

Safer and Less Unpleasant Incision and Drainage of Epidermal Inclusion Cysts

Letter to the Editor:

A number of methods exist for the treatment of epidermal inclusion cysts.¹⁻³ Intralesional steroids can be employed for mildly inflamed lesions, where in some cases not only inflammation but also the entire lesion may resolve with this modality. Piezosurgery can be used for small cysts. A small incision is made overlying the cyst through which the intact lesion is expressed by the application of pressure deep to the cyst. This method is notable for its cosmetically pleasing results. Enucleation of small to medium-sized lesions can be done by punching directly into the cyst's upper surface followed by extraction of the cyst's glistening capsule, grasped with toothed forceps or hemostat gently rotated in a clockwise or counterclockwise direction. Elliptical excision can be done for larger lesions where the wall of the lesion must be dissected out to ensure a low risk of recurrence. Incision and drainage may be re-

quired for large inflamed lesions combined with temporarily packing the area with a gauze wick and appropriate antibiotic coverage and cultures.^{1,2} The method involves incising into the cavity of the inflamed lesion and the application of lateral pressure to the side walls of the lesion by the surgeon's gloved hand.¹ It carries the troublesome risk of splashing the surgeon and assistants, and possibly any observers, like family members, who may be accompanying the patient to the office visit, with the cyst contents.⁴ Perhaps the risk of eye and mouth contact with the cyst contents carries the greatest risk, in that it inoculates potentially infectious biologic material onto mucous membrane surfaces. Wearing protective clothing and eyewear is usually recommended for such procedures.^{1,4}

Comedone extraction is done as an adjunct to the standard thera-

pies for comedonal acne.⁵ The procedure involves the application of lateral pressure to the sides of the comedone, open or closed, leading to extrusion of the contents of the dilated follicular lumen through the follicular orifice.⁶ For closed comedones, a small incision before extraction may be necessary to allow for extrusion of the material when the comedone extractor applies lateral pressure to the lesion.⁶

The authors use an inexpensive method, much akin to comedone extraction, for safely expressing and containing cyst contents during incision and drainage using the barrel of a standard disposable syringe. The cyst is first incised with a No. 11 scalpel blade following standard surgical preparation of the site (Figure 1). A syringe of the appropriate diameter is chosen that is about the size of the cyst diameter or slightly



Figure 1. Incised epidermal inclusion cyst.



Figure 2. The open end of the syringe barrel is positioned over the incised cyst.



Figure 3. The cyst's contents are expressed into the syringe barrel avoiding any spraying of foul-smelling material.

smaller. Typically, a 3- or 5-mL plastic syringe is used. The plunger of the syringe is removed, the barrel is inverted, and the larger open end is placed over the incision line covering the cyst (Figure 2). Gentle pressure is then applied vertically, and then horizontally, to express the cyst contents into the inverted barrel. The barrel traps the expressed cyst contents, preventing splashing of the usually foul-smelling keratinous contents of the cyst (Figure 3).

The method offers an inexpensive means of expressing a cyst's contents safely. The size of the syringe barrel can be varied depending on the size of the cyst allowing for the treatment of lesions of virtually any size. No sterilization is

required because a new disposable syringe is used for each patient. In addition, the containment of the cyst's malodorous contents makes this a less unpleasant procedure for both the surgeon and the patient.

References

1. Parlette HL. Management of cutaneous cysts. In: Wheeland RG, editor. *Cutaneous surgery*, 1st ed. Philadelphia: Saunders, 1994:p. 647-63.
2. Humeniuk HM, Lask GP. Surgical and medical treatment of benign cutaneous lesions. In: Lask GP, Moy RL, editors. *Principles and techniques of cutaneous surgery*, 1st ed. New York: McGraw-Hill, 2001:p. 221-33.
3. Humeniuk HM, Lask GP. Treatment of benign cutaneous lesions. In: Parish LC, Lask GP, editors. *Aesthetic dermatology*, 1st ed. New York: McGraw-Hill, 1990:p. 39-49.
4. Zuber TJ. Minimal excision technique for epidermoid (sebaceous) cysts. *Am Fam*

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5. Gollnick H, Cunliffe W, Berson D, et al. Management of acne: a report from a Global Alliance to Improve Outcomes in Acne. *J Am Acad Dermatol* 2003;49: S1-S38.
6. Plewig G, Kligman AM, editors. *Acne and rosacea*, 2nd ed. New York: Springer-Verlag 1993.

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