

A Case Report on Management of unusually presenting Anorectal Giant Condyloma Acuminata

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Abstract

Case Report

Condyloma acuminata, or anogenital warts, caused by human papillomavirus are a common sexually transmitted disease. In rare cases, the disease could progress to an extensive neoplasm called Buschke–Löwenstein tumour (BLT), also known as giant condyloma acuminatum. BLT differs from normal condyloma acuminata by presenting with locally invasive growth, lack of spontaneous resolution, and tendency for recurrence after treatment and potential for malignant squamous cell carcinoma. Risk factors include anoreceptive intercourse, HIV and immunosuppression. We present a case of perianal BLT and discuss about the nature and treatment of this disease. Wide perineal excision with negative margins is the best surgical choice if the anal canal is not involved. The radical pelvic surgery is indicated only in patients with proved visceral invasion. Excision is mandatory even in very small condylomas to prevent BLT later.

Keywords: Unusually presenting Condyloma Acuminata.

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INTRODUCTION

Buschke–Löwenstein tumour (BLT), or giant condyloma acuminata, was initially described in 1925. Incidences of BLT have been reported in mostly anogenital regions [1, 3].

BLT is a slow-growing, cauliflower-like, locally destructive tumour and has propensity for secondary infections, foul odour and fistulations [4]. GCA is a rare lesion tending to present in the fifth decade with a 2.7: 1 male: female ratio.

Risk factors include HPV (6, 11) anoreceptive intercourse, HIV and immunosuppression. It has a low-grade histopathological appearance and rare metastasis, BLT is generally classified as a verrucous carcinoma, a well-differentiated regional variant of squamous cell carcinoma [5]. It is characterized by aggressive down growth into underlying dermal structures.

Mostly, patients present with bleeding, lymph node enlargement, peri anal fistula and discharge. The loco-regional extension must be carefully ascertained to establish the management.

BLT treatment is controversial, the majority of authors agree that surgery is the treatment of choice and is efficient in the early stages of the disease. Wide local excision is to be done and lymph node dissection is indicated only in cases of suspected malignancy.

BLT is associated with high local recurrence after excision in about 50-60% and the need of pre- and postoperative use of radiation and chemotherapy has been suggested. Post op surveillance is mandatory because of high recurrence rates.

CASE REPORT

28 year old male came with chief complaints of peri rectal mass, slowly growing for the past six years. The mass was insidious in onset and gradually progressing from initial size of approx. 3cm x 4 cm (approx.) to current size of 14 cm x 13 cm.

On examination, patient had a cauliflower like tumour in the peri rectal region extending from anal verge to S4 vertebra. Biopsy taken from the mass suggested Condyloma Acuminata.

MRI Pelvis s/o large heterogenous exophytic growth in perianal region measuring 15x14x9cm with multiple branching linear tracts seen within the lesion

extending supero-anteriorly external to external sphincter without obvious internal communication with the anus. Loss of fat plane with anal canal noted and anal canal is displaced towards the left side.

Routine blood investigations were done and patient was found to be severely anaemic (Hb: 4.8gm/dl) and GBP suggestive of microcytic hypochromic anaemia. 4 units PRBC were transfused and the patient was taken up for surgery.

Wide local excision of mass was done leaving the anal mucosa and the anal verge intact. Gluteal V-Y flap advancement was performed to cover the defect. Sigmoid colon loop was mobilised and colostomy done. Complete excision was achieved. Post-operative period was uneventful.

HPE was suggestive of: Wide excision of gluteal mass shows features of condyloma acuminata. Three months following surgery no recurrence was seen.

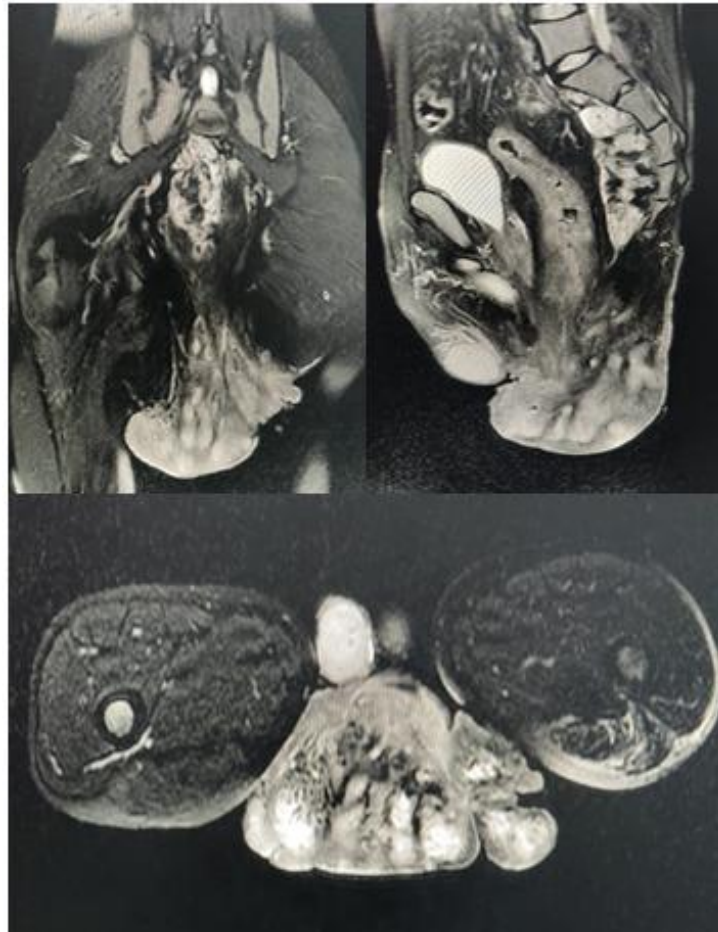


Fig-1(a), 1(b), 1(c): MRI Pelvis showing large (12x12x9cm) heterogeneously exophytic mass lesion in perianal region



Fig-2: Clinical Presentation of Peri anal mass



Fig-3: Intra-op picture of mass resection



Fig-4: V-Y Gluteal flap advancement



Fig-5: Post resection and flap coverage

DISCUSSION

Buscke-Lowenstein tumour is a rare entity, with an incidence of 0.1% in the general population [17-19]. Predominantly affects men, with few reports in women, being more common during pregnancy [17-22]. Presents rates of up to 56% of malignant transformation to squamous cell carcinoma, 66% recurrence and 20% mortality, with fatal cases only in recurrences [17-19, 23, 24]. This disease has been considered an intermediate step between squamous carcinoma and condyloma acuminata or a benign entity in itself with malignant behaviour [18, 19, 23-25]. There are little known clinical characteristics and imaging, and there is no agreement on handling/management. Risk factors described are HPV subtype infection [6, 11, 16, 18], immunosuppression (HIV infection, use of corticosteroids, immunomodulators, diabetes mellitus) sexual promiscuity and co-existence of condylomas [18, 19, 22]. The most frequent locations in males are the penis (81-94%) and in females the vulva (90%), secondly in both sexes is the perineum [19, 24, 26]. Lymphadenopathy associated with this lesion are mostly reactive to the lesion or super infection, they rarely correspond to metastasis [19, 24, 26, 27].

Clinically these lesions often present with similar findings, and can be distinguished by

histological examination [30, 31]. BLT resembles condyloma acuminatum histologically with its benign appearance and negligible cellular atypia, but also has characteristics of thick stratum corneum, marked papillary proliferation, deep local invasion and displacement of surrounding tissues. These features, seen also in verrucous carcinomas, led several authors not to recognize a distinction between verrucous carcinoma and Buschke Löwenstein tumour [28]. However, GCA does not present histological evidence of malignancy, such as infiltration of basement membrane, lymphatic invasion, angioinvasion or distant metastases [32]. Despite this, GCA can coexist with verrucous carcinoma or squamous cell carcinoma in up to 50% of patients [29, 33].

Due to its rarity and lack of controlled studies, the optimal management for BLT has not been defined. However, wide local excision with tumour-free margins remains the treatment of choice along with several other therapeutic strategies, including topical agents (podophillin, 5-fluorouracil, bleomycin, interferon and imiquimod) or systemic therapy with chemoradiation [13]. Since the tumour has minimal potential for distant metastasis, local control of the disease usually leads to improved prognosis [14].

Although surgical excision remains the mainstay treatment, definitive chemoradiation could possibly be used to treat certain cases of recurrence or extensive pelvic invasion, and potentially decrease local recurrence rates [13].

While vaccination is an effective method for preventing anogenital warts, early and adequate treatment of condyloma acuminata could prevent its potential growth into an extensive verrucous tumour. Early detection of the disease and close vigilance and follow-up could have led to a better outcome in our patient.

CONCLUSION

The treatment of choice for Buschke Löwenstein tumour is debatable because of the rarity of the disease. In our opinion, wide local excision with tumour free margins and same sitting reconstruction of skin defect appears to be the best choice.

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