Step-by-Step Sebaceous Cyst Excision: A Pictorial Guide

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INTRODUCTION

We demonstrate a step-by-step pictorial guide of the method we follow to excise sebaceous cysts. This technique minimizes the probability of cyst rupture due to minimal direct handling of the cyst itself. This method, if carried out correctly, is effective in ensuring that all cyst contents and the cyst wall are removed.

METHOD

STEP-BY-STEP GUIDE

1. Palpate the cyst and surrounding area to confirm its exact location and punctum. (Image 1)

2. Draw an ellipse around the punctum over the cyst with a skin marker. The longitudinal direction of the ellipse should be in the direction of the natural skin creases. (Image 2)

3. Infiltrate local anaesthesia using 2% Lignocaine with adrenaline.

4. Clean with anti septic solution. e.g. Betadine / Chlorhexadine.

5. Cover the skin around the site of the cyst with sterile drapes. (Image 3)

6. First incise the skin up to the subcutaneous tissues using a scalpel (Image 4).

7. Then, using blunt and sharp dissection, identify the plane between the cyst and surrounding subcutaneous tissues. (Image 5)

8. Once this plane is identified separate the superficial 25% of the circumference of the cyst with blunt dissection.

9. Now press the normal surrounding skin and soft tissues on both sides gently with the thumbs, first in one direction, then at 90 degrees to the previous direction. (Images 6 & 7)

10. Around 80-90% of the cyst emerges from the incised area.

11. Gently lift up the incised ellipse of skin and attached cyst with forceps, and separate the deep pole of the cyst from underlying tissues using scissors. (Image 8)

12. Ensure haemostasis and close the skin with non absorbable interrupted sutures. e.g. 6/0 Ethilon. (Image 9)

13. Clean the wound with saline solution and dry.

14. Apply steristrips and skin coloured tape.

IMAGES
DISCUSSION

Sebaceous cysts are benign, firm to fluctuant lesions that often occur behind the ears, on the face, neck, scalp, trunk and scrotum. They have a dark keratin plug overlying the cyst cavity and are usually mobile on palpation. They can range from a few millimetres to a few centimetres in diameter and their contents are a thick, foul smelling combination of keratin and lipids. The most common cause of a sebaceous cyst is rupture of a pilosebaceous follicle associated with acne. Other causes include a developmental defect of the sebaceous duct or traumatic implantation of surface epithelium beneath the skin.

We are not aware of another step-by-step pictorial guide for
this novel technique. The method described is effective in removing the cyst while ensuring it stays intact however, if handled roughly the cyst wall may still rupture.

References

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