

## **Giant Anal Condyloma Acuminatum in Childhood: A Case Report**

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### **ABSTRACT**

The authors report a case of anal giant condyloma acuminatum present for 10 years in a 14 year old. The giant tumor was responsible for difficulty in the sitting and difficulty with defecation. Surgical excision was a little limited in order to conserve the anal sphincter. Cauterization with diathermy was done on the remaining small sized lesions at the level of the perineum and at the level of anal canal mucosa. Post-operative follow-up was marked by the recurrence of the tumor after 3 months. Giant ano-rectal condylomas are very rare. The treatment is surgical excision and chemotherapy.

*KEY WORDS: Giant Condyloma, Anus*

### **Introduction**

Condyloma acuminata are one of the most common sexually transmitted infections. They are hyperplastic, sessile or pedunculated neoformations, red or pink, forming sometimes soft exuberant masses, strangulated at their base. The human papilloma virus (HPV)<sup>1,2</sup> causes them. In men, they occur most commonly on the preputial area, on the coronal sulcus and the urethral meatus, rarely on the scrotum and the anus. In women, they predominate on the posterior vaginal vestibule and the vulva; they can extend to the vagina, the urethra, the perineum and the uterine

cervix. Pregnancy, diabetes, some hematological conditions, immunosuppressive therapy and immunosuppression accelerate their growth. They are frequently recurrent and contagious. There are pseudo-tumoral forms like giant anal condyloma and degenerative forms. Histological examination of any excised piece must be systematic.<sup>3,4</sup> Two particular forms are the Buschke-Löwenstein tumor and the verrucous carcinoma (perianal Bowen disease).<sup>5,6</sup>

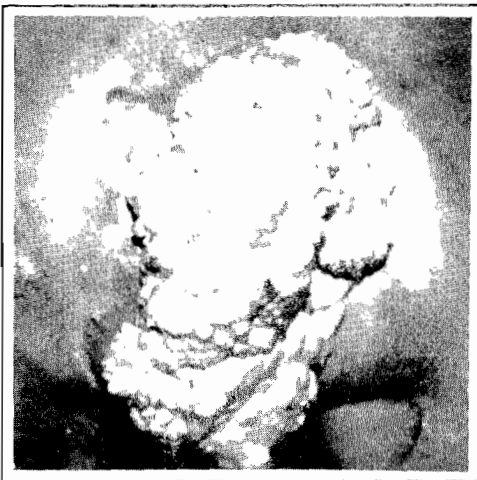
### *Case Report*

A 14 years old boy was admitted for a voluminous anal tumor present

since the age of 4 years. The tumor at this period was small in size, diagnosed and treated as hemorrhoids by local application of herbs without success. The tumor increased in size and almost obstructed the anal orifice, making defecation difficult and painful and sitting difficult. The tumor was exuberant, pink, extending up to the inter-gluteal sulcus and to the posterior perineum. It was offensive. There was no bleeding on contact or fistulous trajectories (Figure 1).

The patient was abandoned by his mother who had been divorced from the father when he was one year old. It was not possible to establish the perinatal conditions as well as the presence of maternal genital condylomata. Examination of the father revealed no ano-genital condylomata. The patient has 3 stepsisters in good health. It was not possible to verify sexual abuse since infancy. History of sodomisation was not obtained. HIV test was negative.

*Figure 1: Giant Anal Condyloma*



The treatment consisted of surgical excision under general anaesthesia with conservation of the anal sphincter. Colostomy performed to allow a good healing of the wound. Electrocoagulation was done on the remaining small lesions. A rectal tube was inserted for few days to prevent anal canal stenosis. Adjuvant treatment included antibiotics and chemotherapy using methotrexate and bleomycine.

Histology of the excised tumour showed hyperplastic condyloma acuminatum with signs of moderate intra-epithelial hyperplasia. The chemotherapy was discontinued due to the limited resources of the family. There was recurrence after 3 months at the level of the anal canal with extension to the rectum and the appearance of bilateral inguinal adenopathies (no biopsy was performed). Closure of colostomy was performed 3 months later in order to simplify home care as the child was returning to his village. On the same occasion excision of the recurrence at the level of the anal canal was performed. This was incomplete and was complicated by destruction of the anal sphincter with fecal incontinence in the post-operative period. Chemotherapy was proposed but could not be given due to the limited resources of the family. The child died 8 months later.

## Discussion

All authors agree with the incidence of condylomata which affects 0.5 -1% of young adults.<sup>1, 3</sup> In the United States, the prevalence of condylomata acuminata have increased 7 fold from 1966 to 1981. If the clinically latent forms are considered, lesions of the

HPV represent the first sexually transmitted infection. <sup>4</sup> Anal lesions can be associated with other genital lesions. Anal localization is particularly frequent and almost exclusive in boys. <sup>7</sup> Concerning the giant condylomas, their anal or ano-rectal localization is rare and represents 10% of cases. <sup>8</sup> Transmission routes are multiple; direct venereal contact, the most habitual transmission route and related most frequently to the practice of sodomy; direct non venereal contact which may be the cause of some cases at the time of delivery. Indirect contact may be the cause as HPV is very resistant, which explains contamination with infected material (gloves, biopsy needles, underwear's, speculums). <sup>2, 3, 9-11</sup> In the present case, the mechanism of transmission is unknown. The beginning of the disease since childhood may be due to sexual abuse without violence such as touches of the penis above the thighs while the child was innocently playing.

Virologically, HPV are the origin of condylomata. They induce tumors in the malpighian epithelium resulting in hyperkeratinisation. Since 1977, more than 60 different types have been identified. <sup>12</sup> The third of HPV actually identified are detected in ano-genital lesions. In a first group of benign HPV, type 6 is associated with exophytic lesions in two-third of the cases and the type 11 in one-third, without clinical difference. HPV is potentially oncogenic of the second group (in particularly types 16, 18, 31 and 35) and are found in cases with dysplasia, carcinoma in situ and invasive cancers. HPV 6 and 11 are found in the Buschke-Löwenstein tumor. Many methods may be used to identify the HPV in the ano-genital

condylomas; electron microscopy, histochemical methods, molecular hybridization methods, and the southern technique, <sup>13</sup> which is long and expensive. Investigation for factors responsible for immune deficiency is important. The occurrence of giant anal condylomas has been notice in patients with HIV infection. <sup>14</sup>

The treatment of giant anal condyloma is surgical. Excision followed by histological examination, and if possible by detection of the virologic type of HPV to determine the prognosis. We do not have at our disposal, in our hospital, the appropriate technical facilities to detect the type of HPV. In case of perineal extension, some authors advice perineal resection and adjuvant radiotherapy. <sup>15</sup> When there is a recurrence or a malignant transformation as in the present case, the treatment is anorectal excision and permanent colostomy. Adjuvant chemotherapy is beneficial. The recommended chemotherapeutic agents are methotrexate and bleomycine. The use of electro-coagulation and cryotherapy with liquid azote and podophyllin is reserved for small condylomas with little extension. Argon or CO2 laser may be used when other forms of treatments have failed or are contraindicated. <sup>16</sup> We have no experience with these. Many authors are unanimous on the malignant transformation of giant anal condylomas. Some authors by analogy with the observations on uterine cervix cancers have demonstrated the role of HPV in anal cancers. <sup>17-19</sup>

Giant ano-rectal condylomas are rare. Few cases have been described in the literature. The treatment remains surgical excision and adjuvant

chemotherapy. Unfortunately the reported case was discovered at a stage beyond our therapeutic facilities.

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