

Scarry Tumors: Buschke- Löwenstein Tumor

Research Article

Nassiri A*, Souhli OA, Tazi MF, Farih MF, Mernissi FZ

¹ Department of Dermatology, Hassan II hospital, Fes, Morocco.

² Urology Department, Hassan II hospital, Fes, Morocco.

Introduction

Buschke-Löwenstein tumor also called giant condyloma acuminatum, is a rare sexually transmitted disease [1]. Men are the most affected, but some cases were described in women [2].

It is usually an exophytic, ulcerative and cauliflower-shaped tumor. It can infiltrate the adjacent tissue.

The treatment is based on surgery, but relapses are very frequent.

Material and Methods

The search strategy employed MeSH terms and keywords designed to optimize the identification of randomized trials, guidelines, and systematic reviews on Buschke Löwenstein disease.

From January 2012 to December 2017, we dermatologists of Hassan II hospital in Fez, conducted a prospective trial in collaboration with urologist of the same institution. The trial protocol was approved by the Institutional Ethical Committee of the Hassan II University Hospital. Informed, written consent of all participants was taken prior to enrolment.

We analyzed the result of primary surgery, long term survival, recurrences.

Recurrence Evaluation

Recurrence was clinically evaluated and defined as the appearance of new condylomatous lesions.

Surgical Management

A large resection involving subcutaneous fat was performed. Local treatments were applied with hydrocolloid dressing until com-

plete recovery. All the tumors were excised and send to pathological examination to confirm the diagnosis.

We didn't perform an HPV research because it's not available in our laboratory.

Follow-up

Patients were examined 3 months after surgery and underwent a follow-up every 6 months. If the cutaneous defect was very important, the patients were seen monthly until complete recovery.

Pictures were taken for all the patient at the first time and in each follow-up.

All Data was noted on excel.

Results

From January 2012 to December 2017, 12 patients were included. All of them were men with a mean age of 51 years (40-63). They all underwent a surgery within the genito-urinary area. All the patients were sexually active. Only two patient had a history of homosexuality. 6 patients were smokers and 4 were cannabis addict.

One patient was HIV seropositive.

In all patients, the tumors were exophytic, ulcerative cauliflower-shaped, dotted with super infection sites. All the tumors were large with a minor tumor of 11 cm.

The localisation on genital area was constant. In 4 cases the tumor affected thighs and perianal area, in one case the tumors affected the neck area, and in one another it affected the back.

In pathology anatomy, all tumors were diagnosed to be giant con-

*Corresponding Author:

A. Nassiri,
Department of Dermatology, Hassan II hospital, Fes, Morocco.
E-mail: aichanassiri6@gmail.com

Received: February 28, 2018

Accepted: May 17, 2018

Published: May 21, 2018

Citation: Nassiri A, Souhli OA, Tazi MF, Farih MF, Mernissi FZ. Scarry Tumors: Buschke- Löwenstein Tumor. *Int J Clin Dermatol Res.* 2018;6(2):162-164.

doi: <http://dx.doi.org/10.19070/2332-2977-1800037>

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Figure 1. Cauliflower-Shaped Tumors.



Figure 2. Buschke-Löwenstein tumor.

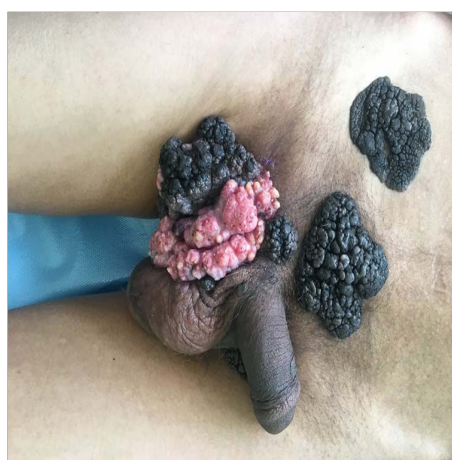


Figure 3. Patients characteristics and oncological outcome with associated treatment.

12 men	44 years	57 years	63 years	40 years	42 years	45 years I	63 years	52 years	47 years	47 years	55 years	58 years
Initial lesion	19cm	11cm	19cm	20cm	14cm	15cm	18cm	20cm	12cm	25cm	28cm	25cm
HIV	-	-	-	+	-	-	-	-	-	-	-	-
FIRST SURGERY	total excision	total excision	total excision	total excision	total excision	total excision	total excision	total excision	total excision	total excision	total excision	total excision
Pathology	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin	Condylomata with normal margin
Reccurences	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No
Second surgery	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No
Follow-up, months	95	lost of sight	116	129	92	99	175	142	lost of sight	lost of sight	dies	lost of sight

dylooma acuminatum.

All our patient were treated by a large surgery with dressing until full recovery. In 2 patients we conducted a covering in a second time.

The follow-up was allowed in 7 patients. One patient died because of myocardial infarction during his hospital stay.

No surgical complications were noted.

A relapse was noted in 3 patients ,and it was treated by surgical revision.

The 5-year disease-free survival rate was 80%.

Discussion

First described by Abraham Buschke and Ludwig Löwenstein, Buschke-Löwenstein disease (BLD) was classified as a potential malignant condyloma acuminatum [3]. Then in 1979, Mohs and sahl included this disease into verrucous carcinoma category with oral florid papillomatosis and epithelioma cuniculatum [4].

It is a rare sexual transmitted disease that affects 0.1% of the

population [5], which explains the limited number of the hospitalized cases in our trial.

Usually it affects men between 40 and 60 years [6] as in our study. A large panel of risk agents were described in literature, as smoking, immune deficiency, anaerobic infections, chronic inflammation [7]. In our trial we could prove that smoking and immune deficiency are closely related to development of Buschke-Löwenstein tumor.

Clinically, BLD, is found on the penis in 81% to 94% of cases and in 10% to 17% in anorectal area [8]. Urethral area is describes in only 5% [9]. It can invade the cavernous body and urethra by creating a fistula.

Histological examination of BLD shows a benign appearance as it is a pseudo-epitheliomatous proliferation characterized by exo- and endophytic hyper papillomatosis with epithelial hyperplasia, hyperacanthosis and koilocytosis [10].

All the other sexual transmitted diseases hold be looked for, as we did in all our patients.

The prognosis of these tumors is conditioned by the incidence of local recurrence (60–70%) and the risk of malignant transformation [11].

The principal differential diagnosis is epithelioma spinocellular which can lead to dark prognosis [12].

Many treatments are discussed in literature as cryotherapy [13], carbondioxide and ND-YAG laser seems to be satisfying especially in small or lesions or as recurrence treatment [13]. Other topical treatments are used as podophyllin, 5-fluorouracil, bleomycin with cisplatin, acetic acid, imiquimod [13].

Photodynamic therapy using 5-aminolevulinic acid were also reported to allow 40% resolution, but it is not accessible in all centers [14].

But all these forms of treatment are either complementary to surgery or used in patients with limited biological resources.

The surgical treatment is the gold standard therapy. The tumor and the adjacent fat should be excised and margins should be tumors free [13]. CT scan and in sometimes MRI are required in order to evaluate the local disease extension.

The follow-up must be very close because the risk of relapse is very important. As we described it was seen in 3 patients of our trial.

Conclusion

BLD is a rare curable disease. If untreated precociously, it can have dramatic evolution as penectomy. The surgical treatment is the first step to recovery, since dressing and follow-up are necessary to complete recovery and to look for relapses that are very frequent.

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