

Anorectal Buschke-Löwenstein Tumor: A Case Report

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DOI: [10.36347/sjmcr.2022.v10i11.001](https://doi.org/10.36347/sjmcr.2022.v10i11.001)

| Received: 22.09.2022 | Accepted: 29.10.2022 | Published: 02.11.2022

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Abstract

Case Report

Giant condyloma acuminata (GCA) or Buschke Lowenstein tumour (BLT) is a rare clinical entity of viral origin, transmitted essentially by sexual transmission, and is common in immunocompromised patients. It develops in the genital or perianal area, creating a large, bulging lesion that may be ulcerated or fistulised in neighbouring organs. The search for other associated sexually transmitted infections is mandatory. A rigorous clinical examination and additional imaging allow a precise assessment of the lesion to be made. Treatment is essentially surgical and must be extensive because of the tumour's high recurrence potential. Neo-adjuvant treatments such as chemotherapy or immunotherapy deserve to be better evaluated to limit the disabling nature of surgery.

Keywords: Condyloma acuminatum, Buschke-Löwenstein, HPV.

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INTRODUCTION

BLT is a pseudo epitheliomatous growth belonging to the group of verrucous carcinomas. It was first described in 1896, and in 1925 Buschke and Löwenstein made it a characterized entity. It is a viral infection induced by the human papillomavirus (HPV) whose most frequent serotypes are serotypes 6, 11, 16 and 18 [1]. The risk factors are: poor anorectal hygiene, pregnancy, multiparity, homosexuality, immunosuppression, smoking, alcohol and sexually transmitted infections [1]. Management is often controversial: therapeutic abstention, surgical excision, electrocoagulation, CO₂ laser, immunotherapy. A consensus seems to be emerging for the surgical option. We report in this work a case of ano-rectal and perineal BLT treated by surgical excision. The aim of our work is to describe the anatomical clinical, histological and therapeutic aspects of BLT.

CASE REPORT

Ms B.C, 22 years old, widow with a history of history of unprotected sexual intercourse, multiple sexual partners with notion of anal intercourse, presented with multiple verrucous lesions initially at the perianal level extending to the external genitalia rapidly increasing in size and number with a tendency to

ulceration causing her to have an impact on her sexual life (Figure 1, Figure 2).



Figure 1: Genital cauliflower-like lesion

Citation: A. Snoussi, M. Zouaoui, F. Z. Boubakr, N. Elmoutaouakil, S. Noubail, M. Boussouab, S. Boustani, Y. Hnach, M. Azouaoui, N. Aqodad. Anorectal Buschke-Löwenstein Tumor: A Case Report. Sch J Med Case Rep, 2022 Nov 10(11): 1074-1076.



Figure 2: Ano-rectal cauliflower-like lesion

The rest of the examination (rectal exam and lymph nodes) was unremarkable. The sexually transmitted infection test (TPHA, VDRL, chlamydia serology, HIV) was negative. A skin biopsy showed a condyloma acuminata: a Buschke-Lowenstein tumour with no signs of transformation or invasion (Figure 3).

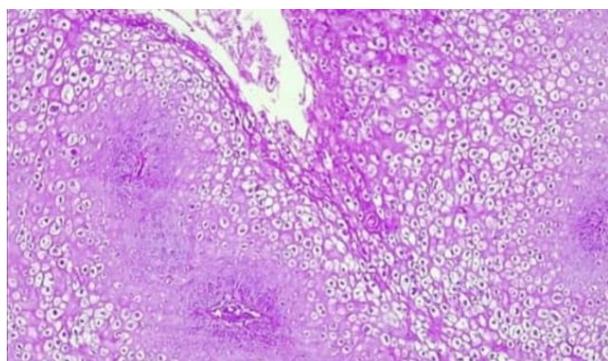


Figure 3: Histological lesion of giant condyloma acuminata

Pelvic magnetic resonance imaging (MRI) showed a vegetative ano-perineal tissue process, with a cauliflower-like appearance invading the external genitalia and respecting the sphincter. After a multidisciplinary meeting, an excision with preservation of the sphincter and reconstruction was performed in our patient.

DISCUSSION

BLT or giant condyloma acuminata was first described in 1896. It was in 1925 that Buschke and Löwenstein made it a characteristic entity [1, 2]. The transmission of BLT is mainly sexual [3]. Pregnancy is a factor that favours the onset and

development of BLT. During pregnancy, BLT is more common [3]. The condylomata in pregnancy usually regress and disappear after delivery and do not aggravate dysplastic lesions, even if severe [3]. HPV infection affects 70% to 80% of the sexually active population, only 0.1% of the general population affected will develop BLT [4]. In the literature, young adults are the most affected. Mother-to-child transmission can occur in utero via the placenta or during placenta or during vaginal delivery, justifying the need to examine all newborn child of a mother with a BLT. The natural course may be to local invasion, recurrence or malignant transformation malignant transformation, 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, of which 16 is the most common. 16 and 18 are more oncogenic. The diagnosis is often based on clinical findings. Histology is necessary in order not to miss a malignant transformation. Imaging (CT scan and/or magnetic resonance imaging of the pelvis) is necessary to assess perineal tumour extension and the operability of the lesion. Local treatments, based on silver nitrate and podophylline, have shown the limits of their effectiveness and their indication. For our patient, we opted for a surgical treatment with a satisfactory result. Once the surgical removal of the tumour. After surgical treatment, Buffet *et al.*, [6] recommend destructive adjuvant treatment, chemical or physical, or with an immunomodulator. The monitoring should be carried out for a period of at least two years to ensure that there is no recurrence or malignant transformation.

CONCLUSION

BLT is a viral condylomatous epithelial proliferation of uncertain genesis with a risk of transformation into squamous cell carcinoma. Its prevention is imperative based on the treatment of condyloma acuminata and the fight against sexually transmitted diseases. Treatment must be early and is essentially surgical, requiring a large exeresis. Close and prolonged postoperative clinical and histological surveillance is necessary, without losing sight of the notion of degeneration of the recurrence.

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