Section: Pathology

Case Series

SUBCUTANEOUS CYSTICERCOSIS MASQUERADING AS BENIGN PSEUDOTUMOROUS LESIONS: A CASE SERIES

L. Priyadharshini[1], Sharon Roshin Reginald[2], Sharath Soman[3], K. Brindha[4], Deepana P.[5]

[1]*Assistant Professor, Department of Pathology, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur, Tamil Nadu, India.*
[2]*Associate Professor, Department of Pathology, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur, Tamil Nadu, India.*
[3]*Associate Professor, Department of Pathology, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur, Tamil Nadu, India.*
[4]*Assistant Professor, Department of Pathology, D Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur, Tamil Nadu, India.*
[5]*Second Year Postgraduate, Department of Pathology, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur, Tamil Nadu, India.*

Received *: 22/09/2026*
Received in revised form *: 19/10/2026*
Accepted *: 03/11/2026*

Corresponding Author:
Dr. Sharath Soman,
Associate Professor, Department of Pathology, Dhanalakshmi Srinivasan Medical College and Hospital, Siruvachur, Perambalur, Tamil Nadu, India.
Email: dr.sharathsoman@gmail.com

DOI: 10.70034/ijmedph.2026.4.253

Source of Support: Nil,
Conflict of Interest: None declared

Int J Med Pub Health
2026; 16 (4); 1651-1657

ABSTRACT

Cysticercosis is a parasitic infection caused by the larval stage of Taenia solium and may present at unusual extracranial sites, mimicking common benign or inflammatory lesions. We present a case series of five patients with histopathologically confirmed extracranial cysticercosis involving the cervical region, buccal mucosa, anterior chest wall, and shoulder. The lesions clinically mimicked cervical lymphadenitis, mucocele, abscess, and lipoma. Fine-needle aspiration cytology showed variable findings, including eosinophilic acellular material, refractile or feathery structures, mixed inflammatory cells, proteinaceous material, and necrotic debris. Excision specimens demonstrated characteristic cysticercal larval structures with variable inflammatory responses, including palisading histiocytes, multinucleated giant cells, fibrosis, necrosis, and calcareous corpuscles. The cases highlight the diverse clinical and cytological presentations of extracranial cysticercosis and the limitations of cytology when parasitic structures are not directly sampled. Awareness of cysticercosis in the differential diagnosis of superficial cystic or nodular lesions can facilitate accurate diagnosis, particularly in endemic settings.

Keywords: Cysticercosis, Taenia solium, Extracranial cysticercosis, Subcutaneous cysticercosis, Fine-needle aspiration cytology, Histopathology

INTRODUCTION

Cysticercosis is a parasitic tissue infection caused by the larval stage of the pork tapeworm, Taenia solium (cysticercus cellulosae).[1] It remains an important public health problem in endemic regions, particularly India, Southeast Asia, China, sub-Saharan Africa, and Central and South America.[2,3] Humans acquire cysticercosis primarily by ingestion of T. solium eggs through contaminated food or water. Following ingestion, the eggs hatch in the gastrointestinal tract, and the released oncospheres penetrate the intestinal wall and disseminate through the bloodstream to various tissues, where they develop into cysticerci. Humans act as the intermediate host in cysticercosis, whereas the adult tapeworm resides in the intestine during taeniasis.[3,4] The clinical manifestations depend on the anatomical site, number and stage of cysts, and the host inflammatory response.[5] The central nervous system is the most frequently recognised site, resulting in neurocysticercosis, while other commonly affected sites include skeletal muscle, subcutaneous tissue, and the eye.[6] Cysticercosis may also involve less common sites such as the heart, lungs, liver, pancreas, and thyroid. Although extracranial cysticercosis is well recognised, isolated lesions at unusual anatomical sites may present as solitary nodules or cystic swellings without specific clinical features. Such lesions can mimic common

conditions, including cervical lymphadenitis, abscess, lipoma, and benign cystic lesions of the oral cavity, resulting in considerable diagnostic difficulty.[7,8]

Fine-needle aspiration cytology (FNAC) is a useful minimally invasive diagnostic modality for accessible extracranial lesions. Cytological findings may include eosinophilic acellular material, parasitic fragments, and mixed inflammatory infiltrates comprising eosinophils, lymphocytes, neutrophils, histiocytes, and multinucleated giant cells.[7,9] However, the larval structure may not always be identified, particularly in degenerating or inflammatory lesions, and cytological findings may therefore be non-specific. Histopathological examination of an excised lesion remains important for definitive diagnosis, with identification of characteristic larval or cuticular structures, calcareous corpuscles, and the associated inflammatory response providing diagnostic confirmation.[7,10] Recognition of these features is particularly important when cysticercosis is not initially considered clinically.

Although isolated extracranial cysticercosis has been reported at several unusual anatomical sites, the cytological, gross, and histopathological spectrum across different clinical presentations remains incompletely characterised. The present case series describes five cases of extracranial cysticercosis involving the cervical region, buccal mucosa, anterior chest wall, and shoulder, with lesions clinically mimicking common inflammatory or benign conditions. The cases highlight the variable FNAC findings and characteristic gross and histopathological features of cysticercosis and emphasise the importance of considering this diagnosis in the differential diagnosis of localised cystic or nodular swellings, particularly in endemic settings.

CASE REPORTS

CASE 1

A 10-year-old male child with a documented dietary history of pork consumption presented with a left cervical swelling of 2 weeks' duration. No other relevant medical, family, or psychosocial history was documented in the available clinical records. On examination, the swelling measured 2 × 1.5 × 1 cm and was firm, mobile, and non-tender. Based on the clinical examination, cervical lymphadenitis was considered. Complete blood count revealed mild eosinophilia. No other significant laboratory abnormality was documented.

Fine-needle aspiration cytology (FNAC) was performed and yielded haemorrhagic material. Cytological examination showed scattered eosinophilic acellular material admixed with mixed inflammatory cells, predominantly eosinophils, lymphocytes, and neutrophils, in a haemorrhagic background (Figure 1A). Although the aspirate demonstrated eosinophilic acellular material and prominent eosinophilic infiltration, the cytological findings were not diagnostic of cysticercosis.

The patient subsequently underwent excision biopsy. Grossly, the specimen consisted of a fibrofatty nodule measuring 2 × 1.3 × 1 cm, attached to two small lymph nodes, each measuring 0.8 × 0.5 cm. The cut surface of the nodule showed grey-white fibrous tissue with a central small cystic cavity containing white friable material (Figure 1B). Microscopic examination revealed fibrocollagenous tissue containing a larval form of *Cysticercus*, surrounded by mixed inflammatory cells, multinucleated giant cells, and palisading histiocytes (Figure 1C). The combined morphologic findings were diagnostic of cysticercosis.

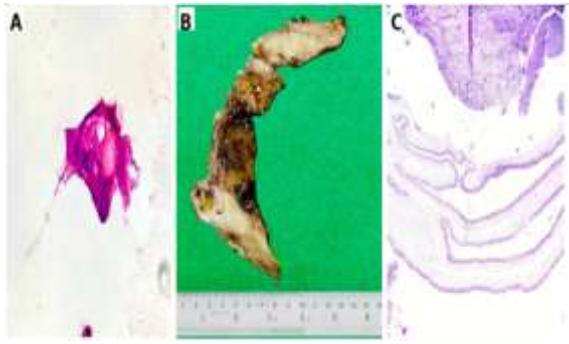


Figure 1: Cysticercosis of the cervical region. (A) FNAC showing scattered eosinophilic acellular material admixed with mixed inflammatory cells, predominantly eosinophils, lymphocytes, and neutrophils, in a haemorrhagic background. (B) Gross specimen showing a fibrofatty nodule with grey-white fibrous tissue and a central small cystic cavity containing white friable material. (C) Histopathology showing fibrocollagenous tissue containing a larval form of Cysticercus, surrounded by mixed inflammatory cells, multinucleated giant cells, and palisading histiocytes.

CASE 2

A 13-year-old male child with a dietary history of pork consumption presented with a swelling in the oral cavity of 10 days' duration. No relevant past medical, family, or psychosocial history was documented in the available clinical records. On examination, a cystic swelling measuring 1.8 × 1.5 cm was noted in the left buccal mucosa and was mildly tender. Based on the clinical presentation, a mucocele was considered as the provisional diagnosis.

FNAC was performed and yielded approximately 0.5 mL of clear fluid. Cytological examination revealed only a few scattered eosinophilic, refractile structures (Figure 2A). The cytological findings were limited and did not permit a definitive diagnosis.

Excision biopsy was subsequently performed. Grossly, the specimen consisted of a greyish cystic nodule measuring 1.8 × 1.5 cm x 1cm. On sectioning, a cystic structure filled with clear fluid was identified, containing a single whitish nodule and surrounded by a thick fibrotic wall (Figure 2B). Histopathological examination demonstrated a cross-section of a larval form with invaginated body segments, surrounded by a dense mixed inflammatory infiltrate composed of eosinophils, lymphocytes, neutrophils, fibroblasts,

histiocytes, and multinucleated giant cells (Figure 2C). These findings were diagnostic of cysticercosis. Complete surgical excision was the documented therapeutic intervention.

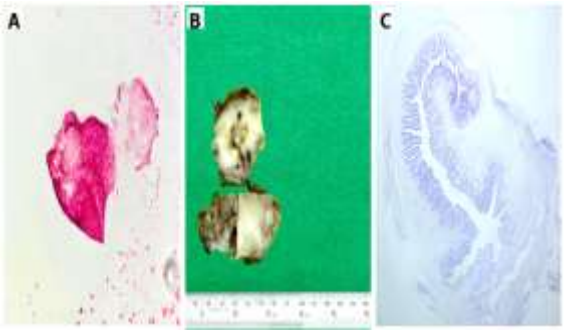


Figure 2: Cysticercosis of the buccal mucosa. (A) FNAC showing a few scattered eosinophilic, refractile structures. (B) Gross specimen showing a cystic structure filled with clear fluid, containing a single whitish nodule and surrounded by a thick fibrotic wall. (C) Histopathology showing a cross-section of a larval form with invaginated body segments, surrounded by dense mixed inflammatory infiltrates comprising eosinophils, lymphocytes, neutrophils, fibroblasts, histiocytes, and multinucleated giant cells.

CASE 3

A 24-year-old male presented to the outpatient department with a right cervical swelling of 2 weeks' duration and a documented dietary history of pork consumption. No relevant past medical, family, or psychosocial history was documented in the available records. On examination, the swelling measured 2.3 × 2 cm and was firm, mobile, and non-tender. The clinical and radiological assessment favoured cervical lymphadenitis. Details of the imaging modality and specific radiological findings were not available in the clinical information provided.

FNAC was performed and yielded approximately 0.2 mL of clear fluid. Cytological examination demonstrated tiny fragments of acellular eosinophilic, feathery material admixed with haemorrhage and mixed inflammatory cells (Figure 3A). The cytological findings were suggestive of a parasitic cystic lesion but were insufficient for definitive classification.

Excision biopsy was performed. Grossly, the specimen consisted of a single grey-brown, firm nodule measuring 2.5 × 2 × 1 cm. The cut surface showed grey-white fibrotic tissue with a central cystic cavity containing glistening white material measuring 0.8 × 0.3 cm and surrounded by clear fluid (Figure 3B). Microscopic examination revealed a complete cross-section of a cysticercus larva with invaginated cuticular layers (Figure 3C). The characteristic histomorphologic features established the diagnosis of cysticercosis.

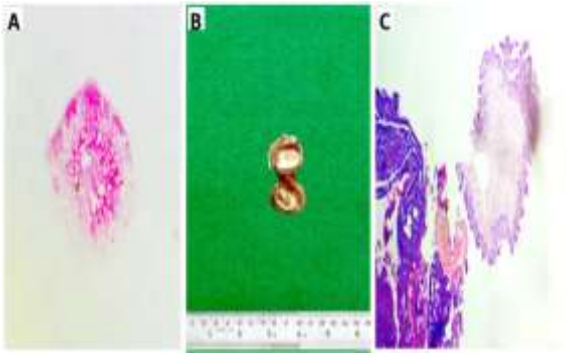


Figure 3: Cysticercosis of the cervical region. (A) FNAC showing tiny fragments of acellular eosinophilic, feathery material admixed with haemorrhage and mixed inflammatory cells. (B) Gross specimen showing grey-white fibrotic tissue with a central cystic cavity containing glistening white material measuring 0.8 × 0.3 cm and surrounded by clear fluid. (C) Histopathology showing a complete cross-section of a Cysticercus larva with invaginated cuticular layers.

CASE 4

A 7-year-old male child presented with a small swelling over the right anterior chest wall that had been noticed for approximately 2 months. The available clinical history did not document any relevant past medical, family, or psychosocial history. On examination, a skin-coloured swelling measuring 2 × 1.5 cm was noted. The lesion was mobile and firm, with overlying excoriation marks. A clinical diagnosis of abscess formation was considered.

FNAC of the swelling yielded approximately 0.3 mL of whitish fluid. Cytological examination revealed acellular material admixed with mixed inflammatory cells in a proteinaceous background (Figure 4A). The cytological findings were non-specific.

Biopsy was subsequently performed. Gross examination showed a grey-brown lesion measuring 2 × 1.5 × 1 cm, with a small cavity containing clear to milky fluid. The cut surface showed grey-white fibrous tissue with grey-white friable areas (Figure 4B). Histopathological examination revealed a cystic lesion with mixed inflammatory infiltrates and palisading histiocytes. Parts of an organism were identified, composed of an outer cuticular layer and an inner nuclear layer, with numerous calcareous corpuscles scattered along its body (Figure 4C). Periodic acid–Schiff (PAS) staining was negative for other organisms. The characteristic parasitic structures and associated inflammatory response supported a diagnosis of cysticercosis.

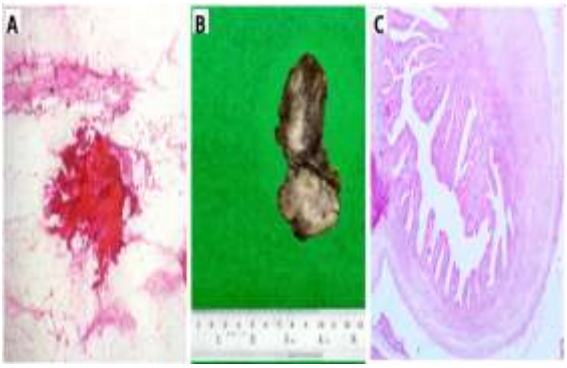


Figure 4: Cysticercosis of the anterior chest wall. (A) FNAC showing acellular material admixed with mixed inflammatory cells in a proteinaceous background. (B) Gross specimen showing a grey-brown lesion with grey-white fibrous tissue and grey-white friable areas. (C) Histopathology showing a cystic lesion with mixed inflammatory infiltrates and palisading histiocytes, along with parts of the organism demonstrating an outer cuticular layer, inner nuclear layer, and numerous calcareous corpuscles.

CASE 5

A 10-year-old male child was brought to the surgical outpatient department with a swelling over the left shoulder. No relevant past medical, family, or psychosocial history was documented in the available clinical records. On examination, the swelling was smooth, mobile, and non-tender, measured 4 × 3 × 2.2 cm, and had a soft-to-firm consistency. A clinical diagnosis of lipoma was considered.

FNAC of the lesion yielded predominantly necrotic debris (Figure 5A). The cytological material was non-specific and did not establish the diagnosis.

Gross examination revealed a grey-white, firm tissue measuring 4 × 3 × 2.5 cm. On cut section, a cystic structure measuring 0.5 × 0.5 cm was identified within the surrounding fibrofatty tissue (Figure 5B). Histopathological examination demonstrated organised and palisading necrosis. The cystic cavity contained a larval form showing duct-like invaginations, morphologically consistent with a larval form of *Cysticercus* (Figure 5C). The histomorphologic findings were consistent with cysticercosis.

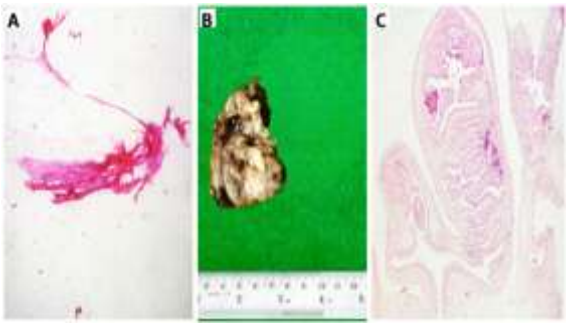


Figure 5: Cysticercosis of the shoulder. (A) FNAC showing predominantly necrotic debris. (B) Gross specimen showing grey-white fibrous/fibrofatty tissue with a small cystic structure measuring 0.5 × 0.5 cm. (C) Histopathology showing organised and palisading necrosis with a cystic cavity containing a larval form of Cysticercus demonstrating duct-like invaginations

Table 1: Clinicopathologic, Cytologic, Gross, and Histopathologic Features of the Cysticercosis Cases

Case	Age/Sex	Site	Clinical presentation and provisional diagnosis	FNAC findings	Gross findings	Histopathologic findings
1	10/M	Left cervical region	Swelling for 2 weeks; firm, mobile, non-tender; clinically diagnosed as cervical lymphadenitis	Haemorrhagic aspirate with scattered eosinophilic acellular material and mixed inflammatory cells, predominantly eosinophils, lymphocytes, and neutrophils	Fibrofatty nodule measuring 2 × 1.3 × 1 cm with central small cystic cavity containing white friable material; two small lymph nodes attached	Fibrocollagenous tissue containing larval form of *Cysticercus* surrounded by mixed inflammatory cells, multinucleated giant cells, and palisading histiocytes
2	13/M	Left buccal mucosa	Cystic swelling for 10 days; mildly tender; clinically considered mucocele	0.5 mL clear fluid with few scattered eosinophilic refractile structures	Greyish cystic nodule measuring 1.8 × 1.5 cm; cystic structure containing clear fluid and a single whitish nodule with thick fibrotic wall	Cross-section of larval form with invaginated body segments surrounded by dense mixed inflammatory infiltrate, including eosinophils, lymphocytes, neutrophils, fibroblasts, histiocytes, and multinucleated giant cells
3	24/M	Right cervical region	Swelling for 2 weeks; firm, mobile, non-tender; clinical and radiological diagnosis of cervical lymphadenitis	0.2 mL clear fluid with tiny fragments of acellular eosinophilic feathery material, haemorrhage, and mixed inflammatory cells	Grey-brown firm nodule measuring 2.5 × 2 × 1 cm; central cystic cavity containing glistening white material measuring 0.8 × 0.3 cm surrounded by clear fluid	Complete cross-section of *Cysticercus* larva with invaginated cuticular layers

4	7/M	Right anterior chest wall	Small swelling for 2 months; firm and mobile with excoriation marks; clinically considered abscess	0.3 mL whitish fluid showing acellular material admixed with mixed inflammatory cells in a proteinaceous background	Grey-brown lesion measuring 2 × 1.5 × 1 cm with a small cavity containing clear to milky fluid and grey-white friable areas	Cystic lesion with mixed inflammatory infiltrates and palisading histiocytes; organism showing outer cuticular and inner nuclear layers with numerous calcareous corpuscles; PAS negative for other organisms
5	10/M	Left shoulder	Smooth, mobile, non-tender swelling measuring 4 × 3 × 2.2 cm; clinically diagnosed as lipoma	Predominantly necrotic debris	Grey-white firm tissue measuring 4 × 3 × 2.5 cm; cystic structure measuring 0.5 × 0.5 cm surrounded by fibrofatty tissue	Organised and palisading necrosis with cystic cavity containing larval form showing duct-like invaginations, morphologically consistent with *Cysticercus*

DISCUSSION

Cysticercosis is a parasitic tissue infection caused by the larval stage of Taenia solium and may involve a wide range of organs and tissues. Although neurocysticercosis represents the most clinically recognised form, extracranial involvement of the subcutaneous tissue, skeletal muscle, head and neck, and other soft tissues is well documented.[1,6] The clinical manifestations of extracranial cysticercosis are influenced by the anatomical site, stage of evolution of the cyst, number of lesions, and host inflammatory response.[5] The present case series demonstrates this clinical variability through five histopathologically confirmed cases involving the cervical region, buccal mucosa, anterior chest wall, and shoulder. In all five cases, the lesions clinically resembled more common benign or inflammatory conditions, including cervical lymphadenitis, mucocele, abscess, and lipoma, emphasising the diagnostic challenge posed by isolated extracranial cysticercosis.

The pseudotumorous or inflammatory presentation of extracranial cysticercosis has been described in both subcutaneous and muscular lesions. Rathi et al. highlighted that head and neck cysticercosis commonly presents as a solitary soft to firm, mobile, and non-tender nodule and may be clinically mistaken for lipoma, neurofibroma, lymphadenopathy, or infectious lesions. They further described pseudotumoural and abscess-like patterns among the clinical manifestations of musculoskeletal cysticercosis.[11] Similarly, Singh et al. reported four cases of isolated cervicofacial cysticercosis that were initially considered inflammatory lesions, with the final diagnosis established following appropriate investigation.[1] Pachuau et al. described subcutaneous cysticercosis of the anterior chest wall mimicking a soft-tissue neoplasm, further demonstrating that the pseudotumorous appearance is not restricted to the head and neck.[12] In the present series, the cervical lesions in Cases 1 and 3 were clinically diagnosed as lymphadenitis, the anterior chest-wall lesion in Case 4 was considered an abscess, and the shoulder lesion in Case 5 was clinically diagnosed as a lipoma. These findings support the importance of considering cysticercosis among the differential diagnoses of localised soft-tissue swellings in endemic regions.

The oral lesion in Case 2 represents another important diagnostic challenge. Oral and perioral cysticercosis are relatively uncommon, and previous reports have documented lesions involving the tongue, buccal mucosa, lips, and floor of the mouth. Goenka et al. reported oral cysticercosis in a child presenting as a solitary tongue nodule,[10] while Manchanda et al. described cysticercosis involving the cheek musculature.[8] Rathi et al. noted that oral cysticercosis frequently presents as a painless, firm or cystic submucosal nodule and may clinically resemble a mucocele, fibroma, lipoma, dermoid cyst, or benign salivary gland lesion.[11] In the present case, the buccal mucosal swelling was clinically considered a possible mucocele, and FNAC yielded clear fluid containing only a few eosinophilic refractile structures. The diagnosis was subsequently established by excision biopsy, demonstrating the larval form with an associated inflammatory response. This case reinforces that the rarity and nonspecific clinical appearance of oral cysticercosis can result in consideration of more common benign lesions initially.

FNAC demonstrated a variable cytological spectrum across the five cases. Case 1 showed haemorrhagic material with eosinophilic acellular material and mixed inflammatory cells, whereas Cases 2 and 3 yielded clear fluid with only scant eosinophilic or feathery acellular material. Case 4 showed acellular material with mixed inflammatory cells in a proteinaceous background, while Case 5 yielded predominantly necrotic debris. These findings illustrate an important limitation of FNAC. Although it can provide a definitive diagnosis when characteristic parasitic structures are present, the aspirate may contain only nonspecific inflammatory or degenerative material when the cyst is partially sampled or undergoing degeneration. Kala et al., in a series of 137 cases, obtained a definitive cytological diagnosis in 129 cases (94.2%) by identifying parasitic structures including tegumental fragments, parenchymatous portions, hooklets, and calcareous corpuscles.[9] In the remaining cases, a diagnosis

suspicious for parasitic infestation was suggested from findings such as clear fluid, eosinophils, histiocytes, giant cells, and a granular inflammatory background, with subsequent biopsy confirming cysticercosis in most cases. Santosh et al. similarly emphasised that FNAC is a useful minimally invasive modality for superficial cysticercosis, but recognition of the characteristic cytomorphological features is essential.[7] The findings in the present series are consistent with this spectrum, as FNAC provided supportive clues in several cases but did not consistently demonstrate the complete larval structure.

The histopathological findings in the present series demonstrated the characteristic morphological spectrum of tissue cysticercosis and provided definitive confirmation in all cases. The inflammatory response varied considerably between lesions, ranging from mixed inflammatory infiltrates and palisading histiocytes to multinucleated giant cells, fibrosis, necrosis, and calcareous corpuscles. Case 1 showed fibrocollagenous tissue containing a larval form surrounded by mixed inflammatory cells, giant cells, and palisading histiocytes. Case 2 demonstrated a cross-section of the larval form with invaginated body segments and dense mixed inflammation. Case 3 showed a complete cross-section of the cysticercus with invaginated cuticular layers. In Case 4, parts of the organism with an outer cuticular layer and inner nuclear layer were identified together with numerous calcareous corpuscles, while Case 5 demonstrated organised and palisading necrosis with a cystic cavity containing a larval structure with duct-like invaginations. Such variation is consistent with the evolving host response described in previous studies, in which degeneration of the parasite may be accompanied by eosinophilic and mixed inflammatory infiltrates, palisading histiocytes, giant cells, granulomatous inflammation, fibrosis, and calcification.[13,14]

Recognition of parasitic structures is particularly important when the cytological findings are nonspecific. Kala et al. emphasised that fragments of the larval bladder wall, hooklets, and calcareous corpuscles are diagnostic when identified in cytological preparations.[9] Santosh et al. similarly described the diagnostic importance of parasitic structures against an inflammatory or granular background.[7] In the present series, however, definitive parasitic morphology was more readily demonstrated in the excision specimens than in the FNAC material. This was particularly evident in lesions in which cytology showed clear fluid, acellular material, or necrotic debris without an intact larval structure. The complementary value of cytology and histopathology is therefore important in superficial cystic lesions: FNAC may provide an early diagnostic clue and guide further evaluation, whereas tissue examination allows assessment of the cyst wall, larval structures, associated inflammatory response, and degenerative changes.[7,10]

An additional feature of the present series is the predominance of lesions in children and young adults. Rathi et al. noted that cysticercosis can occur across a wide age range, with younger individuals also being affected, while oral cysticercosis in children has been described as particularly uncommon.[11] The presence of localised lesions in otherwise clinically nonspecific settings emphasises that extracranial cysticercosis should not be restricted to older patients or individuals with neurological manifestations. Furthermore, although pork consumption was documented in Cases 1-3 of the present series, cysticercosis results from ingestion of T. solium eggs and can therefore occur even in individuals without a history of pork consumption. This distinction is important when taking the clinical history and when considering cysticercosis in patients presenting with isolated soft-tissue lesions.

From a diagnostic perspective, imaging can provide important supportive information in extracranial cysticercosis, particularly when a characteristic cyst with an eccentric scolex or surrounding inflammatory change is identified. Rathi et al. and Singh et al. emphasised the usefulness of high-resolution ultrasonography in evaluating superficial head and neck swellings,[1,11] while other reports have described the complementary role of CT and MRI in defining lesion location and extent.[8,15] However, imaging findings were not available for all cases in the present series, and the diagnosis was ultimately established by histopathological examination. Therefore, the present cases primarily illustrate the pathological spectrum rather than the radiological characteristics of extracranial cysticercosis.

This case series provides a useful clinicopathological correlation of extracranial cysticercosis across multiple anatomical sites, including presentations that clinically mimicked benign and inflammatory lesions. Correlation of FNAC findings with excision biopsy allowed assessment of the diagnostic contribution and limitations of cytology and highlighted the value of histopathological confirmation when parasitic structures are not identified in aspirates. However, imaging and serological investigations were not uniformly available for all cases, and detailed clinical follow-up and treatment information were not available in the records reviewed. Therefore, the findings primarily emphasise the diagnostic and pathological spectrum of extracranial cysticercosis rather than comparative diagnostic accuracy or treatment outcomes.

CONCLUSION

Extracranial cysticercosis can present as localised cystic or nodular swellings and may clinically mimic common benign and inflammatory lesions such as lymphadenitis, mucocele, abscess, and lipoma. The present case series demonstrates the varied cytological, gross, and histopathological appearances of cysticercosis at unusual extracranial sites. FNAC

may provide valuable diagnostic clues by aspirating clear fluid from lesion & identifying eosinophilic acellular material and inflammatory changes, although parasitic structures may not always be demonstrable. Histopathological examination remains important for definitive diagnosis, particularly in cytologically inconclusive or degenerating lesions. A high index of suspicion for cysticercosis in the evaluation of superficial soft-tissue swellings, particularly in endemic settings, can facilitate accurate diagnosis and appropriate management.

REFERENCES

1. Singh S, Jaiswal V, Tiwari S, Yadav S. Revisiting extracranial cysticercosis: A rare case series of mycoparasitism affecting the cervicofacial region from an endemic zone. Natl J Maxillofac Surg. 2023;14(2):317-320. doi: 10.4103/njms.njms_141_22.
2. Singla M, Galhotra A, Bansal N, Chanday R, Pooni N. A Case Report of Extracranial Intramuscular Cysticercosis As Soft Tissue Swelling in the Forearm and Thenar Eminence. Cureus. 2025;17(10):e94161. doi: 10.7759/cureus.94161.
3. Prasad KN, Prasad A, Verma A, Singh AK. Human cysticercosis and Indian scenario: a review. J Biosci. 2008;33:571-82.doi: 10.1007/s12038-008-0075-y.
4. Singh G, Singla M. Neurocysticercosis - a journey from pre-independence to modern India. ANN Natl Acad Med Sci (India). 2016; 52:76-99. doi: 10.1055/s-0040-1712609
5. Ganaraja HV, Mahadevan A, Saini J, Nalini A, Pal PK, Satishchandra P, et al. Disseminated Cysticercosis in Indian Scenario – Experience from a Teaching University Hospital. Neurol India 2022;70:1032-40. doi: 10.4103/0028-3886.349634.
6. Attri N, Kumari S. Cysticercosis of breast: A rare finding. J Med Sci Clin Res. 2019;7(8):838-40. doi:10.18535/jmscr/v7i8.142.
7. Santosh T, Kothari K, Agnihotri M. Cytological diagnosis of cysticercosis: Role of FNAC with on-site evaluation. IDCases. 2019;15:e00477. doi:10.1016/j.idcr.2018.e00477.
8. Manchanda A, Agrawal A, Vagha S. Cysticercosis of cheek – a rare site. J Pharm Res Int. 2021;33(60B):3281-5. doi:10.9734/JPRI/2021/v33i60B35006.
9. Kala P, Khare P. Fine-needle aspiration cytology as a diagnostic modality for cysticercosis: A clinicocytological study of 137 cases. J Cytol. 2014;31(2):68-72. doi:10.4103/0970-9371.138665.
10. Goenka P, Sarawgi A, Asopa K, Gumber P, Dutta S. Oral cysticercosis in a pediatric patient: A rare case report with review. Int J Clin Pediatr Dent. 2016;9(2):156-61. doi:10.5005/jp-journals-10005-1355.
11. Rathi A, Gupta AK, Virk R, Bansal S, Gupta S. Clinical profile of cysticercosis in head and neck. Int J Trop Dis Health. 2016;13(3):1-12. doi:10.9734/IJTDH/2016/23606.
12. Pachuau L, Vanlalhlua C. Subcutaneous cysticercosis mimicking soft tissue neoplasm: A case report. IOSR J Dent Med Sci. 2020;19(8):15-20. doi:10.9790/0853-1908021520.
13. Takayanagui OM, Haes TM. Update on the diagnosis and management of neurocysticercosis. Arq Neuropsiquiatr. 2022;80(5 Suppl 1):296-306. doi: 10.1590/0004-282X-ANP-2022-S115.
14. Talebzadeh AT, Talebzadeh N. Neurocysticercosis infection: A case report. Cureus. 2023;15(3):e36133. doi:10.7759/cureus.36133.
15. Raoot A. Lacrimal sac cysticercosis: A rare site for manifestation. Case Rep Ophthalmol Med. 2014;2014:961815. doi:10.1155/2014/961815.