

Condyloma Acuminata in Children: A Case Report

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DOI: [10.36347/sjmcr.2022.v10i07.031](https://doi.org/10.36347/sjmcr.2022.v10i07.031)

| Received: 18.06.2022 | Accepted: 23.07.2022 | Published: 30.07.2022

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Abstract

Case Report

The acuminata condyloma or rooster crest is a benign sexually transmitted infection caused by human papilloma virus. It is common among sexually active adults and adolescents. Its discovery in children raises two problems: identifying the mode of transmission so as not to miss a possible sexual abuse and opt for an appropriate therapeutic choice. We report a case of genital condyloma for a 2,5 old girl with no known risk factors for immunosuppression. We discuss the main epidemiological, diagnostic, therapeutic and evolutionary aspects of this condition in children.

Keywords: condyloma, infant, contamination, papillomavirus infection.

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INTRODUCTION

Condyloma acuminata are warty lesions elevated from 1 to 5 mm in diameter that cluster in plaques. They are linked to a *papillomavirus* (HPV) infection. At the perineal level, they can be located in the peri-anal, peri-vulvar, peri-urethral or at the level of the genital cervix.

Due to the mode of transmission of HPV in adults, condyloma acuminata are considered sexually transmitted diseases and may call to mind a sexual assault in children or adolescents. Nevertheless, it is now estimated that the frequency of sexual contamination by HPV during situations of sexual assault is less than 10%.

We report in this work an observation of condyloma acuminata in a case at the pediatric medical emergency department of the children's hospital of Rabat.

OBSERVATION

The subject is a 2.5-year-old girl, youngest of 3 siblings, living with her both parents, grandmother and sisters, having a history of vaginal delivery without ATCD of genital condyloma at the mother's side, nor any context suggestive of abuse.

The history of the disease goes back 6 months with the appearance of papular, non-pruritic, painless

lesions on the perineal level, without bleeding next to it or associated genital secretions, or associated urination disorders.

All are evolving in a context of apyrexia and preservation of the general condition, the evolution was marked by an increase in number of lesions, hence her consultation with a dermatologist who referred her to us for additional care.

At admission the child was awake, afebrile, in good general condition, good staturoponderal development, the urogenital examination: papular lesions, sessile, with a smooth surface, pink in color at the confluent Peri-vulvar level in a sheet associated with formations pedunculated, pink Confluent in fleshy masses at the level of the anal periphery without lesions from scratching, nor inflammatory signs opposite, nor bleeding or genital secretions opposite. The rest of the examination is unremarkable.

Viral serologies (hepatitis B and C, syphilis, HIV) came out negative.

The biopsies of the lesions were carried out with anatomopathological study finding a morphological aspect compatible with a condyloma acuminata without histological sign of malignancy.

An additional demonstration of HPV by molecular biology (search for the p16 protein) was

carried out in progress. And a cervicovaginal smear is requested from the mother who returned in favor of HPV confirming maternal-fetal transmission.



Condylome perivaginal



Condylome perianal

DISCUSSION

These are warts of secondary genital topography of a papillomavirus infection, and they exist among adults and children. There are several types of warts which are differentiated according to their clinical aspect, location, virological status: Condyloma acuminata, which are generally due to HPV 6 and 11 [1, 2]. Giant warts of Buschke Loewenstein, is a lesion which quickly becomes extensive, infiltrating like an invasive carcinoma but this tumor due to HPV 6 and 11 is benign and does not produce metastasis [3]. Bowenoid papulosis which is rare in children.

The diagnosis of condyloma is clinical and easy in most cases. But some lesions can be misleading, and it is important to identify the differential diagnoses of condyloma (Molluscum contagiosum, Perianal pyramidal protrusion...)

Among adults, warts are sexually transmitted (STI) [5]. In children, it would seem that other modes of contamination are possible: Vertical or perinatal transmission (in utero by transplacental passage of the virus, either by contact, during childbirth), Horizontal transmission by car or by hetero-contamination from

digital warts of the child or an adult in charge of the child for the gestures of everyday life. Or sexual transmission; consequence of child sexual abuse.

In order to treat condyloma in children, numerous but unsatisfactory therapeutic possibilities. Unfortunately, these methods are very often painful and therefore difficult to apply in pediatrics. In addition, most of these treatments do not benefit from marketing authorization for pediatric use for this indication.

There is no standardized protocol for the management of condyloma in children and the therapeutic indications are not clearly defined [4].

Therapeutic Possibilities

- Therapeutic abstention: As with common warts, condyloma disappears spontaneously in two-thirds of cases in 2 years and in the absence of any treatment.
- Destructive methods: They are mainly used for the treatment of common warts and very little for Condyloma
- Chemical treatments: Keratolytics: these are salicylic acid-based preparations that are difficult to apply to children's warts because they induce painful local irritation [6].

Physical Treatments

- **Cryotherapy:** with a cotton swab or cryac. This treatment remains very painful. It is therefore not indicated in the treatment of condyloma.
- **The CO2 Laser:** This method may seem interesting in terms of efficiency, but it remains expensive, requires specialized equipment, the use of general anesthesia and the possibility of recurrence after treatment is described [6].
- **Surgical Treatments:** Some practitioners have recourse to these treatments when a lesional assessment under general anesthesia is envisaged, for example in the context of suspicion of sexual abuse.

Antimitotic Treatments

- **Podophyllotoxin:** The powerful antimitotic and cytolytic action leads to the necrosis of the lesions. It is nevertheless preferable to contraindicate the use of podophyllotoxin on ulcerated or exophytic lesions to avoid transcutaneous passage [6].

Antiviral Treatments

- **Imiquimod:** This is a treatment capable of inhibiting HPV viral replication. Imiquimod is easy to use. The treatment should be applied 3 times a week and massaged in until completely absorbed. 6 to 10 hours after application, the area should be washed with soap and water.

This treatment will be continued until the disappearance of the visible lesions and for a maximum of 16 weeks.

CONCLUSION

Childhood warts remain lesions whose treatment is not codified in pediatric dermatology although many studies have focused on.

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