

## Giant Condyloma Acuminatum (Buschke–Löwenstein Tumor) of the Perineoscrotal Region: A Case Report and Surgical Management

Ouzidane Yassine<sup>1\*</sup>, Elftouhi Hamza<sup>1</sup>, Benkerroum Abdelmouiz<sup>1</sup>, Oussama Moumen Deghdagh Yassine<sup>1</sup>, Kbirou Adil<sup>1</sup>, Moataz Amine<sup>1</sup>, Dakir Mohamed<sup>1</sup>, Debbagh Adil<sup>1</sup>, Aboutaieb Rachid<sup>1</sup>

<sup>1</sup>Department of Urology, CHU Ibn Rochd, Casablanca, Morocco

DOI: <https://doi.org/10.36347/sjmcr.2026.v14i04.005> | Received: 11.02.2026 | Accepted: 30.03.2026 | Published: 04.04.2026

\*Corresponding author: Ouzidane Yassine  
Department of Urology, CHU Ibn Rochd, Casablanca, Morocco

### Abstract

### Case Report

Giant condyloma acuminatum (GCA), or Buschke–Löwenstein tumor (BLT), is a rare HPV-associated verrucous lesion that exhibits locally aggressive behavior despite often having a benign histology. We report the case of a 46-year-old patient with no significant past medical history, presenting with a large verrucous lesion that had been evolving for 10 years, extending from the scrotum to the posterior perineum and into the perianal region. Rectocolonoscopy revealed no abnormalities. Pelvic MRI showed a nodular parietal thickening involving the scrotum, inguinal regions, and perianal region, measuring approximately 60 × 170 mm. Complete multidisciplinary surgical excision was performed in collaboration with the colorectal surgeons, combined with a protective colostomy, followed by secondary closure surgery. The outcome was favorable with no recurrence at follow-up.

**Keywords:** Giant condyloma acuminatum; Buschke–Löwenstein tumor; HPV; verrucous lesion; perianal tumor.

Copyright © 2026 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY-NC 4.0) which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.

## INTRODUCTION

Buschke–Löwenstein tumor (BLT) represents the “giant” and invasive end of the spectrum of anogenital condylomas, generally associated with low-risk HPV types (particularly 6 and 11), but capable of mimicking or coexisting with dysplastic or carcinomatous lesions [1–3]. Its clinical significance stems from its locoregional spread, the difficulty in defining “clear” margins on infected skin, a significant risk of recurrence, and the possibility of malignant transformation reported in the literature [1,4].

## CASE REPORT

A 46-year-old patient with no known medical history, unmarried, with no children, presented for evaluation of a genital lesion that had been gradually progressing over the past 10 years.

## CLINICAL EXAMINATION

Large, wart-like scrotal mass extending to the posterior perineum and the perianal region up to the anus,

with local complications: foul odor, bleeding, ulceration, infection, functional discomfort; TR: good sphincter tone, clean digital examination.

### Workup:

Rectal colonoscopy: no abnormalities.

Pelvic MRI: nodular parietal thickening extending to the scrotum, inguinal regions, and perianal area, measuring approximately 60 × 170 mm (≈ 6 × 17 cm).

STI screening performed according to protocol (including HIV), and HPV testing.

### Treatment

Complete surgical resection using a multidisciplinary approach (urology + general surgery).

Performance of a protective colostomy to reduce fecal contamination, optimize wound healing, and minimize the risk of infection.

Secondary skin closure via surgery



Figure 1: Giant scrotal condyloma acuminatum.

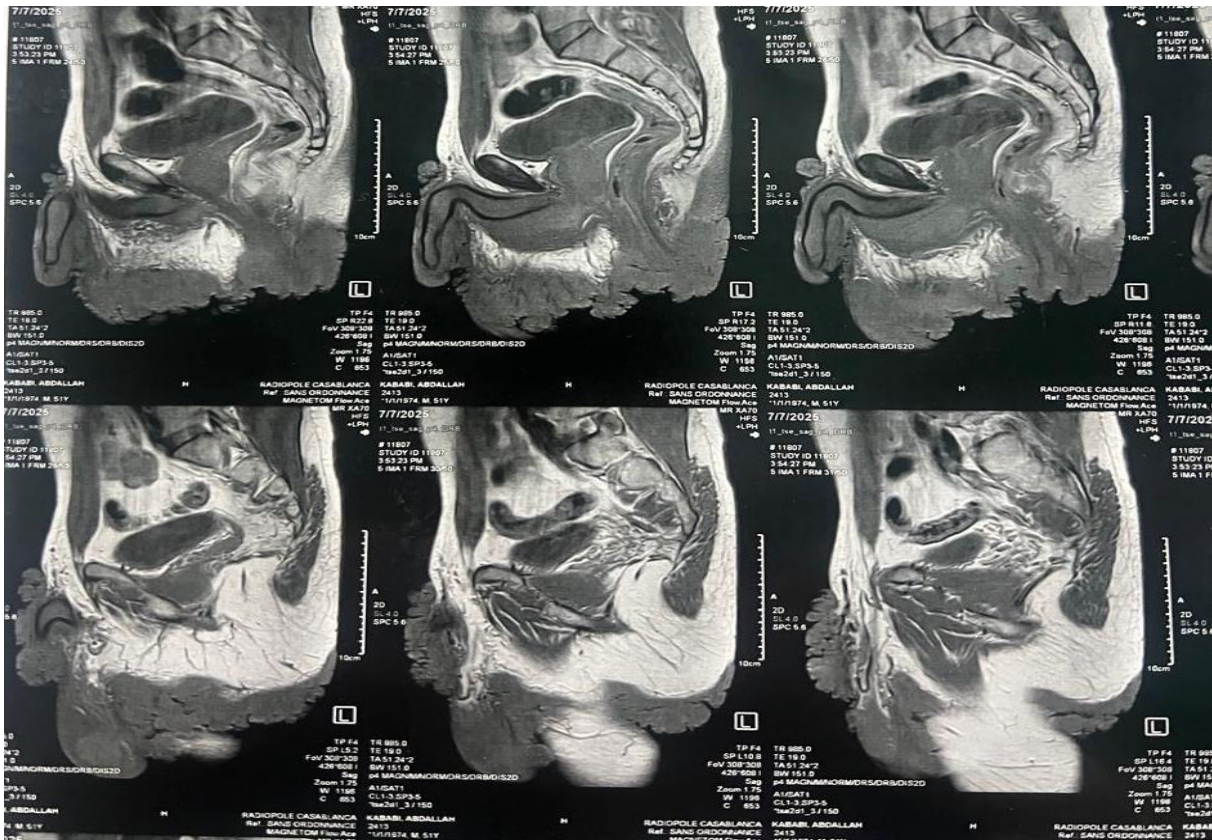


Figure 2. Pelvic MRI showing thickening of the scrotum extending to the inguinal and posterior perineal regions



Figure 3. Postoperative appearance.

**Outcome**

Uncomplicated recovery, satisfactory healing, and no recurrence at follow-up.

**DISCUSSION****1) Pathophysiology and Risk Factors**

LBT is strongly associated with persistent HPV infection, particularly HPV types 6 and 11, which are responsible for the majority of “classic” genital warts and are frequently found in LBT [2,3]. Factors contributing to chronicity and spread include immunosuppression, co-infections, smoking, poor local hygiene, and duration of the condition (often spanning several years), as in our case [1–3].

**2) Diagnostic challenges: BLT vs. verrucous carcinoma / SCC**

Clinically, BLT is exophytic, “cauliflower-like,” often foul-smelling and fragile, and may ulcerate, become infected, and infiltrate surrounding tissues. The major pitfall is the potential discrepancy between the massive/aggressive appearance and an initially benign histology. Transformation into squamous cell carcinoma has been reported, including within multiple lesions, hence the importance of comprehensive histological analysis of the specimen [1,4]. Recent cases highlight the need to avoid relying solely on isolated superficial biopsies when the tumor is large [4].

**3) Role of Imaging and Endoscopy**

MRI allows for precise assessment of soft tissue extension (scrotum, perineum, inguinal regions, perianal area) and aids in planning excision and reconstruction [5]. Rectoscopy/rectocolonoscopy is useful for ruling out rectal mucosal involvement or other associated pathology when the tumor is perianal or anal, as in our case.

**4) Treatment: What Recent Data Show****a) Complete surgical excision = the cornerstone**

Recent publications (reviews and case series) confirm that wide excision with margins, when feasible, remains the most well-documented treatment and the one offering the best local control, while also allowing for histological analysis of the entire lesion [1–3,6]. Recurrences are typically linked to incomplete excision or subclinical infection of the margins [2,6].

**b) Protective colostomy: a “pragmatic” indication in extensive perianal forms**

For circumferential perianal/anal forms or in cases of major risk of contamination, several surgical strategies include temporary fecal diversion, facilitating healing and reconstruction while reducing infectious complications [7]. Your case fits perfectly into this approach.

**c) Reconstruction: often in two stages**

Tissue loss following extensive excision frequently requires reconstruction (grafts, flaps,

combined techniques). Recent series emphasize the value of early reconstructive planning, sometimes in two stages (excision followed by secondary coverage), depending on the patient’s condition and the histopathological findings [6,7].

**d) Adjuvant treatments (selected cases)**

Imiquimod / combination therapies: Case reports and small series describe strategies combining excision/electrosurgical resection + dynamic phototherapy + imiquimod, particularly for residual or recurrent lesions [8].

Laser/electrocoagulation: primarily as an adjunct or for limited recurrences, as the lack of a histological specimen is a major drawback in giant lesions.

Radiotherapy/chemotherapy: discussed primarily in cases of malignant transformation or inoperability (heterogeneous evidence, case-by-case decisions in multidisciplinary team meetings) [4,6].

**5) Follow-up and prevention (data and recommendations)**

Follow-up should be prolonged, focusing on local recurrence, the appearance of satellite lesions, and any signs of transformation.

From a preventive standpoint, international recommendations confirm the importance of HPV vaccination, with regimens adapted to age and immune status [9,10]. Although vaccination is primarily discussed in the context of primary prevention, its population-level impact on reducing HPV infections (and thus condylomas) is well established [9–11].

**CONCLUSION**

Giant BLT/condyloma acuminatum is a rare condition with locally aggressive behavior, requiring a rigorous diagnostic approach (comprehensive histology) and often a multidisciplinary management strategy. Recent data confirm the primacy of complete excision; in extensive perianal forms, a protective colostomy and reconstruction (often secondary) optimize functional outcomes and healing. Long-term follow-up remains essential.

**REFERENCES**

1. Serpa-Irizarry M, Rodriguez-Quilichini S. A rare presentation of a rare entity: giant condyloma (Buschke–Löwenstein) tumor. *J Surg Case Rep*. 2024.
2. Grosu-Bularda A, *et al.*, Clinicopathological findings and comprehensive review (Buschke–Löwenstein / giant condyloma). 2024.
3. StatPearls. Giant Condylomata Acuminata of Buschke–Löwenstein. NCBI Bookshelf.

4. Müdüroğlu M, *et al.*, Extraordinary case with malignant transformation. *Afr J Urol*. 2024.
5. Daha I, *et al.*, Contribution of MRI in Buschke-Löwenstein tumor (case report). 2025.
6. Ajagbe OA, *et al.*, Surgical treatment of perineal giant condylomata (case series). 2024.
7. Chen MT, *et al.*, Buschke-Löwenstein tumour: surgical management... including diverting colostomy and reconstruction. 2025.
8. Huang X, *et al.*, Combined treatment (electroresection + photodynamic therapy + topical 5% imiquimod). *Indian J Dermatol Venereol Leprol*. 2021.
9. WHO. Human papillomavirus (HPV) position papers / policy resources (incl. updates/considerations 2024).
10. CDC. HPV Vaccination Recommendations (schedules by age/immunocompromise).
11. Schuind AE, *et al.*, Human papillomavirus prophylactic vaccines: update... 2024