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Verrucous carcinoma of the scrotum with epigastric secondary: case report

Eziyi AK[1], Olaofe OO[2], Oseni GO[1], Olajide AO*[1], Ojomo[1], Akinyemi HAM[2]
[1]Department of Surgery LAUTECH teaching Hospital, Osogbo, Nigeria
[2]Department of Pathology LAUTECH teaching Hospital, Osogbo, Nigeria

***Corresponding Author:**
Name: Olajide AO
Email: lajidea@yahoo.com

Abstract: Verrucous carcinoma of the scrotum is very rare and most cases are thought to result from poor hygiene and chronic irritation. Regional lymph node metastasis is rare and distant metastasis has yet not been reported1.. Surgery with a negative resection margin offers the best hope of cure as adjunctive therapy has not proved useful. We report a case of verrucous carcinoma in a 60 year man with epigastric secondary. A 60 year old farmer with multiple sexual partners presented to our clinic on account of extensive scrotal ulcer which started 8 years prior to presentation as multiple swellings in form of blisters but increased progressively to the perineum after bursting to form ulcers. About a year prior to presentation he developed an epigastric mass that increased in size slowly. Incisional biopsy of the scrotal lesion with excisional biopsy of the epigastric mass showed verrucous carcinoma of squamous cell type. An extensive surgical excision with at least 2 cm margin was performed and a split thickness skin graft was done. Wound healed almost completely before he was discharged home but he was lost to follow-up.
Keywords: Squamous cell carcinoma, verrucous carcinoma, scrotum, epigastric secondary

INTRODUCTION

Verrucous carcinoma of the scrotum is very rare and most cases are thought to result from poor hygiene and chronic irritation. Regional lymph node metastasis is rare and distant metastasis has yet not been reported [1]. Surgery with a negative resection margin offers the best hope of cure as adjunctive therapy has not proved useful. We report a case of verrucous carcinoma in a 60 year man with epigastric secondary. This is the first case of verrucous carcinoma with epigastric secondary

CASE REPORT

A 60 year old farmer with multiple sexual partners presented to our clinic on account of extensive scrotal ulcer which started 8years prior to presentation as multiple swellings in form of blisters but increased progressively to the perineum after bursting to form ulcers. Various forms of traditional herbs and chemicals were applied before the blisters ulcerated. He has a poor personal hygiene but there was no exposure to radiation. There was associated bleeding on contact with occasional dizziness, no weight loss and anorexia. About a year prior to presentation he developed an epigastric mass that increased in size slowly.

On examination he was not pale and had an irregular firm epigastric mass 5cmby5cmattached to underlying skinand muscle (figure 1). There was a foul-smelling grotesque fungating ulcero-proliferating mass with everted edges measuring 30cm by 30cm, involving the whole perineum, scrotum and the medial aspect of the thigh, unhealthy floor with mobile base (figure 2). Incisional biopsy of this masse with excisional biopsy of the epigastric mass showed verrucous carcinoma of squamous cell type.

Complete blood count, liver function tests (LFT), and renal function test (RFT) and abdominopelvic ultrasound and chest x-ray were normal. Computerized tomography of the abdomen could not be done due to paucity of fund. HIV1 and 2 testing were negative and blood sugar assessment normal. An extensive surgical excision with at least 2 cm margin was performed and the excised tissue was sent for histopathological examination (figure 3 and 4). The tumour at the scrotum was not infiltrative into or adhesive to the testis. Both testes were buried in a pouch in the medial side of the upper thigh and a split thickness skin graft was done (figure 5).Histology revealed orthokeratosis, parakeratosis, with acanthosis and marked papillomatosis. The cells displayed a vacuolated cytoplasm with irregular and large nuclei scattered in the stratum malpighi (koilocytes) (figure6 and 7). There was no severe nuclear atypia uniquely consistent with verrucous carcinoma. The dermis showed polymorphous inflammatory infiltrate. Excised lymph nodes showed reactive lymphoid hyperpesia with no evidence of malignancy.

He had wound infection and was commenced on continuous daily dressing with providon iodine mixed with metronidazole drip, andtopical 5-fluorouracil cream.

Wound healed almost completely (figure 8) before he was discharged home on request for follow up in the clinic. Unfortunately the patient did not show up in the clinic and every effort made to contact him proved abortive.

Figure 1: Clinical Photograph showing Perineal tumour with supra-umbilical secondary

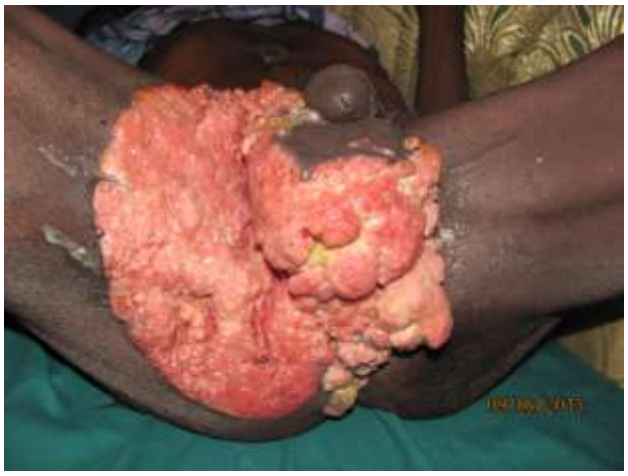

Figure 2: Clinical photograph showing extensive involvement of the scrotum, anus and thighs

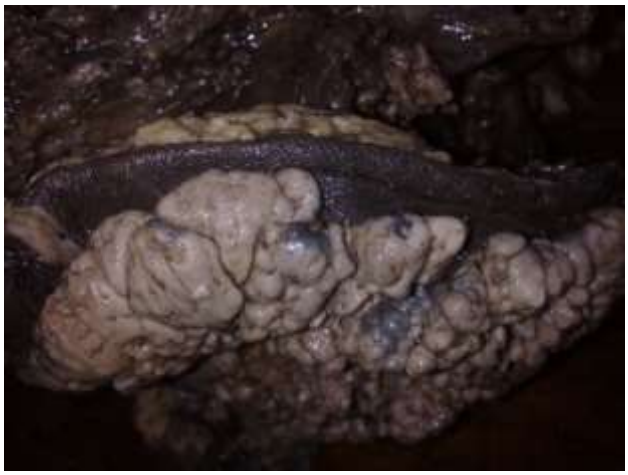

Figure 3: Close-up view of the fungating mass after excision and fixation in formalin

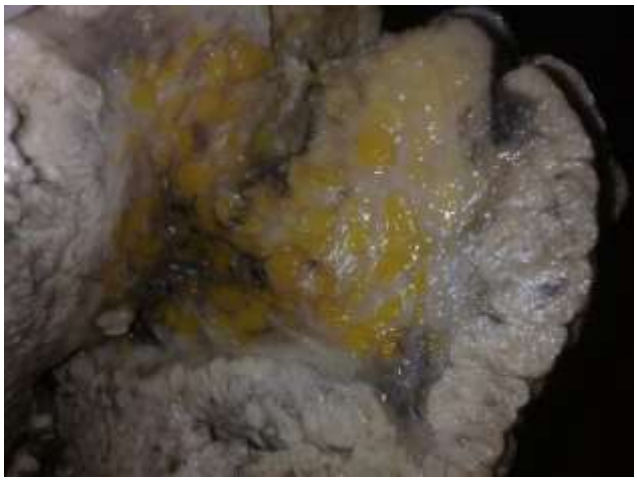

Figure 4: Cut surface of the excised mass showing well delineated tan-white tumour mass with non-infiltrative pushing borders and adjacent loose fibro-fatty tissue

Figure 5 Clinical photograph showing perineum (post-excision of the tumour) with skin graft

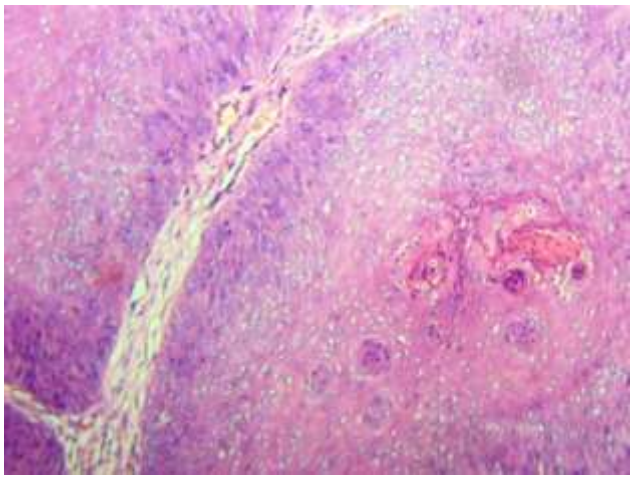

Figure 6: Photomicrograph of the histologic section showing relatively bland epithelial cells with minimal cytologic atypia

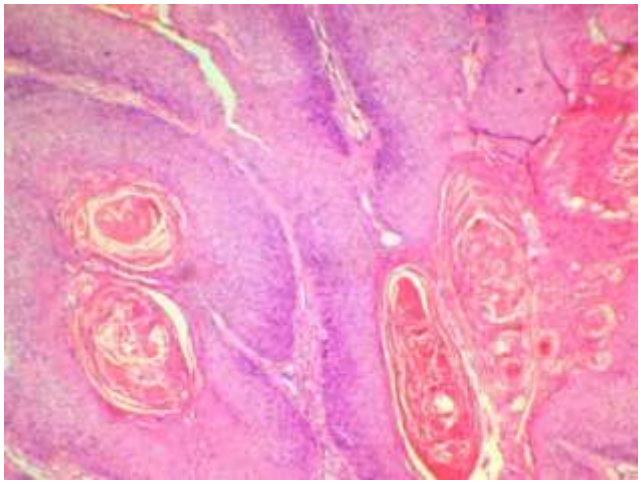

Figure 7: Photomicrograph of the histologic section showing a pushing border and formation of keratin pearls

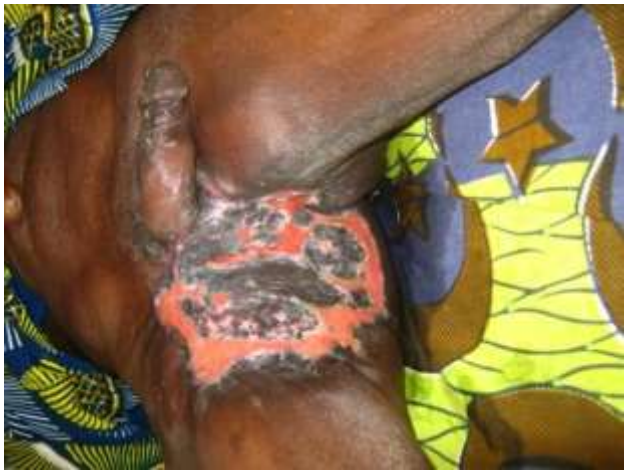

Figure 8: Clinical photograph showing successful skin grafting after ?? weeks of surgery

DISCUSSION

Verrucous carcinoma is an uncommon, exophytic, low-grade and well-differentiated variant of SCC with slow invasive growth and without any distant metastasis. Its presence was first described in 1948 by Ackerman in the oral cavity [2]. Since then it has also been described at other sites, including the anus, female genitalia, penis, sole and at any location on the skin [3]. Verrucous carcinoma is also known by several other names, e.g., giant condyloma acuminatum or Buschke-Lowenstein tumor [4]. However, some researchers consider giant condyloma acuminatum or Buschke Loewenstein tumor as a distinct disease which only represents an intermediate condition between condyloma acuminatum and verrucous carcinoma [5,6]. Currently, the common opinion is that both the lesions are similar and should not be separated into two different entities [7].

Squamous cell carcinoma of the scrotum is a tumor that is of interest for clinical and historical reasons. Squamouscell carcinoma of the scrotum has historically been associated with exposure to occupational(industrial) and non-occupational (environmental) carcinogens. Most authors consider verrucous carcinoma (VC), as a variant of squamous cell carcinoma that seldom metastasizes [8,9]. Verrucous carcinoma is a low-grade, locally aggressive variant of squamous cell carcinoma. VC on the genitals is extremely rare, especially at the scrotum. Human papillomavirus (HPV) has beenassociated with the oncogenesis of carcinoma and lymphoma.Howevercase reports exist which correlated squamous cell carcinoma of the scrotum with human papilloma viruses, mainly oncogenic types 16 and /or 18 or 6/11 [10], but a direct causal relationship has not been established. Squamous cell carcinoma of the male genitalia may be multifocal [l,11] especially when oncogenic human papillomavirus types are present[10].

Patients frequently delayed seeking medical help,[12] mainly due to embarrassment, ignorance or both; that the initial lesion is usually slowly growing and painless may also be contributory. Our patient presented 8 years following the onset of symptoms.

The tumor enlarges slowly but may be locally destructive and can penetrate deeply into the skin, fascia, and even bone, but it has a low metastatic potential [13]. Regional lymph node metastasis is rare and distant metastasis has yet not been reported [1]. Our case report had anepigastric secondary; this may possibly be the first case of distant metastasis from verrucous carcinoma of the scrotum.

Surgery is the treatment of choice and is effective in the early stages of the disease. Excision

must be wide and the Mohs technique is often used [14,15,16]. Lymph node dissection is indicated only in cases of suspected malignant transformation. The few dissected lymph nodes in our case report showed reactive lymphoid proliferation with no evidence of malignancy. Radiotherapy is rarely used; if so, usually when excision is not recommended or in recurrences. Post-treatment clinical monitoring is strongly suggested.

CONCLUSION

In our patient, wide excision of the tumor was performed. The patient recovered well after extensive surgery (figure 5). Our patient failed to present for proper follow-up. A possible home visit should be arranged before discharge for proper follow-up for such an uncommon case.

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