macrophage tissue response to a foreign material. However, no foreign body giant cells were observed.

We did find phlebothrombosis in 4 cases. Inflammatory phlebitis characterizes many cases of erythema nodosum and may be seen in the postphlebitic leg associated with lipomembranous panniculitis. We call attention to this because it was so frequently present and can be observed in inflammatory nodules of the skin and subcutaneous tissue.

We have observed rare cases of erythema nodosum in which the inflammatory infiltrate consists principally of masses of macrophages. Such cases could progress to form the typical Miescher nodule observed in some erythema nodosum cases. We believe that either some hosts are capable of an almost pure macrophage response or that in certain circumstances a monokine is produced in inflammatory tissue that elicits a massive macrophage response. It is conceivable that this may have occurred in the unique cases of wound healing reported here. Lipomembranous changes can be a normal tissue response to injury such as incision.

REFERENCES


Epidermal and Urethroid Penile Cyst

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The authors describe a 74-year-old man who presented with a 2-cm nodule on the ventral face of the penis, showing histologically a cyst lined by both epidermal and urethroid epithelium. The authors discuss the various histological forms of raphe median cysts of the penis. Key words: Median raphe; Urethra; Penis.

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Median raphe cysts result from an abnormal embryologic closure of the urethral groove (1). The cyst wall may derive from entodermal, ectodermal, or mucous glands which are a normal constituent of the male urethra (2). We report a case of a median raphe cyst with both ecto- and entodermal lining.

CASE REPORT

A 74-year-old white man presented with an asymptomatic nodule on the ventral face of the penis just outside the

![Fig. 1. Clinical aspect of the cyst on the ventral part of penis.](Acta Derm Venereol (Stockh) 70)
DISCUSSION

During embryogenesis, a ventral depression forms the urethral tube. The median raphe results from the closure of the tube (1, 2). The urethral mucosa has an entodermal origin, except for its glans portion which originates from an ectodermal component. In the case of an abnormal ventral midline fusion of the median raphe, cysts and canals may form (3, 4). The cysts result from embryonic remnants at the site of closure of the urethral groove and may occur anywhere between the meatus and the anus (1, 5). Despite the absence of connection with the urinary tract, cysts developing along the median raphe have been thought to be the result either of a defective fusion of the edges of the urethral groove or of an anomalous development of ectopic periurethral glands (Littre’s glands) (6). In the former explanation of its origin, the cyst has no attachment to the overlying epidermis and the cyst wall consists of a structure identical to urethral epithelium (urethroid epithelium) or of embryologic epithelial remnants.

In the latter explanation, the cyst wall contains intraepithelial mucous glands which are a normal constituent of the male urethra (4).

Median raphe cysts do not communicate with the urethra as urethral diverticula do. These cysts have to be differentiated from true epidermal cysts, steatocystomas and apocrine cystadenomas, which are not related to a defective closure of median raphe.

In our patient, the cyst wall was composed of epidermis, as found in epidermal cysts, and of urethroid epithelium, without any mucous glands. It may thus have resulted from the growth of congenitally buried epithelium at the site of a defective fusion of ectoderm and entoderm on the distal portion of the median raphe. This type of cyst is different from the urethroid cyst, as described by Paslin (7), formed exclusively by budding and separation of urethral epithelium without any epidermal component.

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