Esophageal ectopic sebaceous glands: endoscopic and histologic findings

Manuel A. Marcial, MD
Myriam Villafana, MD

Sebaceous glands are a normal component of pilosebaceous structures in the skin. In addition, sebaceous glands have been reported in the oral mucosa, vermilion border of the lips, prepuce, vulva, cervix, parotid glands, larynx, and esophagus. In these locations they have been referred to by terms such as chorista, heterotopia, or ectopic glands, all denoting the occurrence of normal tissue in an aberrant location. Within the buccal mucosa they are known as Fordyce’s spots or granules. Fordyce’s spots are usually detected in the post-pubertal years and are considered to peak in number during the third decade of life.¹ They are said to occur in up to 80% of adults¹ and therefore are not considered a disease. However, the finding of ectopic sebaceous glands in the esophagus is very rare.²⁴ We have followed a patient with ectopic sebaceous glands and gastroesophageal reflux for the past 11 years.

CASE REPORT

A 56-year-old man presented in 1982 with heartburn in the supine position and intermittent dysphagia. Endoscopy was initially performed in January 1982. Multiple small yellow plaques, slightly elevated above the esophageal mucosal surface, were noted in the upper and middle sections of the esophagus (Fig. 1A). No oral lesions were seen. The distal esophagus was erythematous, with leathery confluent erosions and a whitish exudate on the mucosa. A hiatal hernia was also documented. In addition, reddish nodularities were noted within the proximal duodenal mucosa; these were considered to be the result of hyperplasia of Brunner’s glands.

Mucosal biopsies obtained from the esophageal yellow plaques revealed sebaceous glands composed of large cells with dark, round, pyknotic nuclei and abundant vacuolated cytoplasm (Fig. 2). The esophageal epithelium overlying and adjacent to the sebaceous glands was unremarkable and showed no evidence of inflammation. Distal esophageal biopsy specimens revealed hyperplasia of the basal cell layer and scattered intra-epithelial eosinophils and neutrophils, diagnostic of esophagitis resulting from gastroesophageal reflux.

Because of recurrent symptoms, predominantly pyrosis and regurgitation, the patient underwent UGI endoscopy in October 1982, June 1984, September 1990, and May 1993. The endoscopic findings were virtually identical in every ex-
Figure 1. A, Endoscopic photo of esophageal Fordyce's spots. Yellow plaques are prominent in the mucosa (arrowheads). B, Endoscopic view of fundic gland heterotopia. Mucosal nodules are seen in the duodenum (arrowheads).

amination, with a slight variability in the degree of reflux esophagitis. The number of mucosal Fordyce's spots did not appear to change throughout the years, and the presence of ectopic sebaceous glands was confirmed by histologic examination on each occasion. Biopsy specimens of the polypoid nodularities of the proximal duodenum, thought to be hyperplasia of Brunner's glands (Fig. 1B), were taken during the last endoscopic procedure. These disclosed fundic gland heterotopia—gastric foveolar epithelium overlying fundic (oxyntic) glands containing parietal and chief cells (Fig. 3).

DISCUSSION

De la Pava and Pickren detected microscopically the presence of esophageal ectopic sebaceous glands in 4 of 200 autopsy subjects. Their post-mortem study included evaluation of the entire esophageal mucosa using a "Swiss roll" embedding technique. A single heterotopic focus was disclosed in 2 of the cases; two ectopic foci were noted in 1 case, and no data were given for the other. In no case was heterotopia detected on gross examination.

VOLUME 40, NO. 5, 1994

Figure 2. Photomicrograph of ectopic sebaceous glands (H&E, original magnification ×125). Inset (lower left): Cells with pyknotic nuclei and vacuolated cytoplasm (H&E, original magnification ×400).

Figure 3. Photomicrograph of fundic gland heterotopia. Oxyntic glands are seen adjacent to duodenal villi (H&E, original magnification ×125). Inset (lower right): Parietal cells with centrally placed nuclei (arrowheads) (H&E, original magnification ×400).

Zak and Lawson reported ectopic sebaceous glands in the esophagus during the autopsy of a 68-year-old man with polycythemia. The sebaceous glands were grossly visible in the middle esophagus. They favored the possibility that these lesions were metaplastic rather than heterotopic in origin.

Merino et al. reported sebaceous glands in a 38-year-old woman with symptoms of gastroesophageal reflux. Although microscopic examination revealed scattered foci of sebaceous glands, the so-called Fordyce's spots were not seen on endoscopy. These investigators concluded that most probably the sebaceous glands were heterotopic and that their finding was incidental and fortuitous, with no relationship to the patient's symptoms.

To our knowledge, our report represents the first documented case of an endoscopic diagnosis of esoph-
Mucinous cystadenocarcinoma of the pancreas: an uncommon presentation with hemobilia

Ka-Lau Leung, FRCS (Edin)
Wan-Yee Lau, FRCS (Edin), FRACS, FACS
John E. Cooper, FRCPA
Arthur K.C. Li, MA, MD, FRCS, FRACS, FACS

Cystic neoplasms of the pancreas are uncommon; only about 500 cases have been reported in the English literature.1 Patients usually present with epigastric pain or an abdominal mass, and the diagnosis is made by ultrasonography or CT. A case of pancreatic mucinous cystadenocarcinoma presenting with hemobilia and diagnosed by ERCP is reported, with a brief review of the medical literature.

CASE REPORT

An obese 30-year-old woman first presented to another hospital with acute, continuous epigastric pain radiating to the back. She did not drink, and her past health was good. Physical examination showed no pallor or jaundice, and her abdomen was soft, with only mild epigastric tenderness. Serum amylase level was 182 IU/L. Results of other blood investigations were normal. Serum amylase level was 270 IU/L, hemoglobin level was 12.0 g/dL, and results of other blood investigations were normal. Immediate UGI endoscopy confirmed the presence of coffee ground material in the stomach and fresh blood in the second part of duodenum. Hemobilia was suspected. Abdominal ultrasonography showed a persistent echogenic bowel gas. Her symptoms subsided soon after admission; the serum amylase level returned to normal, and she was discharged home.

The patient presented to us 3 weeks later with epigastric pain and hematemesis. Physical examination results were normal. Serum amylase level was 270 IU/L, hemoglobin level was 12.0 g/dL, and results of other blood investigations were normal. Immediate UGI endoscopy confirmed the presence of coffee ground material in the stomach and fresh blood in the second part of duodenum. Hemobilia was suspected. Abdominal ultrasonography showed a persistent echogenic line in the common bile duct, consistent with blood clots. Full examination of the pancreas by ultrasonography was impossible because of the patient’s obesity. ERCP done 1 day later showed a normal common bile duct with no filling defect, but a pancreatogram revealed a cystic lesion with filling defects communicating with the pancreatic duct in the tail of pancreas (Fig. 1). A cystic tumor with bleeding into the pancreatic duct was diagnosed. CT confirmed the presence of a 5-cm cystic lesion. Laparotomy revealed a cystic tumor at the tail of pancreas. Distal pancreactectomy and splenectomy were performed. The patient recovered uneventfully and was discharged 8 days after the operation.

Pathologic examination revealed a unilocular cyst measuring 5 cm in diameter. It contained blood-stained mucinous material, and two complex papillary-cystic structures.