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Extensive vulvar and perianal condylomatosis: A rare case
Condilomatose vulvar e perianal extensa: Um caso raro

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Abstract

Vulvoperineal condylomatosis is a condition characterized by the presence of warts in the vulvar, perineal, and anal regions, associated with infection by the human *papillomavirus* (HPV), particularly subtypes 6 and 11, and it is more common in women of reproductive age. In rare cases, it may exhibit exuberant growth and, despite being a benign entity, malignancy needs to be excluded if clinical suspicion is present. We report a rare case of extensive vulvoperineal condylomatosis, that was successfully treated by surgery, requiring a multidisciplinary approach due to the complexity and extent of the lesions.

Keywords: Condylomata Acuminata; Papillomavirus infections; Squamous cell carcinoma; Vulva.

Resumo

A condilomatose vulvo-perineal caracteriza-se pela presença de condilomas na região vulvar, perineal e anal e associa-se à infeção pelo vírus do Papiloma humano (HPV), sobretudo os subtipos 6 e 11, sendo mais frequente em mulheres de idade reprodutiva. Raramente, pode apresentar um crescimento exuberante e, embora se trate de uma patologia benigna, deve ser excluída malignidade perante suspeita clínica. Apresenta-se um caso raro de condilomatose vulvo-perineal extensa, tratada, com sucesso, através de cirurgia, que exigiu uma atuação multidisciplinar face à complexidade e extensão das lesões.

Palavras-chave: *Condylomata Acuminata;* Infeção por *Papilomavirus;* Carcinoma pavimento-celular; Vulva.

Extensive vulvoperineal condylomatosis is characterized by excessive growth of verrucous lesions on the genitals and/or perianal region and is usually associated with HPV subtypes 6 and 11. Its development is typically slow and favored by a state of immunosuppression. The presence of a co-existing carcinoma should be excluded. We present a case of a woman with extensive Condyloma acuminatum (CA). A 50-year-old woman was referred to the gynecologic oncology department for a vulvar mass with 4 year history of progression, previously treated with imiquimod unsuccessfully. The patient had a medical history of chronic kidney disease secondary to reflux nephropathy, having undergone two kidney transplants in the past. Her gynecological history includes *menarche* at 13 years old, amenorrhea for the past 2 years, no contraception use, and no previous pregnancies. Her *coitarche* was at 20 years old and had two sexual partners in her life. Her cervical cancer screening was outdated. On examination, a large tumor measuring approximately 12 cm and a right inguinal abcess was identified (Figure 1). The tumor was exophytic and verrucous, involving the labia minora and majora, vaginal introitus, distal third of the urethra, and perianal region. Biopsies revealed condyloma acuminatum, fragments with low-grade dysplasia. Magnetic resonance showed lymphadenopathies, possibly of inflammatory origin. A surgical treatment

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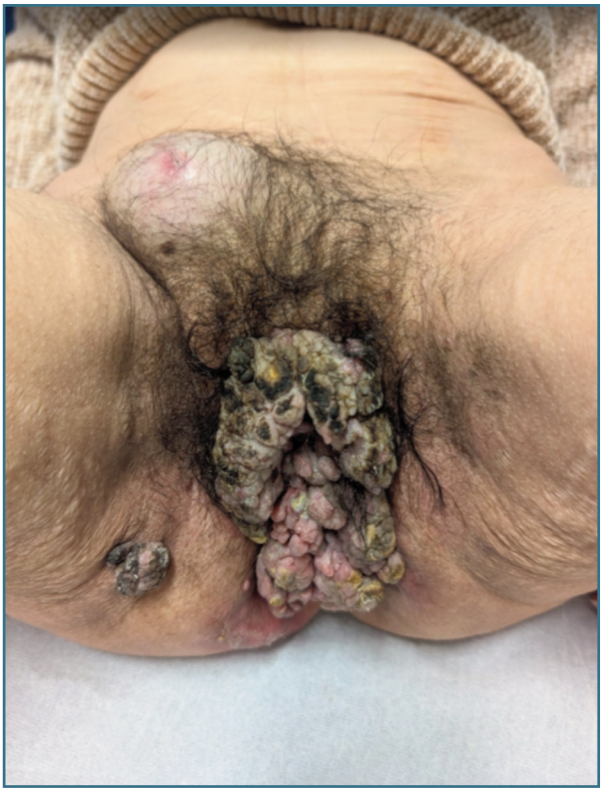

FIGURE 1. Extensive *Condyloma Acuminatum* involving the labia minora and majora, vaginal introitus, distal third of the urethra and perianal region. A right inguinal abscess is observed.

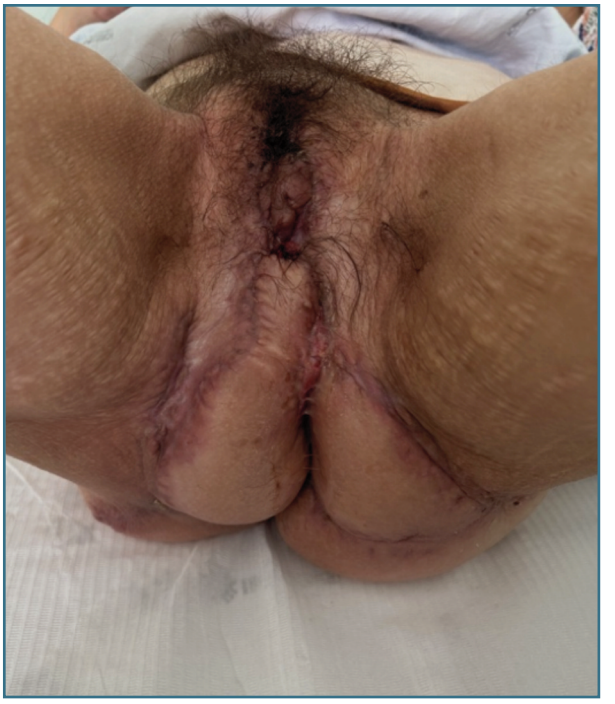

FIGURE 2. Vulva one month after surgery.

approach was chosen, involving a multidisciplinary team of gynecology, general surgery, and plastic surgery. A complete *"en bloc"* excision of the tumor was performed, preserving the urethra and anal sphincter, along with a temporary protective colostomy and perineal reconstruction. Reconstruction of the excision defect was performed using bilateral gluteal fasciocutaneous V-Y advancement flaps. Postoperatively, the patient developed a surgical wound infection by *Enterococcus* and *Klebsiella pneumoniae,* treated successfully with intravenous antibiotic. Histological analysis confirmed the diagnosis of condyloma acuminatum. One month after the surgery, the wound was almost completely epithelized (Figure 2).

CA are benign epidermal growth lesions which result, usually, from HPV infection, generally types 6 and 11, but coinfections with high-risk HPV types are frequent[1-3]. The prevalence of CA peaks in the early sexually active years and the median time between infection and development of lesions is about 5-6 months[1]. Lesions are commonly multiple, multicentric and multifocal, affecting the perianal, vaginal, and cervical regions. They are typically exophytic and may range from papillary excrescences to extensive and large coalescent "cauliflower-like" masses. Immunodeficiency is a major risk factor for development and of recurrence of CA[2,4]. Despite being a benign lesion, premalignant and malignant lesions can be found. If clinical suspicion is present, histopathological assessment via deep incisional biopsy is essential[5]. Its occurrence significantly impacts quality of life and is often associated with patient embarrassment, which contributes to delayed healthcare-seeking and subsequent diagnosis[5]. Management is challenging and should be multidisciplinary. The choice of treatment depends on lesion size, location of the tumor and invasion of adjacent tissues. The presence of a large tumor often requires surgical treatment followed by reconstructive surgery[1,4]. Patients require long-term follow-up to detection of potential relapses[4]. Prophylactic HPV vaccination is recommended to prevent HPV-associated dysplasia and neoplasia[1,3-5].

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AUTHORS CONTRIBUTIONS

BF wrote the article. FG and MB contributed to the interpretation of the data, revision and final approval of the manuscript.

CONFLICTS OF INTEREST

Authors have no conflict of interest.

DETAILS OF ETHICS APPROVAL

Written informed consent was obtained.

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