CASE REPORT

Buschke–Löwenstein Tumor mimics Carcinoma Vulva

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ABSTRACT

Giant condylomata are uncommon in developed countries; however, they are prevalent in developing nations. Condylomata acuminata are maximally transmitted by sexual contact. Giant condyloma acuminata, also called Buschke–Löwenstein tumor, is known to be a slow-growing cauliflower-like tumor, which is locally aggressive, with possible malignant transformation. Common management is conservative on medical lines. However, in extreme cases, surgical excision is required. A case of a 68-year-old nulliparous lady with giant condyloma acuminata is reviewed. She presented with a 3-year history of slowly progressive lesion on the vulva, with associated itching and another complaint of difficulty in walking. The growth measured 6 × 5 cm on left labia and was successfully excised with no evidence of malignancy. Concomitant reconstruction was also done.

Keywords: Buschke–Löwenstein tumor, Giant condylomata, Reconstruction, Vulva.

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INTRODUCTION

Condylomata acuminata tumor/venereal warts/or genital warts is a benign condition with proliferative changes in the epidermis and mucosa. These lesions are mainly caused by human papillomavirus (HPV) type 6 or 11. Nonetheless, coinfections with high-risk type of HPV are frequent. They are the most common sexually transmitted diseases (STDs) and are highly contagious. The prevalence is highest in the early years of sexual activity, with two-thirds of the partners of such patients complaining of these warts.¹

Condylomata acuminata are commonly transmitted through sexual/labioscrotal contact.¹ They are hyperplastic, pedunculated, or sessile growths, which appear red or pink, forming soft exuberant masses that are strangulated at their bases.² They are caused by the low-risk serotype of HPV.²

CASE REPORT

This is to report a case of a 68-year-old nulliparous lady residing at an old age home in Delhi. She came to the gynecology outpatient department with the complaint of itching over vulva for 3 years and growth over vulva for 1 year. She also complained of burning micturition for the last 1 month. She was a known diabetic for the last 10 years, but was taking on and off treatment for the same. She did not have any family history suggestive of malignancies or tuberculosis.

On local examination, left subcentric inguinal lymph node was palpable. On local examination, 6 × 5 cm exophytic growth was seen involving the left labia majora extending to the clitoris and urethra (Fig. 1). A patch of leukoplakia was seen over the introitus and the area was excoriated. A small ulcer was noted near the urethral meatus. On per speculum examination, cervix was seen to be high up, flushed with the vagina, and apparently healthy. Vagina also was atrophic and fibrosed near the introitus. On performing a per vaginal examination, her uterus was found to be atrophic, retroverted, mobile, and firm. Bilateral fornices were found to be free.

Fig. 1: Preoperative clinical photograph showing 6 × 5 cm exophytic growth involving the left labia majora extending to the clitoris and urethra

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Fig. 2: Postvulvectomy specimen

After initial examination and blood investigations, her sugar and blood pressure were controlled with appropriate drugs. Once preanesthetic checkup was clear, she was taken up for surgery.

On initial workup, her papanicolaou smear was taken and vulval biopsy was done from four areas, namely, from the growth over the left vulva at the junction with normal skin, right vulva, clitoris, and posterior fourchette. Her biopsy revealed hyperkeratosis, superficial chronic inflammation, multinucleated squamous cells, and parabaasal hyperplasia.

A plan of simple vulvectomy (Fig. 2) was made, and she underwent the same without any complications. Her specimen revealed condylomata acuminata on histopathology.

DISCUSSION

Giant condyloma acuminata or genital warts were first described in 1932 by Buschke and Löwenstein.³ This condition is described as large exophytic cauliflower-like growth affecting the anogenital skin. It is caused by HPV.² Buschke–Löwenstein tumor is usually benign, but malignant transformation occurs in about half of the cases, and rarely, it can metastasize. It is postulated that condyloma increase by expansion rather than by infiltration.^{2,4} Due to the aggressive nature of these masses, they belong to the verrucous carcinoma group. However, a malignant histological variant, described as microinvasive carcinoma or a well-differentiated type of epidermoid keratinizing carcinoma, has been reported.

Predisposing factors for these tumors include unprotected sexual intercourse or intercourse with an infected individual, multiple sexual partners, early age of onset of sexual activity, having intercourse with someone without known sexual history, smoking, alcohol, and a weak immune system. Oral contraceptive pills and pregnancy have been associated with the same.

Condyloma acuminata are seen as soft, raised masses, with a smooth or verrucous contour with lobulated aspects, which may look like pearly or filiform, often fungating, or plaque-like or finger-like projections, noted in the anogenital region. They are usually nonpigmented. They mainly occur in the moist areas around the labia minora and vaginal opening; still, any genital region can be affected. These areas include fourchette, close to labia minora or majora, the pubis, areas at/near clitoris and urethral meatus, perineum and perianal region, the anal canal, vagina, and ectocervix. They usually present with painless lumps, pruritus, bleeding, and discharge.⁵ They can be a major blow to sexual confidence, and may lead to a loss of self-esteem.⁵

Investigations include a colposcopic examination, using acetic acid 2 to 5%, to reveal any spread of disease to a slightly distant site. Also, a preoperative biopsy can clear any confusion of malignancy.

Treatment options include outpatient management, such as podophyllotoxin, imiquimod topical cream, 5-fluorouracil, and sinecatechins ointment.

Daycare procedures like application of trichloroacetic acid (TCA) solution (80–90%) are used directly to the wart surface, weekly. Response rates of 56 to 81% have been seen, with a notable recurrence rate of 36%.¹ The TCA use during pregnancy is allowed. Also, cryotherapy can be performed weekly with an open spray/cotton-tipped applicator, applied for 10 to 20 seconds, and reused when needed.⁶

Surgical treatments have the highest cure and clearance rates; their initial cure rates are up to 60 to 90%. These include electrosurgery, use of curettage, scissors, and carbondioxide laser therapy.⁷ A major chunk of patients may fail to respond to any treatment, or recurrence will occur, leading to patient dissatisfaction.

Primary prevention by prophylactic vaccine (quadrivalent gardasil) is advised. Quadrivalent HPV vaccine has been shown to dramatically reduce genital warts and the HPV6/11 burden.^{8,9} Counseling and treatment of one's partner is important to prevent spread of the disease. Follow-up is needed to ensure cure and rule out recurrence.

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