

Letter to Editor

Solitary Nodule: An Unsolicited Guest

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Dear Editor,

A 22-year-old female presented with a complaint of a solitary swelling over the inner aspect of right arm for the past 4 years, initially painless but was later associated with mild discomfort on pressure. There was no history of any trauma, discharge, fever or constitutional symptoms. She denied any similar swellings in other parts of the body. Dietary history revealed vegetarian food consumption. On physical examination, a firm, well-circumscribed, freely mobile nodule measuring approximately 10 × 0.5 cm was noted over the medial aspect of the right arm [Figure 1a and b]. There was no regional lymphadenopathy, and the remainder of the systemic examination was within normal limits. High-resolution ultrasonography of the nodule showed a well-defined, thin-walled cyst in the subcutaneous plane measuring approximately 13.7 × 3.9 mm with hyperechoic (calcified) content [Figure 2a]. The diagnosis was further confirmed on histopathological examination of the excised lesion, revealing a degenerated round-to-oval tri-layered cyst in the dermis. The cyst wall was thick, predominantly collagenised with focal calcification. Mild inflammatory infiltrate composed of lymphocytes, plasma cells and neutrophils, and occasional giant cells were present in the surrounding stroma along with mild fibrosis [Figure 2b]. These features were diagnostic of subcutaneous cysticercosis/cutaneous cysticercosis cellulosa. Subcutaneous cysticercosis represents an uncommon yet clinically significant manifestation of *Taenia solium* infestation. Although neurocysticercosis is more frequently encountered, soft tissue involvement, as in this case, may go unrecognised for years due to its indolent nature.^[1] The routes of infection typically involve ingestion of *T. solium* eggs through contaminated food or water. Notably, pork consumption is not a prerequisite; even strict vegetarians may develop cysticercosis through feco-oral transmission in endemic settings, as happened in our patient.^[2] Once ingested, the oncospheres penetrate the intestinal mucosa, disseminate hematogenously and encyst in various tissues, including subcutaneous planes and skeletal muscle.^[3] Clinically, subcutaneous cysticercosis may present as slowly enlarging, asymptomatic nodules, often misdiagnosed as benign swellings such as lipomas or epidermoid cysts. In our case, the prolonged 4-year duration without significant discomfort aligns with this classic presentation. Diagnostic suspicion often arises only after imaging with high-resolution ultrasonography playing a pivotal role. The presence of a well-defined cyst containing an echogenic scolex, with or without surrounding inflammatory changes, is highly suggestive of the diagnosis.^[4] Histopathological confirmation remains the gold standard. Although fine-needle aspiration cytology can occasionally detect parasitic fragments, its diagnostic yield is variable – especially in partially degenerated or calcified lesions.^[5] The histological identification of the scolex and cyst wall, along with a surrounding eosinophil-rich inflammatory infiltrate, confirms the diagnosis.^[5] Our patient did not have any history of seizures. Further workup in the form of ultrasonography of the abdomen and magnetic resonance imaging of the brain was

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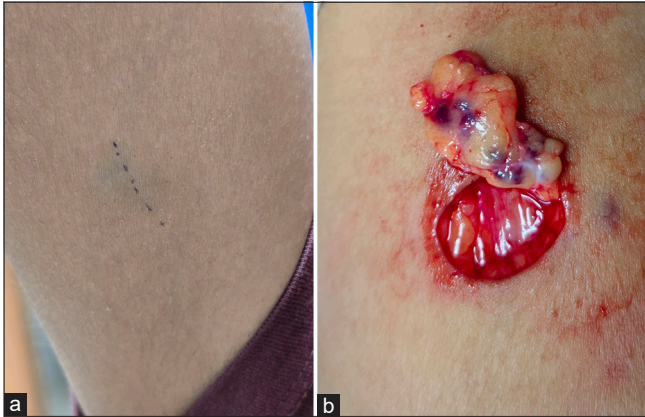


Figure 1: (a) A nodule measuring approximately 1×0.5 cm was noted while palpation over the medial aspect of the right arm with a bluish hue of the overlying skin. (b) Intra-operative image of the nodule within the subcutaneous layer.

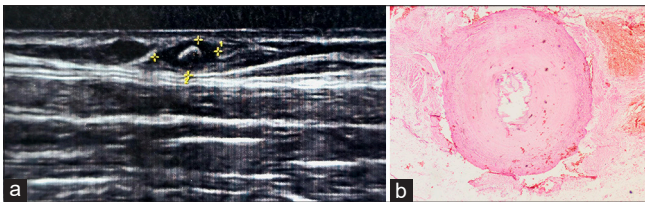


Figure 2: (a) High-resolution ultrasound showing a thin-walled cystic structure in the subcutaneous plane measuring approximately 13.7×3.9 mm with hyperechoic content suggestive of calcification. (b) Histopathology revealing a degenerated round to oval tri-layered cyst with predominantly collagenised thick cyst wall with focal calcification in the dermis (Haematoxylin and eosin stain, $\times 40$).

normal. Management of isolated subcutaneous lesions is typically straightforward. Surgical excision is both diagnostic and curative in symptomatic or uncertain cases. Medical therapy with albendazole or praziquantel may be considered in select cases, particularly if multiple lesions are suspected or in disseminated disease. In our case, excision was justified due to the long-standing nature of the nodule and to exclude other aetiologies. This case highlights the importance of

maintaining a differential diagnosis that includes parasitic infections when evaluating chronic subcutaneous swellings in the endemic regions. Awareness of the characteristic sonological features and appropriate use of histopathology can facilitate early diagnosis and prevent unnecessary interventions.

Ethical approval: Institutional Review Board approval is not required.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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