Verrucous Carcinoma Arising in a Giant Condyloma Acuminata (Buschke-lowenstein Tumour): Ten-Year Follow-up

Dear Editor,

Giant condyloma acuminate (GCA) first described by Buschke, also known as Buschke-Löwenstein tumour (BLT), is a slow growing, semi malignant neoplasm of the external genitalia and perianal region that has a recurrence tendency.[1] Inspite of its histologically benign appearance, BLT clinically behaves in a malignant fashion, destroying adjacent tissues, and is reported as an entity intermediate between an ordinary condyloma acuminatum and squamous-cell carcinoma (SCC).[2] BLT is likely to be a step into a spectrum of diseases that include malignant degeneration.[1] Verrucous carcinoma (VC) was first described as a distinct well-differentiated variety of SCC by Ackerman.[2] VC tends to appear mainly in oropharynx, genitalia and soles, although it may occur anywhere on the skin. Thus, VC has been known by several different names in relation to the anatomical site of the lesion.[3] Different treatment modalities were applied on those patients with VC.[1,3]

A case of BLT in the perianal region and secondary VC, that was treated only by surgical excision and was followed-up for 10 years, is presented and the literature is reviewed in this letter.

Case Report

A 47-year-old male patient had a polypoid mass in the anal region for 14 years. As the mass increased in size, bleeding occurred, thus, he sought treatment at the out-patient clinics. There was no anal intercourse in his past history. A 9 x 7 cm papillomatous mass was found in the perianal region (Fig. 1). Digital rectal examination revealed that an absence of mucosal involvement.

Biopsies of the mass were reported as VC. Human papilloma virus (HPV) deoxyribonucleic acid (DNA) analysis by polymerase chain reaction revealed HPV type 6. Endorectal ultrasound scan showed that the muscular layer of the anal canal was not involved and that there was an absence of any enlarged perirectal lymph nodes. Wide local excision, a closure with rotation flap and a temporary diverting colostomy were performed. Histopathological examination of the resected material was reported as VC with free margins more than 1 cm. He was discharged from the hospital without any complication on the seventh postoperative day. No adjuvant treatment was given. Colostomy closure was performed on the third postoperative month. He is healthy and is without any evidence of tumour at the end of the tenth postoperative year.

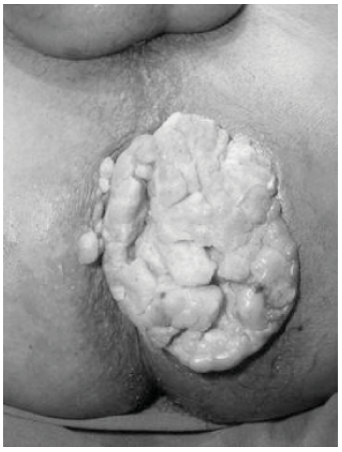

Fig. 1. A 9 x 7 cm papillomatous mass in the perianal region.

Discussion

BLT is a rare form of tumour and its clinical description is still debatable. Although some authors suggested that perianal VC and BLT are synonyms, it has also been described as an intermediate lesion between condyloma acuminata and VC.[2] BLT is more frequently described as GCA that developed into a candyloma acuminata.[1,4] It has been proposed that BLT has a higher tendency to change into SCC and less likely into VC.[1] Chronic alcoholism, immunosuppressive diseases or drugs are risk factors that increase neoplastic transformation and postoperative recurrence rate.[5] Our patient did not have any of these risk factors.

HPV types 16 and 18 are highly malignant whereas HPV types 6 and 11 are relatively low risk. There have been reports about VC cases with HPV type 6.[2] The present patient also had HPV type 6. There is a lack of literature for the treatment after complete resection for various HPV genotypes.

The spectrum of the treatment modalities for those cases with SCC ranges from wide local excision to abdomino-perineal resection with pelvic lymph node dissection and chemo-radiotherapy.[1,4] Since there is insufficient literature about BLT, there is no consensus on the most effective treatment modality. The treatment is more complex for the cases of BLT that transforms into VC.[1]

Biopsy of the lesion before definitive resection is reasonable to establish the diagnosis of GCA. Complete

resection of the tumour is essential.[1,5] Benefits of adjuvant radio-chemotherapy have yet been described. Choosing an appropriate therapy for GCA depends on several factors namely clinical symptoms, location, size and number of warts. Cases reported in literature often lacked controlled studies and the longest period of follow-up was 2 years.[1,3] Our patient was followed-up for 10 years after complete local excision without adjuvant radio-chemotherapy. He is still alive, without any evidence of disease, at the point of writing.

In conclusion, surgical complete excision of VC is necessary. Effect of adjuvant radio-chemotherapy is not clear yet. This case demonstrates the successful treatment of a VC in the setting of GCA. A clinical complete response was shown following wide local excision in a period of 10 years. To the best of our knowledge, this is the first case of VC reported with a ten-year follow-up. The number of cases reported in the literature should increase in order to reach more concrete results.

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