Scholars Journal of Medical Case Reports
Abbreviated Key Title: Sch J Med Case Rep
ISSN 2347-9507 (Print) | ISSN 2347-6559 (Online)
Journal homepage: https://saspublishers.com

OPEN ACCESS

Gastroenterology

Giant Condyloma Acuminata - Buschke Lowenstein Tumor (About 3 Cases)

Naima El Azzam[1*], Mariama Jarti[2], Khadija Krati[2]

[1]Gastroenterology Service, Mohammed VI University Hospital Center, Marrakech, Morocco
[2]Department of Gastroenterology, CHU Mohammed VI Marrakech, Morocco

DOI: 10.36347/sjmcr.2022.v10i10.010 | **Received:** 27.08.2022 | **Accepted:** 01.10.2022 | **Published:** 14.10.2022

***Corresponding author:** Naima El Azzam
Gastroenterology Service, Mohammed VI University Hospital Center, Marrakech, Morocco

Abstract **Case Report**

Buschke-Löwenstein tumor, or giant condyloma acuminata, is a rare viral disease, characterized by a potential for malignant transformation and invasion and recurrence after treatment. We report 3 cases of Buske-Lowenstein tumour. BLT was confirmed by biopsy and was treated by complete surgical resection. Treatment has not been clearly defined and is essentially based on surgery. Sexual education and early treatment of condylomatous lesions can improve the prognosis of this disease.

Keywords: buschke-lowenstein tumour, verrucous carcinoma, VPH (human papillomavirus).

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INTRODUCTION

Buschke-Löwenstein tumor, or giant condyloma acuminata, is a rare, sexually transmitted nosological entity. It is a viral infection induced by the human papillomavirus (HPV) whose most frequent serotypes are 6, 11, 16 and 18 [1]. The histological appearance is in fact benign, it is characterized by a progressive, deteriorating evolution and a particular resistance to treatment, Surgery is the treatment of choice [2]. We report on this subject our experience through a series of 3 observations, reviewing the data of the literature.

OBSERVATION

First Clinical Case

A 50-year-old patient, with a history of risky sexual intercourse, chronic tagagic at a rate of 30 PA, who presented on clinical examination with a painless vegetating lesional process at the anoperineal level evolving for 4 years. The lymph node areas were free. HIV, syphilitic and hepatitis B and C serologies were negative. Histological examination of a biopsy sample had revealed epitheliomatous hyperplasia which was made up of an acanthotic, papillomatous squamous cell coating, surmounted by parakeratotic hyperkeratosis with the presence of koilocytes indicating infection by the HPV virus (Papillomavirus), without cellular atypia. The patient was referred to plastic surgery for surgical treatment

Second Clinical Case

59-year-old patient, with a history of unprotected sexual intercourse, multiple sexual partners, and chronic smoking at a rate of 45 PA, who presented with multiple verrucous lesions initially at the perianal level extending to the inter-gluteal fold, external genitalia, rapidly increasing in size and number, affecting his sex life (Figure 1, Figure 2). Dermatological examination showed multiple irregular exophytic verrucous cauliflower-shaped lesions of brownish- black color, others of pink color with infiltration of the base with the presence of bilateral inguinal adenopathies. A skin biopsy was performed with the histopathological study an aspect of condyloma acuminata: a tumor of Buschke Lowenstein without sign of transformation or invasion.

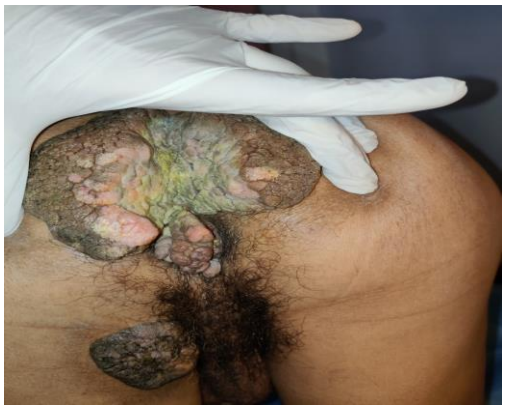

Figure 1

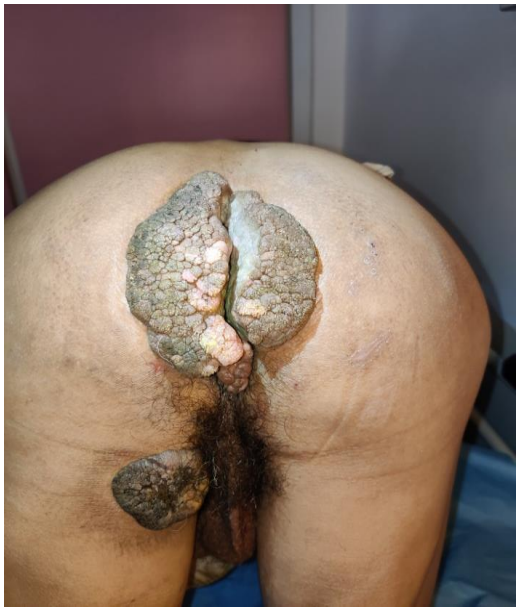

Figure 2

Third Clinical Case

A 51-year-old patient with a history a chronic smoking at 40 year and one packageschronic alcoholism, with the notion ofunprotected sex. Who presented for 5 years pruritic skin lesions at the perineal level with perianal extension progressively increasing in size withoozingand pain. The clinical examination showed a poor general condition, pinkish- white grape-like vegetations (associated with wart lesions) superinfected with bilateral inguinal adenopathies. The balance sheetorganic showed an infectionimmunodeficiency virus. Serologies for syphilis, hepatitis B and hepatitis C were negative. At the end of the radiological assessment, MRI had objected avoluminousx extensive perineal tumor processfromanal canal at basand locally infiltrating middle rectum associated with collections of pelvic fat, skin lesionsbuddingpenile and periscrotal and bilateral inguinal ADP. Anatomopathological examination of the biopsy of the lesion revealed epitheliomatous hyperplasia with an acanthotic, papillomatous squamous cell coating, surmounted by parakeratotic hyperkeratosis without signs of malignancy. The HPV was not sought.

DISCUSSION

CAGs were first described in the 8th century BC, BUSCHKE and LOWENSTEIN in 1925 were the first to describe the bulkiness of these tumors and thus the term BUSCHKE and LOWENSTEIN tumor was born [1]. The transmission of TBL is mainly through sexual contact and also through water, linen, gloves and other soiled materials [3]. Its annual incidence appears to be 0.1% among the sexually active adult population [4, 5]. It occurs at any age after puberty and predominates between the 4th and 6th decades [6]. Multiple risk factors (pregnancy, immunosuppression, etc.) and comorbidities (HIV, syphilis, chlamydia, etc.) are often reported in the literature. The natural evolution can be towards local invasion, recurrence or malignant transformation. For Tufft [7], this malignant transformation can reach 8.5% to 23.8% in the form of squamous cell carcinoma. Types 6, 11, 16 and 18 are the most frequent; among these types 16 and 18 are more oncogenic.

TBL is most often located in the external genitalia and mainly in the penis. The anorectal localization remains less frequent but it is not uncommon. This localization is found in both sexes with a male predominance [4, 8, 9]as was the case in our series. In men, TBL is localized in 81 to 94% of cases in the penis and in 10 to 17% of cases in the anorectal region. In women, the localization is essentially vulvar in 90% of cases, unlike the anorectal localization which remains less frequent.[5]. In our series, localization at the level of the anal margin is constant with two cases of rectal involvement and four cases of invasion of the external genitalia.

Diagnosis is often clinically based for an experienced clinician who easily rules out condyloma of secondary syphilis. Nevertheless, Histologically, it is a perfectly limited squamous tumor, characterized by considerable epithelial hyperplasia, sometimes pseudo-epitheliomatous, hyperacanthosis, hyperpapillomatosis and koilocytes which are pathognomonic markers of HPV infection, however their presence does not is not constant. The basal membrane remains intact, which proves the benignity of the tumor despite its malignant behavior [5, 9, 10].

Depending on the location, the extension assessment may include, in addition to the palpation of the lymph nodes, a rectoscopy, a gynecological examination, a pelvic CT scan or a nuclear magnetic resonance [4].

The evolution is slow; it can be burdened with several complications including dermatitis, infection, fistulization to neighboring organs, necrosis, anal stenosis and hemorrhage [6, 9]. Malignant transformation is one of the evolutionary risks [11]. It has been reported in 30% to 56% of cases [6, 9, 11, 12].

Treatment of TBL is often difficult, even if histology confirms benignity [13]. Surgery remains the treatment of choice for the majority of authors [6, 8]. It must be large enough or even mutilating to rule out the specter of recurrence and hope for a definitive cure. It varies depending on location [6, 14]. In perianal localizations, excision with preservation of the sphincter and reconstruction is carried out as often as possible, but heavier interventions such as amputation of the rectum or abdominoperineal amputations are sometimes necessary [8]. The complete nature of the surgical excision of the TBL must be confirmed by the anatomopathologic examination of the surgical

specimen. If surgical excision is incomplete, revision surgery is indicated [14]. Patients with extensive lesions with multiple fistulous tracts and/or superinfection may require a temporary offloading colostomy [15].

Topical topicals (podophyline, 5FU), electrocoagulation, cryotherapy, and laser destruction widely used in the treatment of banal warts are ineffective in the treatment of TBL [6, 8, 13, 16]. These means have the major drawback of not providing tissue for histological analysis [14, 16].

Immunotherapy by autovaccination seems to have some efficacy in the treatment of old and recurrent warts [6].

Systemic chemotherapy with bleomycin or methotrexate is an alternative treatment, even if it only leads to tumor regression, most often incomplete. The treatment of choice is surgery because it is the most effective, especially in the early stage of the disease [17, 18] and allows histological analysis of the entire piece with search for foci of degeneration [19]. The resection should be as large as possible, leaving a margin of healthy tissue confirmed by pathological examination. This therapeutic imperative sometimes requires, in the case of infiltrating TBL, the total amputation of an organ, in particular the rectum [20, 21] or the vulva. In case of incomplete resection, surgical revision is necessary. Lymph node dissection is not indicated except in cases of degeneration. The repair may require nearby skin or muscle flaps. The frequency of recurrences and the risk of occurrence of squamous cell carcinoma require prolonged clinical (loco-regional) and histological monitoring [22].

The risk of recurrence after excision is 60 to 66% [11, 15] they are the direct consequence of a surgical procedure that is too limited [14].

CONCLUSION

The Buschke-Lowenstein tumor (or giant condyloma acuminata) is a rare tumor requiring early and extensive surgical treatment with post-surgical, clinical and frequent monitoring require rapid diagnosis and the most radical treatment possible, The functional and vital prognosis can be initiated, hence the importance of preventing STIs through safer sex and sex education for young people.

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