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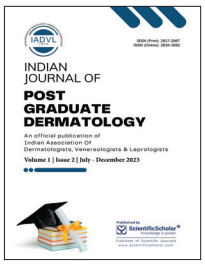

Case Report

Dilated Pore of Winer; What's That!

Sonia Jain[1], Shantanu Sanjay Harode[1], Amruta Dattatray Yadav[1]

[1]Department of DVL, MGIMS, Wardha, Maharashtra, India.

***Corresponding author:**
Sonia Jain,
Department of DVL, MGIMS,
Wardha, Maharashtra, India.

soniapjain1234@gmail.com

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ABSTRACT

The dilated pore of Winer (DPOW) is an adnexal tumour of benign origin arising from the infundibulum of the pilosebaceous unit extending from superficial to deep dermis. Incidence is more common in white males and mostly affects the face, neck and upper trunk. The diagnosis is primarily clinical but dermoscopy and histopathological evaluation are helpful in diagnosis of unusual presentations. Here, we report a case of a 55-year-old female who presented with a giant comedone-like asymptomatic papular lesion over mons pubis. A diagnosis of DPOW was made. The lesion was surgically excised and no recurrence on follow-up was observed.

Keywords: Dilated pore of Winer, Adnexal tumor, Giant comedone, Pilar sheath acanthoma, Surgical excision

INTRODUCTION

Winer's dilated pore (WDP) or dilated pore of Winer (DPOW) is a rare benign appendageal adnexal tumour characterised by dilated follicular pore filled with keratinous material. DPOW typically presents as massive comedone mostly affecting face, neck, upper trunk and genitalia, commonly found in males. Multiple lesions have been observed on rare occasions.[1] Here, we present a case report of a 55-year-old female with a giant comedone-like papular lesion over the mons pubis.

CASE REPORT

A 55-year-old female presented with complaint of single, asymptomatic non-tender swelling over mons pubis for 3 months. Onset was insidious and gradually progressive over 3 months. Physical examination showed a single large hyperpigmented dilated pore over mons pubis surrounded by a similar dilated pore with its opening at a 1'O clock position [Figure 1]. No discharge, tenderness or surrounding lymphadenopathy was found. A massive central keratinous plug was present which entirely filled the pore. Surgical excision was done as shown in [Figure 1]. Excised specimen on histopathological examination showed dilated follicular infundibulum extending into the dermis filled with keratin material lined by epithelium [Figure 2].

DISCUSSION

DPOW was first described in 1954 by Winer.[2] It occurs as a small solitary papule centred by a follicular pore on the face, neck or back, mimicking a giant comedone, presenting in the 4–5th decade. It occurs more frequently in men and is also seen more commonly in whites. It could be multiple or be agminated with a linear distribution (dilated pore nevus).[3] It presents as an asymptomatic, enlarged solitary comedone without any perilesional inflammation or induration.[4] Histopathologically, it is characterised by a markedly dilated follicular infundibulum extending deeply into the dermis. The

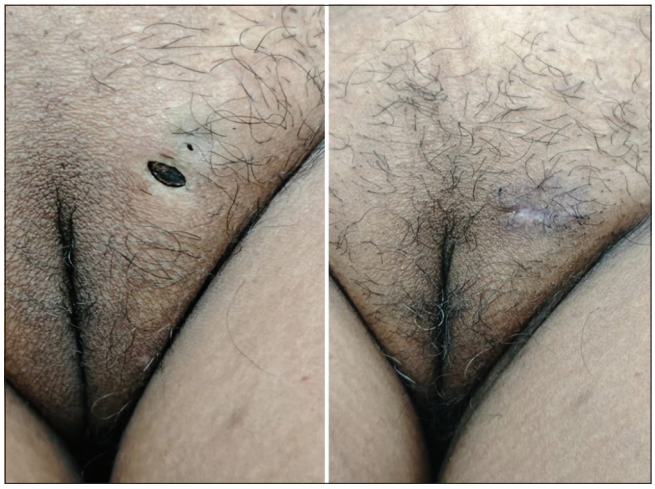

Figure 1: Dilated pore of Winer at the mons pubis at presentation and after excision showing complete healing.

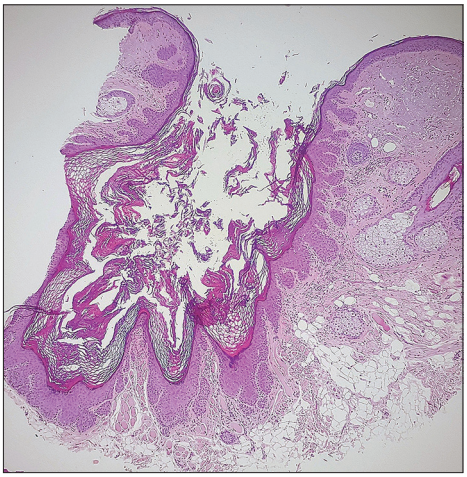

Figure 2: Histopathological image showing dilated follicular infundibulum extending into the dermis filled with keratin material lined by epithelium. (H&E, ×4).

cavity is filled with lamellar keratin material lined by epithelium that is atrophic near the ostium and acanthotic at the deeper portion of the invagination. Radiating epithelial projections push into the surrounding dermis at regular intervals. These projections do not contain keratin cysts, ducts or hair shafts.[3] A clinical diagnosis of a DPOW is due to its classical presentation. Histopathologic analysis might be carried out when the diagnosis is unclear.[5] Klovekorn *et al.* divided the benign neoplasm into four types that is, funnel-shaped, balloon-shaped, multi-lobular with cystic compartments and a superficial type.

Dermoscopic characterisation can help in asserting the clinical diagnosis or when other follicular disorders have to be differentiated.[4] Dermoscopy although not done in our case shows bluish-black central homogenous non-descriptive area of keratin plug with grey-white halo around the central pore.[6] The surrounding skin is usually normal. Other differentials can be a large comedone, which is a dilated infundibular cavity filled with lamellar orthokeratosis and limited by infundibular epithelium without elongated rete ridges.[3]

CONCLUSION

The presence of DPOW around genitalia is unusual and rare, making the case intriguing, although there are case reports of it occurring over the vulva. Although surgical excision is the primary line of treatment for WDP, electrocautery could be used for treating the superficial variant of this entity. Simple comedone extractor can also be of help in treating small DPOWs.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflicts of interest

There are no conflicts of interest.

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