CASE REPORT

Perianal giant condyloma acuminata [buschke lowenstein tumour] – first case report from the Kashmir valley

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Abstract

Buschke Lowenstein tumour or giant condyloma acuminata is a rare entity with only less than 50 cases reported in English literature so far. No such case has been reported from the Kashmir valley. They are considered as intermediate lesions between simple condyloma acuminata and invasive squamous cell carcinoma. A 57-year-old heterosexual male presented with a giant perianal condyloma. The lesion was surgically excised completely. Postoperatively patient was put on topical 5-FU ointment. Patient is recurrence free 6 months after surgery. The giant condyloma acuminata is an aggressive tumour with propensity for recurrence and malignant transformation. Surgical excision is the treatment of choice. One such rare case is discussed with review of literature.

Keywords Condyloma acuminata · Buschke lowenstein · Perianal

Introduction

Perianal giant condyloma acuminatum is rarely encountered with only less than 50 cases reported so far [1]. It starts as a keratotic plaque and slowly expand into a cauliflower like mass, forming a locally invasive but non-metastasising growth that may almost obliterate the anal canal. Most common presenting symptoms are pelvic pain, perianal discharge, anorectal bleeding or disturbance of defecation [2]. They have propensity for fistula formation, infection and malignant transformation. The incidence of malignant transformation has been reported to be as high as 52 percent which is quite high compared to 1.82 percent in ordinary condyloma acuminatum [2]. First case with such pathology from the valley is reported with brief review of world literature.

Case report

A 57-year-old heterosexual male, smoker presented with swelling in perianal region. Two months back he had noticed a small polypoidal mass posteriorly in perianal area at the time of defecation. Gradually the swelling increased in size and involved whole area around anus. There was history of constipation and difficulty in sitting. There was no history of bleeding per rectum, painful defecation, perianal discharge, i/v drug abuse or sexual contact with multiple partners. His general physical examination and systemic examinations were unremarkable. Local examination revealed a warty mass surrounding whole of circumference of anus and even occluding the lumen (Figs. 1, 2). There was no ulceration or discharge. There was no inguinal lymphadenopathy. Sigmoidoscopy was normal. Edge biopsy report was squamous papilloma. Patient was negative for HIV, HBsAg and HCV serology.

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Fig. 1 Giant condyloma acuminata of perianal region

Fig. 2 Pre operative picture

Fig. 3 Postoperative picture

Patient was subjected to wide local excision of giant condyloma followed by primary closure – mucosa to skin using 2'o'catgut (Fig. 3). Postoperative period was uneventful. Patient on follow-up was found to have a few isolated pin head sized recurrent lesions. The patient was put on local application of 5-Fluorouracil to which he showed response with complete disappearance of the lesions. Histopathology of the removed specimen revealed no foci of malignant transformation.

Fig. 4 Patient on follow-up after receiving topical 5-FU

Discussion

Giant condyloma acuminata or Buschke Lowenstein tumour is considered as an intermediate lesion between condyloma acuminatum and invasive Squamous cell carcinoma because of their common Human Papilloma Virus aetiology. While both giant condyloma acuminatum and ordinary condyloma have benign histology, the former is differentiated from latter by thicker stratum corneum, marked papillary proliferation and tendency to invade deeply and displace underlying tissue but with an intact basement membrane.

Factors incriminated in causing this disease are:

- Infection with Human Papilloma Virus [HPV] especially type 6 and 11 [3].
- Irritant effect of long term anoreceptive intercourse [4].
- Smoking plays a role in transformation of anorectal lesions in same way as it is known to cause cervical dysplasia.
- Immunosuppression characterized by development of aggressive condylomata in AIDS patients [5].

Wide surgical excision is the treatment of choice in these lesions. What appears to affect overall survival is early control of the disease with radical surgery [6]. It could not be determined whether the use of Abdominoperineal Resection represents an insightful early aggressiveness or late gesture of desperation. Vigilant followup and in case of recurrence or malignant transformation, early APR appears to provide the most promising hope for cure. Radical surgery of the kind indicated by these lesions inevitably results in the need to reconstruct the perineum. Small skin wounds may be closed primarily or covered with mesh skin grafts, while larger defects may require myocutaneous flaps. Gracilis myocutaneous flaps are favored as they are technically less demanding, provide immediate perineal reconstruction in single stage operation, allow good rehabilitation with minimum morbidity and functional deficit with added benefit of leaving the abdominal wall intact allowing secure stoma sighting [6].

Immunotherapy as an alternative treatment in these large lesions had success rate of 94 percent [7]. Individual vaccine is prepared from each patient and injected back into the patient.

5-Fluorouracil is useful in prevention of recurrence after condyloma ablation. It should be started within 4 weeks especially in immunocompromised patients. It should be administered as 5% cream biweekly for 10 weeks. It has been considered best option for preventing recurrence in immunocompromised patients [8].

Topical application of podophyllin though works well in ordinary condyloma, yields poor results in giant condylomata. Further its use may cause histologic changes that resemble carcinoma and can therefore cause diagnostic difficulties.

The role of radiotherapy and chemotherapy in treating these gigantic lesions is uncertain. Extensive diseases are associated with high rate of recurrence from radical surgery because of spillage during operation. By reducing these lesions preoperatively with chemoradiotherapy this situation can be prevented. So a preoperative chemoradiation needs to be given a trial. Fears of putative carcinogenic effects of neoadjuvant chemoradiotherapy are not borne out, neither are those concerning the disruption of tissue planes, as the lesions themselves distort and destroy the local anatomy.

Carbon dioxide and Nd-YAG laser is also used to excise these lesions and causes less post surgical pain and better healing of surgical wounds [9]. Intralesional Bleomycin or Interferon has also been tried in such lesions. The latter is expensive and requires frequent office visits.

This case illustrates the difficulties encountered in managing Giant condyloma acuminata because of rarity of disease and lack of clinical trials. Early aggressive surgical excision appears to be the treatment of choice. Application of topical 5-FU appears to be important in preventing recurrences. Furthermore, the need for vigilant surveillance postoperatively cannot be underemphasized.

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