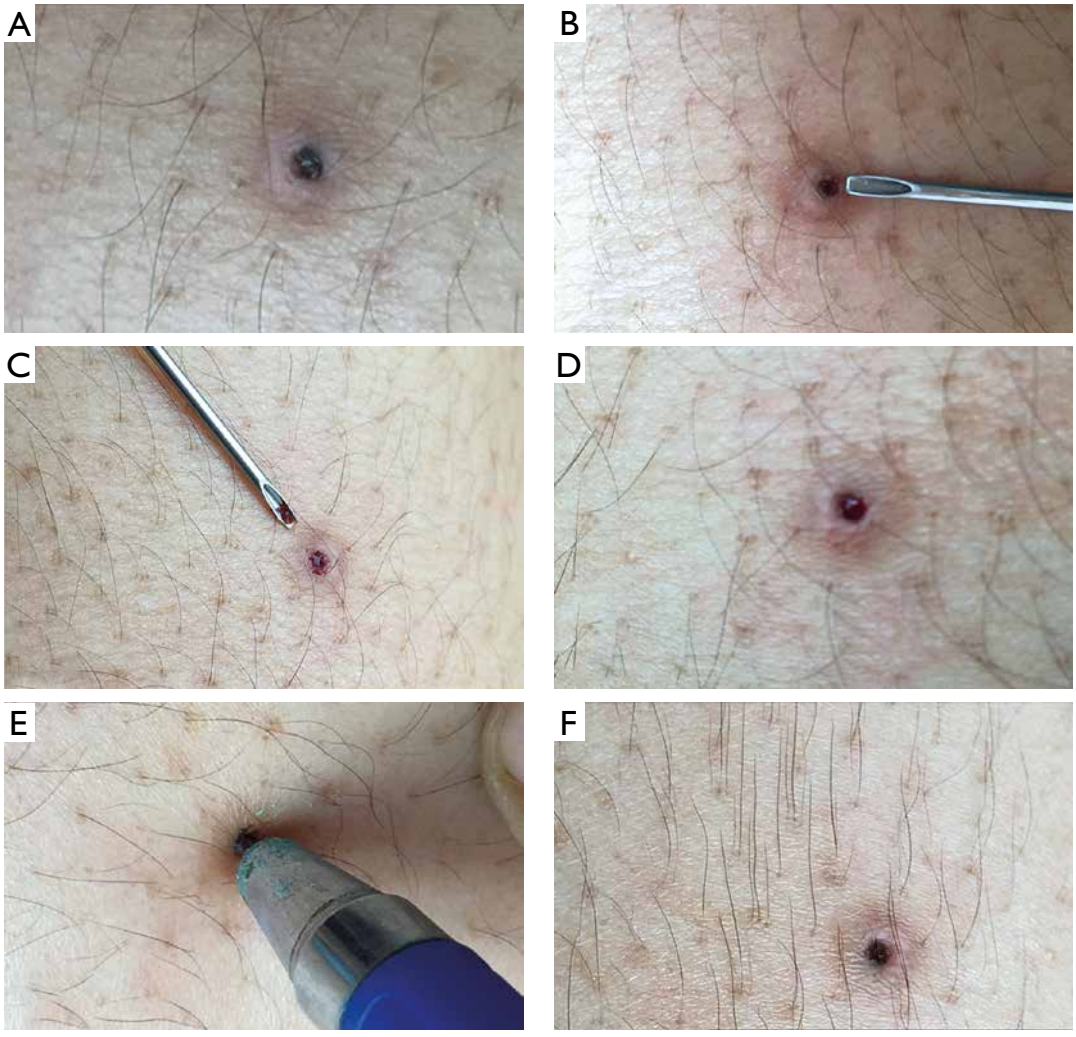

Figure 1. **A** – Pigmented follicular cyst. **B–D** – The pigmented content of the cyst is (after punched out) washed out and then curetted with a snipped 18G needle. **E, F** – The follicular cyst wall is cauterized with a chemical ball pen and left opened to heal

could not be installed in every outpatient office. The cyst should be enucleated or the wall of the cyst should be cauterized well after extraction of the pigmented keratinous content. Moreover, the problem lies in extraction of the content, cleaning (washing) of the cyst cavity, curettage and cauterization of the cyst wall. Extraction dermoscopy has been advised for proper treatment of the cyst [5].

A novel less invasive technique for treating the recurrent follicular cyst is described. First of all, the site is made aseptic with lotion povidone iodine and methylated spirit (70%) (fig. 1 A). After this, with or using local anaesthesia, a tiny prick incision (to broaden the orifice of the cyst) is given with a hypodermic needle. The content of the cyst is expressed out by punching the lesion, like comedone extraction, with the disposable syringe outlet. The remaining content of the cyst is washed away with water jet force using a syringe with a snipped needle. Following this, the distal portion of the 18G needle is cut with a nail cutter, and it is chemically disinfected before use. The cyst wall is mechanically curetted with a snipped needle with or without applying the topical local anaesthetic agents (figs. 1 B–D). Then the cavity of the cyst is cauterized with a chemical ball pen (which empty polytube refill is filled with 50 to 100% trichloroacetic acid) (figs. 1 E, F). The cauterized cyst is left opened and topical antibiotics are advised. The cyst healed with secondary intension in about 3 weeks. No recurrence of the cyst is observed during follow up for 3 months. The novelty of this technique is a combination of extraction of the content, cleaning, curettage and chemical cauterization of the cyst wall and this made an economical, effective and less invasive modality for treating the recurrent pigmented follicular cyst in the outpatient care units.

CONFLICT OF INTEREST

The author declares no conflict of interest.

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