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Petunjuk Penulisan

Format penyusunan manuskrip
Manuskrip diketik pada kertas berukuran A4 (210 x 297 mm) dengan batas tepi 254 mm (*margin Normal)*, huruf diketik dengan tipe huruf (*font) Times New Roman*, besar huruf (*font size*) 12 point dengan menggunakan spasi rangkap 2 (*double space*). Setiap bagian dari manuskrip dimulai pada halaman baru dengan urutan sebagai berikut: halaman judul, abstrak dan kata kunci (*keywords*), teks keseluruhan, ucapan terima kasih, daftar pustaka, tabel dan gambar (setiap tabel dan gambar pada halaman terpisah). Nomor halaman dicantumkan secara berurutan dimulai dari halaman judul pada sudut sebelah kanan bawah. Manuskrip sebaiknya ditulis maksimal 16 halaman.

Halaman judul
Halaman judul mencakup: a) judul manuskrip yang dibuat sesingkat mungkin, spesifik informatif dan ringkasan judul tidak lebih dari 40 karakter (hitung huruf dan spasi) yang dicantumkan dibawah judul, b) nama penulis disusun berurutan dengan nama mahasiswa sebagai pengarang pertama, diikuti oleh Pembimbing sebagai pengarang kedua. Nama penulis ditulis lengkap tanpa gelar dan dicantumkan seperti aslinya, tidak dibalik seperti pada daftar pustaka dan sitasi, c) alamat setiap penulis, nama departemen dan lembaga afiliasi penulis, d) nama dan alamat penulis untuk korespondensi serta nomor telepon, nomor faksimili, alamat email. Judul penelitian dibuat jelas, singkat, spesifik, informatif, dan sesuai dengan topik manuskrip. Jumlah kata tidak lebih dari 12 kata agar mudah dan cepat dipahami pembaca.

Abstrak dan kata kunci
Abstrak berjumlah 200-250 kata ditulis dalam bahasa Indonesia dan Inggris. Abstrak berisikan latar belakang termasuk tujuan penelitian, metode, hasil, dan kesimpulan. Kata kunci dicantumkan di bawah abstrak pada halaman yang sama sebanyak 4-6 kata. Bagian abstrak merupakan ringkasan dari isi makalah yang dibuat secara singkat, informatif, dengan menekankan pada aspek baru dan penting dari penelitian.

Teks
Teks makalah manuskrip dibagi dalam beberapa bagian dengan judul sebagai berikut: ***Pendahuluan, Metode, Hasil, Pembahasan, Kesimpulan dan saran.***

Pendahuluan
a. Latar belakang merupakan bagian yang menjelaskan alasan mengapa masalah ini penting untuk diteliti. Bagian ini memuat penjelasan mengapa masalah itu dipandang menarik, penting, dan perlu diteliti untuk mencari pemecahannya. Penjelasan dapat diperoleh dari penelusuran pustaka yang berkaitan erat dengan masalah yang diteliti.
b. Keaslian penelitian dikemukakan dengan menunjukkan bahwa masalah yang dihadapi belum pernah dipecahkan oleh peneliti terdahulu atau dinyatakan dengan tegas perbedaan penelitian ini dengan penelitian terdahulu.
c. Tujuan penelitian yang menjelaskan hasil yang akan dicapai.

Metode
Metode penelitian berisi uraian terpadu dan sistematis mengenai bagaimana penelitian akan dilaksanakan. Metode terdiri dari :
a. Desain
b. Populasi / sampel (subjek) penelitian
Diuraikan kriteria inklusi dan eksklusi subjek penelitian, cara pemilihan sampel (subjek penelitian) secara random atau non-random, serta besar sampel yang akan di pilih. Teknik pemilihan sampel harus dijelaskan secara rinci. Bila perlu dibuat alur pemilihan sampel.
c. Bahan dan alat serta pengukuran
Bahan dan alat yang harus disajikan pada laporan terbatas pada bahan (materi) dan alat utama yang diperlukan untuk penelitian dan harus disebutkan spesifikasinya. Prosedur pengukuran perlu dijelaskan sesuai dengan tahapan yang dilakukan.
d. Alur kerja penelitian
Jalannya penelitian perlu dijelaskan mengenai jenis pendekatan yang dipakai untuk
mendapatkan data, melalui pendekatan laboratorium, klinik, komunitas, observasi, dll.
e. Analisis data
Perlu dijelaskan jenis teknik statistik yang digunakan untuk menjawab masalah dan mencapat tujuan penelitian. Data yang diperoleh dapat dianalisis menggunakan teknik statistik secara parametrik dan non-parametrik.

Hasil
Suatu hasil penelitian hendaknya disajikan dengan jelas, logis, runut, sehingga mudah untuk dimengerti. Hasil penelitian sebaiknya ditampilkan selain dalam bentuk narasi dapat pula berupa gambar, tabel, foto, dan grafik sehingga memudahkan untuk dipahami. Hasil dan interpretasi analisis statistik dituliskan secara jelas dalam uraian hasil penelitian.
Pada tahap awal disajikan distribusi karakteristik subjek penelitian, yang biasanya dibuat pada sebuah tabel. Kemudian disajikan temuan penting yang diperoleh, kalau cukup banyak sebaiknya pada sebuah tabel. Bila terbatas misalkan hanya satu atau dua temuan cukup dalam bentuk narasi/teks.
Tabel, bagan/gambar, grafik dibuat dengan jelas, diberi nomor urut serta keterangan yang jelas. Keterangan

tabel diletakan di atas tabel dan keterangan gambar diletakkan di bawah gambar. Maksimal tabel dan gambar 5. Semua tabel, grafik dan gambar diberi nomor dan keterangan yang jelas. Setiap tabel dianalisis dan diinterpretasi secara sistematik, dan hasilnya ditulis di bawah tabel tersebut. Perhitungan statistik detail tidak perlu ditulis dalam bagian hasil ini. Bila perhitungan statistik dianggap perlu ditulis, maka sebaiknya diletakkan dalam lampiran saja.

Pembahasan

Langkah awal harus diuraikan temuan penting yang diperoleh dari penelitian sesuai dengan tujuan penelitian. Kemudian bandingkan hasil penelitian yang diperoleh dengan hasil-hasil penelitian sebelumnya. Perlu dijelaskan kesesuaian dan ketidaksesuaian hasil penelitian yang didapat terhadap kerangka teori atau hasil penelitian lain yang telah dilakukan sebelumnya. Selanjutnya menggunakan teori-teori yang ada uraikan mekanisme terjadinya hasil penelitian tersebut. Bagian pembahasan juga menjelaskan mengenai kelemahan dan kelebihan penelitian yang telah dilakukan. Uraikan implikasi dari hasil penelitian yang diperoleh.

Kesimpulan

Kesimpulan hendaknya dibuat dalam bentuk narasi dan menguraikan secara singkat, jelas, padat menurut urutan yang sistematis. Bagian ini memuat tentang hasil penelitian yang telah diperoleh untuk menjawab tujuan penelitian. Saran menguraikan perlunya dilakukan penelitian lebih lanjut untuk memperbaiki kelemahan/ keterbatasan dari penelitian yang telah dilakukan.

Ucapan terima kasih

Ditujukan kepada pihak-pihak yang memberikan bantuan dana dan dukungan antara lain dukungan dari bagian dan lembaga, para professional yang memberikan kontribusi dalam penyusunan makalah, dan untuk penguji I maupun penguji II. Pembimbing tidak perlu dicantumkan pada Ucapan Terima Kasih karena sudah dicantumkan sebagai penulis.

Daftar Referensi

Daftar referensi/rujukan hanya mencatumkan rujukan yang telah digunakan dan ditulis menurut sistem Vancouver.

Online Submission

Penulis dapat mengirim naskah manuskrip melalui *online submission* di *website* Jurnal Biomedika dan Kesehatan.

Langkah online submission:

1. Pastikan naskah yang akan diunggah sudah mengikuti semua petunjuk penulisan
2. Lakukan pendaftaran author di : https://jbiomedkes.org/index.php/jbk/user/register
3. Setelah terdaftar silakan unggah naskah manuskrip dan isi form yang terdapat di dalam website, dan ikuti langkah selanjutnya.

Daftar Cek Pengiriman Naskah Manuskrip

□ Naskah manuskrip belum pernah dipublikasikan sebelumnya, juga tidak dalam pengajuan ke jurnal lain.
□ File manuskrip harus berformat OpenOffice, Ms. Word atau RTF dokumen, *font* 12, *Times New Roman, double spacing.*
□ Halaman judul harus memuat jelas judul, nama lengkap penulis tanpa gelar, departemen penulis, universitas, alamat lengkap, nomor telepon dan email.
□ Pelaporan data manuskrip dari penelitian yang melibatkan manusia dan hewan memerlukan persetujuan formal (kaji etik) oleh dewan peninjau atau komisi etik institusi yang bersangkutan.
□ Daftar rujukan memuat semua rujukan yang terdapat di dalam manuskrip dan ditulis sesuai urutan pengutipannya menggunakan sistem Vancouver.

Daftar Isi

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CASE REPORT

Eyelid Dermoid Cyst: A Case Report

Palpebral Kista Dermoid

Riani Witjaksana[1], Husnun Amalia[1], Nany Hairunisa[2], Erlani Kartadinata[1], Anggraeni Adhiwardani[1], Noviani Prasetyaningsih[1]

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ABSTRACT

Dermoid and epidermoid cysts are prevalent benign orbital tumors in childhood, representing 3-9% of pediatric ocular tumors. Occasionally, dermoid cysts can attain significant size, leading to cosmetic deformities. A precise surgical approach to dermoid cysts can lead to considerable cosmetic improvement for the patient.

A 19-year-old female presented with swelling in the outer corner of her left eye, accompanied by minor discomfort in the affected area. Upon ophthalmologic examination 1.5x1 cm masses were detected in the upper left eyelid near the lateral canthus Clinical diagnosis of Dermoid cyst left eye upper eyelid made. Subsequently, a surgical excision under general anesthesia was scheduled. During the procedure, the cyst was successfully excised while preserving the cyst wall integrity.

The conclusion is imperative for ophthalmologists to recognize the necessity of precisely performing surgical excision of these cysts to achieve favorable functional and aesthetic outcomes.

Keywords: Dermoid Cyst; Epidermoid Cyst; Surgical Management; Pediatric Ocular Tumors; Eyelid.

ABSTRAK

Epidermoid dan dermoid merupakan tumor jinak pada orbita yang paling sering ditemukan pada anak dengan prevalensi 3-9%. Pada keadaan tumor yang besar dapat menyebabkan gangguan kosmetik pada penderitanya. Tindakan operatif sebaiknya dilakukan secara terencana agar didapatkan hasil kosmetik yang baik untuk Pasien

Perempuan 19 tahun datang dengan keluhan pembengkakan pada bagian atas kelopak atas mata kiri. Pada pemeriksaan didapatkan benjolan dengan ukuran 1.5x1 cm pada lateral kelopak mata dekat kantus lateral. Pasien didiagnosis dengan kista dermoid palpebra superior mata kiri. Pasien dilakukan Tindakan operatif dalam anestesi umum. Kista demoid dieksisi secara utuh.

Kesimpulannya adalah sangat penting bagi dokter mata untuk melakukan tindakan eksisi terencana untuk mencapai hasil estetik dan fungsi yang baik.

Kata Kunci: Kista Dermoid; Kista Epidermoid; Penatalaksanaan Opertif; Tumor Pada Anak; Kelopak Mata.

INTRODUCTION

Dermoid and epidermoid cysts are relatively common benign orbital tumors of childhood, constituting 5-9% of pediatric ocular tumors and accounting for 3-9% of all orbital masses.[1-4] These cysts typically arise from the sequestration of surface ectodermal elements during the closure of fetal suture lines in embryogenesis, often co-occurring with other congenital abnormalities. They can manifest in various locations within the orbit, such as the supratemporal and lacrimal sac areas.[2-4] Superficial cysts tend to become symptomatic during childhood, whereas deeper orbital dermoids may not become clinically apparent until adulthood.[1-4,6-7]

Orbital dermoid cysts most frequently appear in the lateral brow near the Fronto-Zygomatic Suture (FTZ), presenting as smooth, painless, oval masses that grow slowly. These masses may exhibit mobility or may be fixed to the periosteum at the underlying suture.[1,5,8-9]

Surgical excision stands as the primary treatment for dermoid cysts, supported by numerous case reports confirming this approach through histopathological analysis. Overall, complete surgical excision remains the cornerstone for managing eyelid dermoid cysts, emphasizing meticulous removal to achieve favorable cosmetic results and minimize the likelihood of recurrence.[5]

CASE REPORT

A 19-year-old female presented to the outpatient department with complaints of swelling in the upper eyelid of her left eye, accompanied by mild intermittent pain in the affected area. The parents reported noticing this change when she was a year old, with intermittent growth observed over the past few years. There were no reports of diplopia on vertical gaze.

The ophthalmic examination revealed normal visual acuity in both eyes (1.0), normal intraocular pressure (13,4 mmHg), and unremarkable findings on both biomicroscopic and ophthalmologic assessments. Eye movements were within normal limits. Examination of the left eye identified a 1.5 cm x 1cm protrusion located 1/3 laterally from the upper eyelid margin, 0.5 cm above it. A tender, cystic structure measuring 0.5cm was palpable and fixed to the subcutaneous tissue. A clinical diagnosis of a dermoid cyst in the left upper lid was established, with X-ray imaging performed to asses orbital involvement and bone erosion. A surgical excision under general anesthesia was scheduled.

On 15 July 2023, an excision surgery was conducted wherein a horizontal incision was performed along the eyelid crease, leading to the dissection of the skin. The cyst wall was then located, and through careful blunt dissection, it was separated from its surrounding attachment. Subsequently, precise sharp dissection was carried out until the surface of the cyst was reached, allowing for the complete removal of the cyst without causing any rupture to its wall. The wound was then closed using a Nylon 6-0 suture. The excised specimen was sent for histopathological examination which revealed the presence of squamous epithelium lining with dermal components such as hair follicles, sebaceous, and sweat glands, thereby confirming the diagnosis of a dermoid cyst. Postoperatively, the patients exhibited a favorable cosmetic outcome, with no signs of inflammatory response during the subsequent follow-up examination. Wound closure was performed with Nylon 6-0 suture.

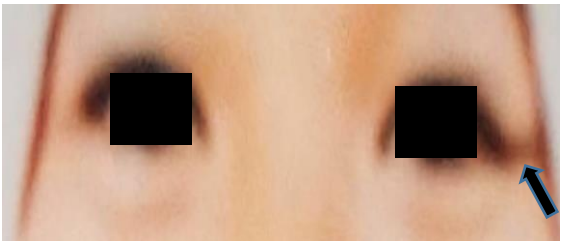

Figure 1. Pre-operative

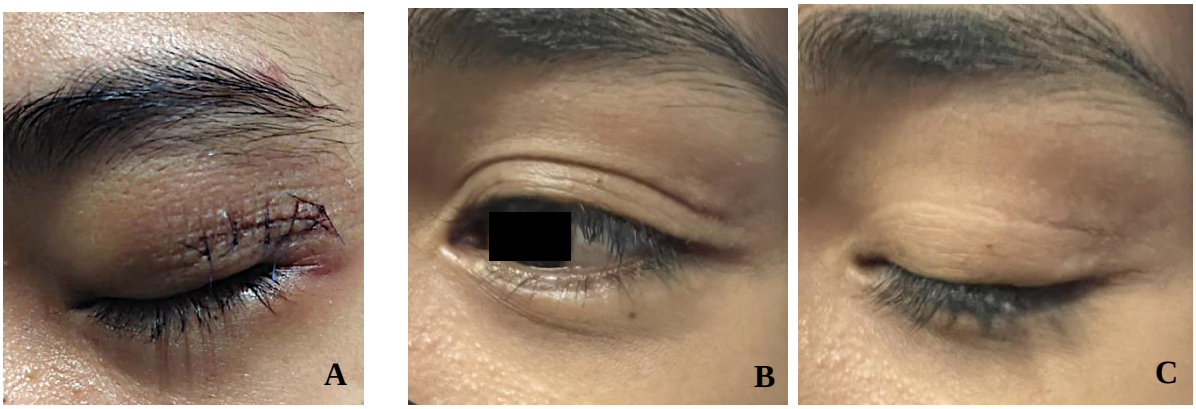

Figure 2. Post-operative: A. day-1, B and C. 1 month.

DISCUSSION

Dermoid cyst represents the frequently used clinical term for benign cystic teratoma, choriostoma resulting from the entrapment of surface ectoderm into underlying mesenchyme along the embryonic line of fusion.[1] These cysts emerge as a consequence of the proliferation of epidermal cells within a restricted region of the dermis.[10] The majority of dermoid cysts identified in ophthalmic clinical scenarios are superficial, typically presenting in early childhood as noticeable swellings in the eyebrow or eyelid.[1,3,4] Orbital dermoid cysts can be categorized according to several criteria including juxta-sutural, sutural, or soft tissue location; superficial or deep positioning; intraosseous or extraosseous presence; and intraorbital or extraorbital localization. Periocular and orbital dermoid cysts are commonly divided into superficial and deep lesion categories.[1,4,10] Certain inherited syndromes have been linked to epidermoid cysts such as Gardner syndrome, basal cell nevus syndrome, and pachyonychia congenital.[2] These cysts, which are smooth, painless, and either mobile or partially mobile, typically appear in the FTZ region. Symptoms such as proptosis, displacement, ptosis, or diplopia, which vary based on the depth and size of the cysts. Dermoid cysts in the orbit are commonly linked with the Fronto-Zygomatic and Fronto-Ethmoidal sutures, which play a significant role in their developmental process.[5,6,8,9]

Deep orbital dermoid cysts are seldom observed, challenging to diagnose, and necessitate more elaborate surgical procedures such as orbitotomy. Typically, the identification of an orbital

dermoid is established before surgery through the assessment of the cyst's location, texture, and characteristic features on imaging modalities like X-ray or CT-scan.[6-8,10]

Orbital dermoids require surgical excision due to their tendency to increase in size and release their contents into surrounding tissues. The cyst's contents are highly irritating and can lead to a severe inflammatory response, which results in fibrosis. It is advised to completely remove the dermoid together with its cyst wall through a surgical method that allows for ideal access to all parts of the lesion [1,5,11] While the primary aim of surgery is the total removal of epidermal and dermal component, some patients may manifest with the recurrent intraorbital lesion, introducing the challenging aspect of a delicate, scarred cyst all adhering closely to normal orbital structures. Aggressive removal of the recurrent lining may result in functional deficits postoperatively. In certain instances, although not ideal, surgical fistulization or marsupialization may be considered as a feasible alternative.[5]

In 1988, Kronish and Dorzbach provided a summary of previously proposed methods for removing dermoid cysts, which include: (1) performing a direct incision directly over the mass, (2) making incisions above, below, or through the eyebrow, (3) utilizing a superomedial approach through a Lynch incision, (4) performing medial lid splitting, (5) conducting a lateral canthotomy, and (6) making an incision in the upper lid crease.[1]

An incision in the eyelid crease is recommended for the management of superficial supertemporal dermoid cysts. This particular incision provides favorable exposure, helps avoid vital structures, and results in an improved cosmetic outcome. when dealing with cysts located anterior to the FTZ, a superior eyelid crease incision offers sufficient exposure and favorable cosmetic results compared to an incision directly above the lesion.[4,5] Cysts located well above the FTZ necessitate an infra-brow or low intra-brow incision to reduce the risk of frontal branch of the facial nerve damage associated with an eyelid crease approach, and to prevent inadvertent transection of the frontalis muscle that may occur with an incision directly over the cysts.[5,13] Intraorbital cysts that expand from the lateral orbital wall sutures may present in early childhood but are more frequently diagnosed in adolescence and adulthood, as proptosis resulting from cyst expansion becomes more apparent.[1,4,5] The majority of the lateral intraorbital dermoid cysts demonstrate osseous involvement, potentially leading to pressure erosion or an atypical morphology, emphasizing the significance of understanding the interaction between the cyst and bone in surgical planning. Complete excision of all epidermal elements of the cyst is imperative, and in instances where there exists a close association between the cyst wall and the bone, bone burring might be deemed necessary.[4,8,9]

Aspiration of cyst walls was contraindicated owing to the potential recurrence of the cyst and the provocation of a severe inflammatory response. Poorly planned, delayed, partial removal or inadvertent rupture of the cyst could trigger an inflammatory reaction and lead to lasting consequences such as the development of an orbicutaneous fistula.[1,8,9]

Complications associated with epidermoid cysts include infection, malignant transformation, and rupture. The frequency of malignant transformation from an epidermoid cyst to cutaneous squamous cell carcinoma is typically low, varying from 0.011% to 0.045%. In our case, there were no visible clinical signs of infection.[14,5]

CONCLUSION

Depression and obesity are two prevalent disorders with a substantial influence on worldwide health and are closely linked and important health conditions. Various factors, including biological, psychological, and behavioral aspects, can impact the intricate relationship between depression and obesity, and play a role in maintaining the two-way relationship.

Interactions between modern antidepressants and newer antipsychotic medications are often significant in clinical practice. Weight gain is a common side effect of antidepressants and antipsychotics. Therefore, it is crucial to educate patients about drug side effects, hunger regulation, the importance of family support, and regular exercise from the start of treatment for depression and obesity. It is also crucial for psychiatrists and dietitians to collaborate to get the best therapeutic outcomes for patients with obesity and depression.

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AUTHORS CONTRIBUTION

All authors contributed to this article.

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CONFLICT OF INTEREST

We declare that we have no conflicts of interest to disclose.

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Eyelid Dermoid Cyst: A Case Report

by Anggraeni Adiwardhani FK

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ABSTRAK

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Perempuan 19 tahun datang dengan keluhan pembengkakan pada bagian atas kelopak atas mata kiri. Pada pemeriksaan didapatkan benjolan dengan ukuran 1.5x1 cm pada lateral kelopak mata dekat kantus lateral. Pasien didiagnosis dengan kista dermoid palpebra superior mata kiri. Pasien dilakukan Tindakan operatif dalam anestesi umum. Kista demoid dieksisi secara utuh.

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Kata Kunci: Kista Dermoid; Kista Epidermoid; Penatalaksanaan Opertif; Tumor Pada Anak; Kelopak Mata.

INTRODUCTION

Dermoid and epidermoid cysts are relatively common benign orbital tumors of childhood, constituting 5-9% of pediatric ocular tumors and accounting for 3-9% of all orbital masses.[1-4] These cysts typically arise from the sequestration of surface ectodermal elements during the closure of fetal suture lines in embryogenesis, often co-occurring with other congenital abnormalities. They can manifest in various locations within the orbit, such as the supratemporal and lacrimal sac areas.[2-4] Superficial cysts tend to become symptomatic during childhood, whereas deeper orbital dermoids may not become clinically apparent until adulthood.[1-4,6-7]

Orbital dermoid cysts most frequently appear in the lateral brow near the Fronto-Zygomatic Suture (FTZ), presenting as smooth, painless, oval masses that grow slowly. These masses may exhibit mobility or may be fixed to the periosteum at the underlying suture.[1,5,8-9]

Surgical excision stands as the primary treatment for dermoid cysts, supported by numerous case reports confirming this approach through histopathological analysis. Overall, complete surgical excision remains the cornerstone for managing eyelid dermoid cysts, emphasizing meticulous removal to achieve favorable cosmetic results and minimize the likelihood of recurrence.[5]

CASE REPORT

A 19-year-old female presented to the outpatient department with complaints of swelling in the upper eyelid of her left eye, accompanied by mild intermittent pain in the affected area. The parents reported noticing this change when she was a year old, with intermittent growth observed over the past few years. There were no reports of diplopia on vertical gaze.

The ophthalmic examination revealed normal visual acuity in both eyes (1.0), normal intraocular pressure (13,4 mmHg), and unremarkable findings on both biomicroscopic and ophthalmologic assessments. Eye movements were within normal limits. Examination of the left eye identified a 1.5 cm x 1cm protrusion located 1/3 laterally from the upper eyelid margin, 0.5 cm above it. A tender, cystic structure measuring 0.5cm was palpable and fixed to the subcutaneous tissue. A clinical diagnosis of a dermoid cyst in the left upper lid was established, with X-ray imaging performed to asses orbital involvement and bone erosion. A surgical excision under general anesthesia was scheduled.

On 15 July 2023, an excision surgery was conducted wherein a horizontal incision was performed along the eyelid crease, leading to the dissection of the skin. The cyst wall was then located, and through careful blunt dissection, it was separated from its surrounding attachment. Subsequently, precise sharp dissection was carried out until the surface of the cyst was reached, allowing for the complete removal of the cyst without causing any rupture to its wall. The wound was then closed using a Nylon 6-0 suture. The excised specimen was sent for histopathological examination which revealed the presence of squamous epithelium lining with dermal components such as hair follicles, sebaceous, and sweat glands, thereby confirming the diagnosis of a dermoid cyst. Postoperatively, the patients exhibited a favorable cosmetic outcome, with no signs of inflammatory response during the subsequent follow-up examination. Wound closure was performed with Nylon 6-0 suture.

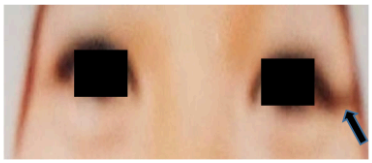

Figure 1. Pre-operative

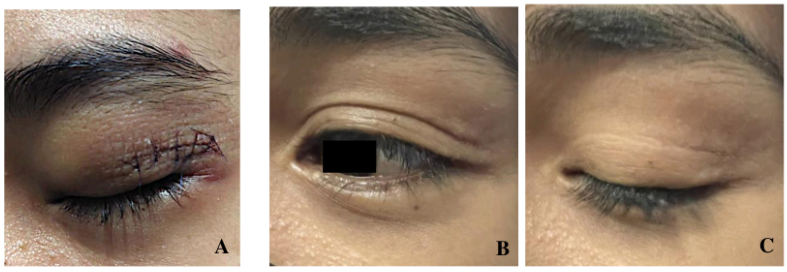

Figure 2. Post-operative: A. day-1, B and C. 1 month.

DISCUSSION

Dermoid cyst represents the frequently used clinical term for benign cystic teratoma, choriostoma resulting from the entrapment of surface ectoderm into underlying mesenchyme along the embryonic line of fusion.[1] These cysts emerge as a consequence of the proliferation of epidermal cells within a restricted region of the dermis.[10] The majority of dermoid cysts identified in ophthalmic clinical scenarios are superficial, typically presenting in early childhood as noticeable swellings in the eyebrow or eyelid.[1,3,4] Orbital dermoid cysts can be categorized according to several criteria including juxta-sutural, sutural, or soft tissue location; superficial or deep positioning; intraosseous or extraosseous presence; and intraorbital or extraorbital localization. Periocular and orbital dermoid cysts are commonly divided into superficial and deep lesion categories.[1,4,10] Certain inherited syndromes have been linked to epidermoid cysts such as Gardner syndrome, basal cell nevus syndrome, and pachyonychia congenital.[2] These cysts, which are smooth, painless, and either mobile or partially mobile, typically appear in the FTZ region. Symptoms such as proptosis, displacement, ptosis, or diplopia, which vary based on the depth and size of the cysts. Dermoid cysts in the orbit are commonly linked with the Fronto-Zygomatic and Fronto-Ethmoidal sutures, which play a significant role in their developmental process.[5,6,8,9]

Deep orbital dermoid cysts are seldom observed, challenging to diagnose, and necessitate more elaborate surgical procedures such as orbitotomy. Typically, the identification of an orbital

dermoid is established before surgery through the assessment of the cyst's location, texture, and characteristic features on imaging modalities like X-ray or CT-scan.[6-8,10]

Orbital dermoids require surgical excision due to their tendency to increase in size and release their contents into surrounding tissues. The cyst's contents are highly irritating and can lead to a severe inflammatory response, which results in fibrosis. It is advised to completely remove the dermoid together with its cyst wall through a surgical method that allows for ideal access to all parts of the lesion [1,5,11] While the primary aim of surgery is the total removal of epidermal and dermal component, some patients may manifest with the recurrent intraorbital lesion, introducing the challenging aspect of a delicate, scarred cyst all adhering closely to normal orbital structures. Aggressive removal of the recurrent lining may result in functional deficits postoperatively. In certain instances, although not ideal, surgical fistulization or marsupialization may be considered as a feasible alternative.[5]

In 1988, Kronish and Dorzbach provided a summary of previously proposed methods for removing dermoid cysts, which include: (1) performing a direct incision directly over the mass, (2) making incisions above, below, or through the eyebrow, (3) utilizing a superomedial approach through a Lynch incision, (4) performing medial lid splitting, (5) conducting a lateral canthotomy, and (6) making an incision in the upper lid crease.[1]

An incision in the eyelid crease is recommended for the management of superficial supertemporal dermoid cysts. This particular incision provides favorable exposure, helps avoid vital structures, and results in an improved cosmetic outcome. when dealing with cysts located anterior to the FTZ, a superior eyelid crease incision offers sufficient exposure and favorable cosmetic results compared to an incision directly above the lesion.[4,5] Cysts located well above the FTZ necessitate an infra-brow or low intra-brow incision to reduce the risk of frontal branch of the facial nerve damage associated with an eyelid crease approach, and to prevent inadvertent transection of the frontalis muscle that may occur with an incision directly over the cysts. [5,13] Intraorbital cysts that expand from the lateral orbital wall sutures may present in early childhood but are more frequently diagnosed in adolescence and adulthood, as proptosis resulting from cyst expansion becomes more apparent.[1,4,5] The majority of the lateral intraorbital dermoid cysts demonstrate osseous involvement, potentially leading to pressure erosion or an atypical morphology, emphasizing the significance of understanding the interaction between the cyst and bone in surgical planning. Complete excision of all epidermal elements of the cyst is imperative, and in instances where there exists a close association between the cyst wall and the bone, bone burring might be deemed necessary.[4,8,9]

Aspiration of cyst walls was contraindicated owing to the potential recurrence of the cyst and the provocation of a severe inflammatory response. Poorly planned, delayed, partial removal or inadvertent rupture of the cyst could trigger an inflammatory reaction and lead to lasting consequences such as the development of an orbicutaneous fistula.[1,8,9]

Complications associated with epidermoid cysts include infection, malignant transformation, and rupture. The frequency of malignant transformation from an epidermoid cyst to cutaneous squamous cell carcinoma is typically low, varying from 0.011% to 0.045%. In our case, there were no visible clinical signs of infection.[14,5]

CONCLUSION

Depression and obesity are two prevalent disorders with a substantial influence on worldwide health and are closely linked and important health conditions. Various factors, including biological, psychological, and behavioral aspects, can impact the intricate relationship between depression and obesity, and play a role in maintaining the two-way relationship.

Interactions between modern antidepressants and newer antipsychotic medications are often significant in clinical practice. Weight gain is a common side effect of antidepressants and antipsychotics. Therefore, it is crucial to educate patients about drug side effects, hunger regulation, the importance of family support, and regular exercise from the start of treatment for depression and obesity. It is also crucial for psychiatrists and dietitians to collaborate to get the best therapeutic outcomes for patients with obesity and depression.

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AUTHORS CONTRIBUTION

All authors contributed to this article.

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CONFLICT OF INTEREST

We declare that we have no conflicts of interest to disclose.

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