Aggregated Comedones on the Neck
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Case Report
A 23-year-old woman presented in our dermatology clinic with many tiny pores on the left lateral neck for at least 1 year. These lesions progressed slowly and caused no pruritus or other discomfort. Neither significant past medical history nor particular preceding event such as trauma or scratch over these sites was noted. No other members of her family had same lesions.

Examination revealed multiple comedone-like openings in grouped arrangement on the left lateral neck. (Fig. 1) The keratin plugs in the openings could be removed by a retractor. No other abnormal physical findings were observed. Then a excisional biopsy was performed. (Fig. 2, 3, 4)
Diagnosis: Dilated Pore Nevus

DISCUSSION

In 1954, Winer first described the dilated pore as a solitary enlarged pore mainly on the face, and its onset was mentioned mostly during adulthood. Histologically, it was a well-circumscribed cystic lesion lined by the epithelium that was atrophic at the level of ostium, whereas became hypertrophic and developed many epidermal pegs and proliferations deeper in the follicle. Sometimes, sebaceous glands and lanugo hair may be associated.¹

Dilated pore was mostly reported as a single lesion or few lesions occasionally.¹ Lesions presented as multiple dilated pores were rarely reported in the literature. Dilated pore nevus was first proposed by Resnik et al. in 1993.² The lesion presented as multiple open comedones grouped into a plaque on the neck since early childhood. Histologically, each of them composed of a cystic lesion resembling the dilated pore of Winer. They believed it was also a developmental anomaly of pilosebaceous apparatus which was unable to form structured hairs but just soft keratin as the dilated pore.²

Another case was reported by Konohana et al. as multiple comedone-like lesions appearing since early childhood. Histologically, each of them resembled the dilated pore of Winer. They believed it was also a developmental anomaly of pilosebaceous apparatus which was unable to form structured hairs but just soft keratin as the dilated pore.²

Resnik et al. proposed the dilated pore nevus as a histologic variant of nevus comedonicus because of its resemblance to nevus comedonicus in clinical appearance.² However, in contrast to the unique proliferative follicular epithelium for the dilated pore nevus, the epithelial lining of infundibulum-like structures of nevus comedonicus is usually atrophic or mildly acanthotic.²,⁴,⁵

Other differential diagnoses should include comedones, but its relatively short epithelial track, presence of sebaceous material and bacteria, and usually obvious infiltrate of inflammatory cells help to make the difference. In our case, the proliferations of epithelial lining of some cystic invaginations were so pronounced that it might be confused with pilar sheath acanthoma. Nevertheless, pilar sheath acanthoma has more marked or lobulated proliferation of epithelium with sebaceous duct-like structures and foci of differentiation toward outer root sheath.⁶ Additionally, porokeratotic eccrine ostial and dermal duct nevus can be excluded due to absence of cornoid lamella and dilated eccrine duct.

In conclusion, dilated pore nevus resembles nevus comedonicus clinically but looks like dilated pores histologically. As in our case, cystic invaginations lined by apparent proliferated epithelium make the difference between dilated pore nevus and ordinary nevus comedonicus.

REFERENCES

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