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A Buschke-Lowestein Tumor or Giant Acuminate Condyloma in a Third Year age Patient

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Abstract **Case Report**

Buschke-Löwenstein tumor or giant condiloma acuminate is a sexually transmitted disease caused by human papillomavirus.It is mainly characterized by it deep extension, degenerative potentiality and character of recurrence after treatment. This work aim is to report a case of an uncommon dimension of giant condiloma acuminate surgically treated, without a relief complication and recidivism after two year observation in a third age subject with more than a decennium evolution which allow us to describe our therapeutic step, show the obtained result, discus clinic and epidemiological aspects and insist on surgery like a method of choice.
Keywords: Giant condiloma acuminate, papillomavirus, Buschke-Löwenstein.

INTRODUCTION

The tumor of Buschke-Löwenstein (TBL), or giant acuminate condiloma, is a sexually transmitted disease due to human papillomavirus, usually of type 6 and/or 11. It is rare and always preceded by warts acuminate [1]. Its frequency in the general population is estimated at 0.1% [2, 3]. This epithelial tumor has still poorly defined relationships with warty carcinoma, the histological aspect is in fact benign, and although it's clinical appearance evokes rather the opposite. It particularly affects man [1] (77%) [3].The malignant transformation of TBL is estimated to be between 8.5% to 23.8% [4] See 30 [5, 6] and 60%. The recidivism rate is very important; estimated by Chu *et al*. at 66% [6].

It is mainly characterized by its deep extension, its degenerative potential and its recurrent character after treatment [1]. The treatment of choice is particularly surgical.

The purpose of this work is to report a case of giant acuminate Condiloma of a very rare size, in a third age subject of an evolution of more than a decade; This allows us to describe our therapeutic approach, to show the result obtained, to discuss the clinical and epidemiological aspects and to insist on surgery as a therapeutic method of choice.

CASE REPORT

This is a 66-year-old patient M.K. D, a retired administrator, with a history of a multiplicity of partners; Inveterate smoker with a history of syphilis treated and heals in his youth who consulted for a mass stretching from the hypogastrium to the perianal part and with small tumors at the small part of the back. The appearance of symptom was about 15 years old; having started with a small non-painful growth at the penis level and increased in volume gradually. He had an emotionally uneasy weeping that day.

The clinical examination found a huge tumor occupying part of the Hypogastrium, the pubis, the inguinal folds; the penis is totally covered and invisible at simple sight. The tumor had the appearance of clusters of grapes or cauliflower, whitish, and friable by location; Ulcerated with purulent and foul blood secretion in the groin region (Figure 1); and measuring 22 cm of large axis.

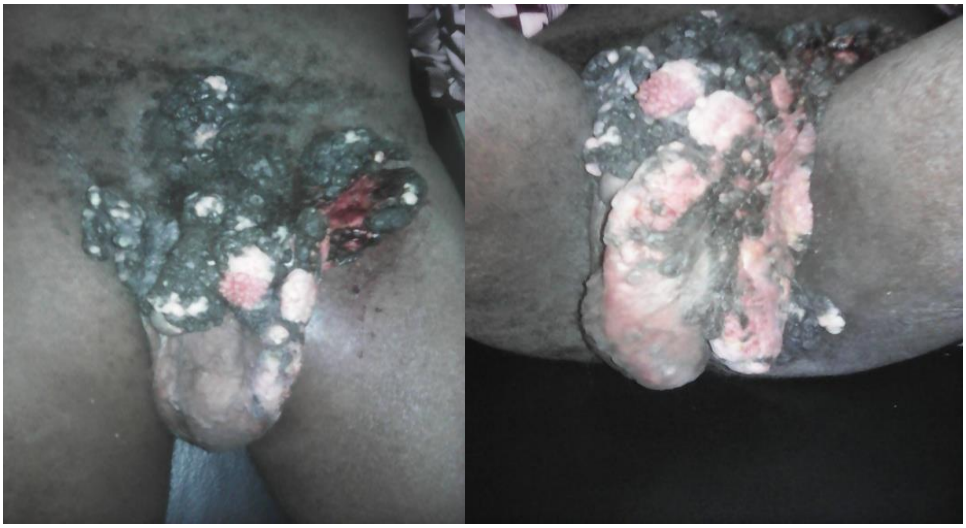

Fig-1: Tumor occupying part of the hypogastrium, pubis, and inguinal folds; the penis is totally covered and invisible at simple sight. The tumor to the appearance of vegetation in grape clusters or cauliflower, whitish, and friable by location; Ulcerated with blood-purulent and foul secretion in groin and femoral region on left

Examination of the inguinal folds had noted adenopathies. Serology of the human immunodeficiency virus was negative and the other results of the pre-operative assessment were uncharacteristic.

The treatment undertaken was a complete surgical resection in blockage of the tumor (Figure 2) and then the resulting area was repaired with hypogastrium skin flaps, groin and scrotal flaps. Drains were placed and removed twenty-four hours after, and a bladder probe was removed after 10 days (Figure 3).

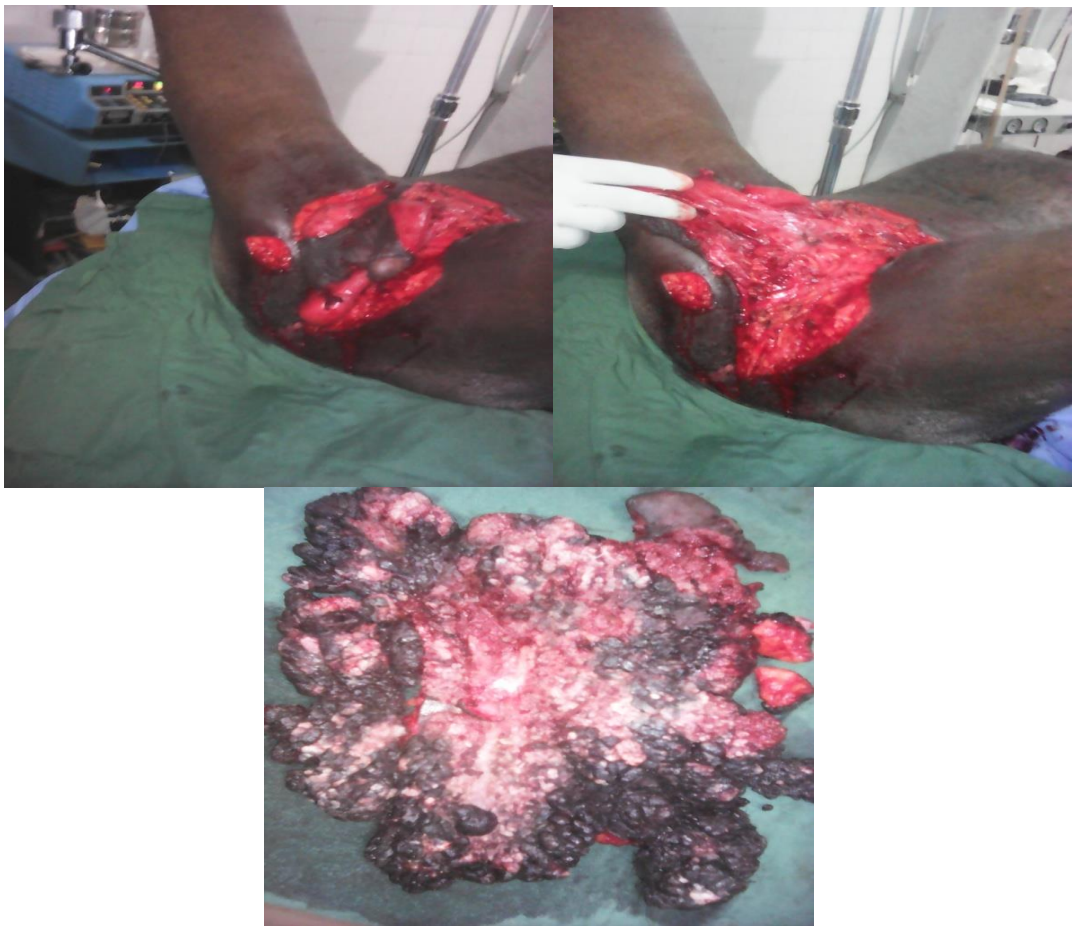

Fig-2: Complete and block surgical resection of the tumor

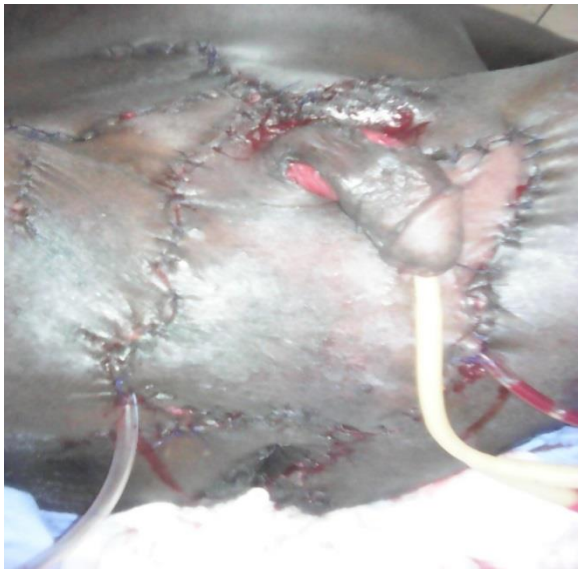

Fig-3: Resulting area of the resection repaired with skin flaps hypo gastric, Inguinal fold and the Scrotum. Drains were placed and removed twenty four hours later as well as a bladder probe that was removed days later

The pathologically examination shows from the macroscopic point of view a piece of about 20cm of large axis against 12 cm wide (Figure 4). While the histological study objectively examined hyper acanthosis, hyperkeratosis, hyper papillomatosis, and koïlocytaires cells without atypia. The chorion was infiltrated by a few inflammatory cells.

Fig-4: Anatomical piece of 20cm approx. large axis against 12 cm wide after a small shrinkage following preservation

The study concluded the histological aspect of a reworked acuminate condiloma (Figure 5). During the follow-up, pain was noted in the most distal part of the hypogastrium flap, which was healed by second intention. No recurrence was observed after a one-year and half observation (Figure 6).

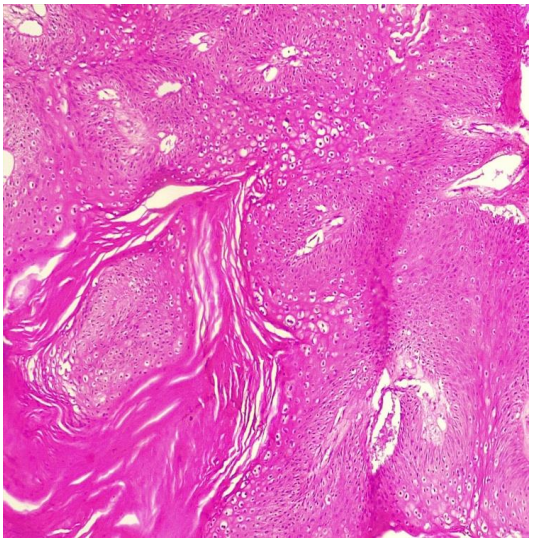

Fig-5.A: 10X

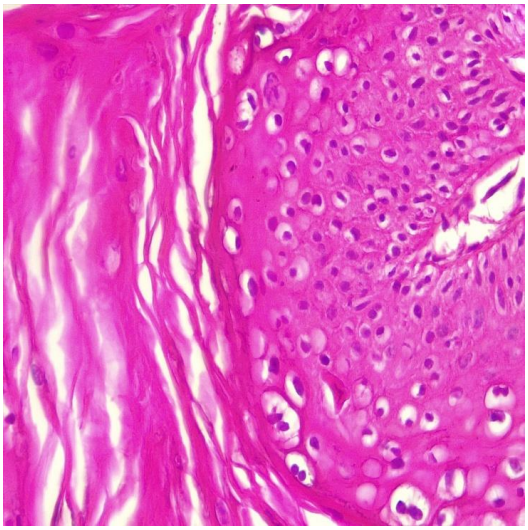

Fig-5.b: 40X

Figure 5: Microscopic view in different resolution showing hyperkeratosis and koïlocytaires cells without atypia

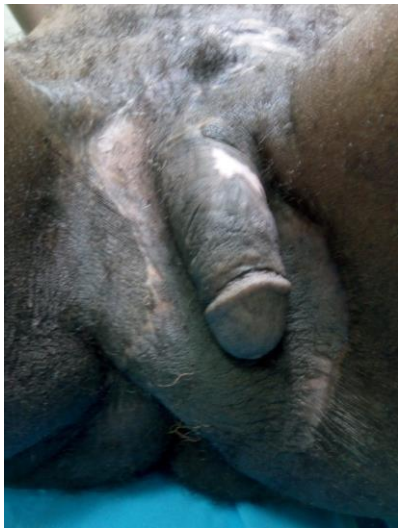

Fig-6: After one year and half of observation no recurrence is observed

DISCUSSION/COMMENTS

The tumor of Buschke-Löwenstein (TBL) or giant condiloma is caused by the papillomavirus originally described by Buschke in 1896. TBL was defined as a separate entity in 1925 by Buschke and Löwenstein [7].

It is a rare disease whose frequency in the general population is estimated at 0.1% [2, 3] The Buschke-Löwenstein tumor occurs at any age after puberty [5]. Its prevalence is 50 times higher among people aged 17-33 years, with a peak at 20-24 years [3]. Other authors evoke his predominance of age between the 4th and 6th decades [2, 5]. The giant warts occur at all ages with an average age of 45 years [6]. It predominates in humans [2.3] (77%) and is located in 81 to 94% of the cases to the penis and in 10 to 17% to the anorectal region [3]. The multiplicity of partners, prostitution, homosexuality, lack of hygiene and chronic infections promote HPV contamination [4].

The giant acuminate condiloma usually occurs in a context of immunosuppression in transplanted, HIV-infected patients and toxicoman homosexuals, multiple sexual partners, smoking, chronic irritation, problems Sexual health [3]. TBL may also be associated with congenital or acquired immunodeficiency by AIDS, immunosuppressive therapy, ethyl, diabetes, and chemotherapy [4].

Clinically, giant acuminate warts usually start with small rounded or filiform pink lesions or normal skin color. The duration of the transformation varies from a few months to several years. In the state phase, there is a large tumor (which can exceed 10 cm of large axis) papillomatosis, irregular, with a bristling surface of digitations, burgeoning, cauliflower, often whitish or yellowish color, often presenting Superficial ulcerations and over added infectious lesions [4].

Histologically it translates into an exo-hyperpapilomatosis and endophytic with hyperacanthosis. The hyperplasic epithelium is well differentiated, regular, without cytonuclear anomalies. The basal membrane is respected. In the underlying chorion a lymphadenitis inflammatory infiltration is present [5]. The TBL is often characterized by apparently benign data [6].

Despite the evoked benignity of this tumor due to the presence of non oncogenic HPV, there is the possibility of evolution towards an invasive tumor which classifies it as a border line tumor [5]. It is characterized by gradual evolution, decaying and special resistance to treatment [8] evolution can be made towards surface and depth extension, it can be complicated by dermatitis, over-infection, or fistulisation to neighbourhood organs, or necrosis. Spontaneous regression is exceptional and recidivism can be seen especially after incomplete resection. Degeneration can be made towards invasive micro-carcinoma. In other cases, the appearance is that of a well-differentiated invasive keratinizing squamous carcinoma [5].

The malignant transformation of TBL is estimated to be between 8.5% and 23.8% [4] See 30% [5]. The most common histological type is represented by squamous carcinoma [4]. There are several therapeutic methods for warts in general such as the use of podophylin, cryotherapy using liquid nitrogen and coagulation; but the treatment of choice is particularly surgical for the TBL because it is most effective especially during the early stage of the disease and allows the histological analysis of the whole room with research of degenerative foci. The resection should be as wide as possible, carrying a healthy margin of tissue confirmed by the pathological examination as well as deep to examine the full thickness of the proliferation and especially the interface with the underlying chorion, in search of an invasive carcinoma.

CONCLUSION

The TBL is a rare pathology in our days whose age of occurrence varies well according to the different authors; however, actions deserve to be taken to prevent it, to diagnose it early in order to facilitate the effective management that is eminently surgical. It would be a real psychological problem with emotional assignment. Her possibility of malignant transformation makes her pathology to be feared.

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