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Sebaceous Adenoma

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Abstract
The presence of sebaceous glands in salivary neoplasms is frequent, however, and in spite of this, salivary neoplasms constituted partially or entirely of these cells are rarely observed. To the surgeon and pathologist, the major problem in dealing with sebaceous adenoma is the recognition of this rare entity, avoiding confusing with other more aggressive neoplasms. The treatment involves surgical excision.

Keywords: parotid gland, sebaceous adenoma, tumors

Introduction
WHO defines sebaceous adenoma as "It is a rare, usually well-circumscribed tumour composed of irregularly sized and shaped nests of sebaceous cells without cytologic atypia, often with areas of squamous differentiation and cystic change" [1]. Sebaceous glands are prominent adnexal components of the skin which are predominantly seen on the face and scalp. Normal glands vary in size from 0.2 to 2 mm in diameter, with the largest appearing in the skin of the nose and the concha of the ear [2]. Sebaceous glands secrete sebum.[3]Sebaceous differentiation in the oral mucosa and salivary glands is an expected normal finding; however, sebaceous neoplasms do occur in these regions, albeit rarely and with low recurrence potential.

Discussion
Approximately 50% of tumours arise in the parotid gland, 17% in the buccal mucosa, 13 % in the retromolar region or area of the lower molars and 8% in the submandibular region [1].

Sebaceous glands are holocrine glands in which the cell dies and secretions are discharged. These glands are normal skin appendages present throughout the skin, with the exceptionof the palms and soles [2]. Ectopic sebaceous glands are principally found in the major salivary glands, and are rarely seen in minor salivary glands [1, 3].

In the oral cavity, sebaceous glands normally appear as yellow-white spots, termed Fordyce spots, and are commonly seen on the vermillion border of the lip, the labial and buccal mucosa, and the retro-molar region [4].

The presence of sebaceous glands, or evidence of sebaceous differentiation, has been noted in submandibular and parotid salivary glands. Their presence in the oral cavity is thought to originate in the Intralobular ducts of the salivary glands [1].

However, an opposing school of thought states that the presence of sebaceous lobules derives from the inclusion of ectoderm in the oral cavity at the time of fusion of the maxillary and mandibular processes, during embryonic development [5].

Histological examination of sebaceous adenoma shows an encapsulated tumour consisting of nests of sebaceous cells in a fibrous stroma. These are well demarcated lesions with a multilobular pattern. The tumour comprises three types of cells: undifferentiated germinal cells (at the periphery), mature sebocytes and intermediate cells [2].

The secretory product of sebaceous glands is called sebum. Sebum comprises a mixture of lipids, including triglycerides, waxes, squalene, and cholesterol and its esters. Sebum may have weak antibacterial and antifungal properties [6].

Sebaceous adenoma should be differentiated from other, sebaceous-related lesions like Sebaceous hyperplasia, Sebaceous adenoma, Sebaceous carcinoma, Sebaceous Lymphadenoma.

Sebaceous adenomas are also found in Muir – Torre syndrome. This is an autosomal dominant condition characterised by a combination of sebaceous tumours of the skin and one or more internal malignancies, most commonly colon cancer [7].

An association with intraoral sebaceous adenomas has not been reported. However, as only a tiny number of intraoral sebaceous adenomas have been reported, an association of such tumours with Muir – Torre syndrome cannot be excluded at this stage.

Sebaceous adenomas do not recur after adequate excision, and the prognosis is excellent [2].

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