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Clinical case

Giant condyloma of the vulva in the general surgery department of the referral health center of the CVI commune of Bamako. About a case

Condylome géant de la vulve dans le service de chirurgie générale du centre de sante référence de la commune CVI de Bamako. A propos d'un cas

M Konaté*[1], M Diallo[1], IK Diakité[1], M Sissoko[1], N Simpara[1], L Diarra[2], A Diallo[1], M Keïta[1], M Maïga[1], A Samaké[1], O Traoré[3], M Zakaria[1], MS Ag Med Elmehdi Elansari[1], D Koné[6], MD Soumaré[7], A Maïga[4], O Coulibaly[1], B Berté[1], ML Diakité[5]

Résumé

Introduction : Le condylome acuminé géant (CAG) de la vulve ou tumeur de Buschke Lowenstein (TBL) est une entité clinique rare, d'origine virale, se transmet par voie sexuelle essentiellement. Le risque d'envahissement local, le fort pouvoir récidivant expliquent sa gravité. Nous rapportons ici un cas clinique à travers lequel nous décrivons les aspects cliniques et thérapeutiques du condylome géant vulvaire.

Méthodologie : Etude de cas clinque chez une femme en post-partum qui présentait un condylome géant vulvaire dans le service de chirurgie générale csréf CVI. Nous avons utilisé le dossier médical pour cette étude.

Résultat : Nous avons réalisé une exérèse chirurgicale de la tumeur chez une patiente de 32 ans séropositive à VIH1 en post-partum. Les suites ont été simples avec une bonne cicatrisation et sans récidive. La prévention des IST et le traitement précoce des lésions condylomateuses permettent d'améliorer le pronostic de cette affection.

Conclusion : Maladie infectieuse, le traitement reste essentiellement chirurgical, et doit être précoce et large avec une surveillance post-chirurgicale, clinique et histologique régulière

Mots-clés : Condylome géant vulvaire, chirurgie, CSRéf CVI Bamako.

Abstract

Introduction: Giant condyloma acuminata (CAG) of the vulva or Buschke Lowenstein tumor (TBL) is a rare clinical entity, of viral origin, is transmitted mainly sexually. The risk of local invasion, the strong recurrent power explain its seriousness. Here we report a clinical case through which we describe the clinical and therapeutic aspects of vulvar giant condyloma.

Methodology: Case study in a postpartum woman who had a vulvar giant condyloma in the general

surgery department csref CVI. We used the medical record for this study. Result: We performed surgical removal of the tumour in a 32-year-old HIV1-positive postpartum patient. The aftermath was simple with good healing and no recurrence. Prevention of STIs and early treatment of condylomatous lesions can improve the prognosis of this condition.

Conclusion: Infectious disease, treatment remains essentially surgical, and must be early and broad with regular post-surgical, clinical and histological monitoring

Keywords: Vulvar giant condyloma, surgery, CSRéf CVI Bamako.

Introduction

Buschke-Lowenstein tumor (BLT), or giant condyloma acuminata (GCA), is a tumor of viral origin, primarily genital in location. It is a rare, sexually transmitted disease. First described in 1896 by Buschke, it was later reported by Lowenstein in 1925, hence its name [1]. The tumor affects both sexes after puberty, with a clear male predominance. It is characterized by a dissociation between the worrying clinical appearance of a giant verrucous proliferation, suggestive of a malignant process, and a histology of exo and endophytic hyperpapillomatosis with hyperacanthosis without invasion of the basement membrane, retaining the benign features of a condyloma acuminata [1,2]. Human papillomavirus (HPV) infection is the most common STD in the world (5% of the population will develop clinical lesions), and latent infection occurs in 25% of people under 25.) Prevalence is increasing in all countries. Sexually active people are 80-85% at risk of HPV infection. Infection most often occurs at the start of sexual activity [3]. Human Papilloma Virus (HPV). This is a circular, double-stranded DNA virus found in mammals, birds and reptiles. There are over 120 genotypes, 110 of which are human, with 16, 18, 45 and 56 being at high risk of oncogenesis. Those responsible for anogenital condylomas are essentially low-risk oncogenic genotypes (especially 6 and 11, more rarely 30, 42, 43...), or even higher-risk oncogenic genotypes (16, 18) [4]. The course of the disease is marked by its surface and deep-seated extension, its potential for recurrence and its risk of degeneration. Treatment is essentially surgical [1-2]. This case report describes the diagnosis and treatment of a giant condyloma in the general surgery department of the commune VI referral health center in the Bamako district.

Clinical case

This is a 32-year-old HIV1-seropositive patient, two months post-caesarean section, admitted for surgery for vulvar swelling. The onset of the disease dates back to 2 months post-pregnancy, marked by the appearance of a small vulvar swelling that increased in volume to cover the entire vulva. The swelling was painless, accompanied by vulvar pruritus, leucorrhoea and no dysuria. On physical examination, a caesarean section scar was noted, and in the gynaecological position, a cauliflower-like swelling was present, with vegetative lesions occupying the entire vulvar region, leaving the vaginal orifice (Image 1). The difficult vaginal touch revealed no mass in the vagina, and the rest of the examination was unremarkable. The diagnosis of giant condyloma of the vulva was accepted. The patient was scheduled for surgery after a normal preoperative blood count (CBC, G Rh, GLYMIE, Créat, TC, TS). Intraoperatively, we excised the condyloma, partially removing the labia majora and minora of the vulva (Fig. 2), followed by hemostatic suturing of the resection slices and insertion of an indwelling catheter (Fig. 3). The post-operative course was straightforward, with good healing and no recurrence (Image4).



Image1: Giant vulvar condyloma



Image2: After resection of vulvar condyloma



Image3: Vulvar condyloma resection specimen

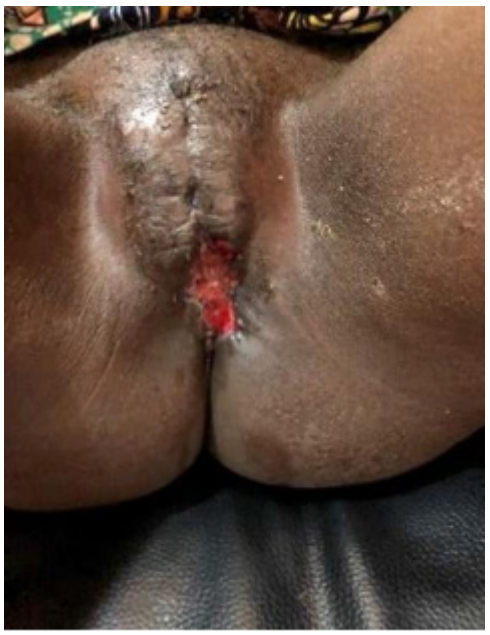


Image4: Healing AT D-15
Post-operative

Discussion

The virus responsible for condyloma is HPV, classified among the papouavividae, with types 6, 11, 16 and 18 most frequently responsible for TBL [5]. The transformation of condylomas into TBL appears to be controlled by the immune system; indeed, TBL may be associated with congenital or acquired immunodeficiency (AIDS, immunosuppressive treatment, ethylism, diabetes, chemotherapy) [6]. TBL is a rare tumor whose frequency is currently estimated at 0.1% of the general population [7]. Population prevalence is not available, probably because patients are recruited from different departments. The case we report is an HIV1-positive patient on antiretroviral therapy. It occurs at any age after puberty and predominates between the fourth and sixth decades [8]. Our patient's age was 32 years. TBL is relatively common in males (77%). In men, TBL localizes in 81 to 94% of cases to the penis and in 10 to 17% of cases to the anorectal region [9]. Urethral localization accounts for 5% of cases in some series [10]. In women, the location is essentially vulvar in 90% of cases, unlike the anorectal location, which is less frequent [9]. In our case, the tumor was located in the vulva of a woman. Transmission is sexual, requiring cofactors to play a favourable role, such as multiple sexual partners (as in our patient's case), recurrent local infection, lack of protection during intercourse, microtrauma and poor hygiene [11,12]. Our patient had been serologically tested for other sexually transmitted infections (viral hepatitis A and B, HIV1 and 2). HIV1 serology was positive and she was The tumour is always preceded by greyish or pinkish condylomatous lesions, gradually evolving to take on a papillomatous, irregular, cauliflower-like appearance [13,14,15]. Histologically, it is a perfectly limited squamous cell tumor, characterized by considerable epithelial hyperplasia, sometimes pseudoepitheliomatous, hyperacanthosis, hyperpapillomatosis and koilocytes, which are pathognomonic markers of HPV infection, although their presence is not constant. The basement membrane remains intact, proving the benign nature of the tumour despite its malignant behaviour [13,14,15,16]. Progression is slow, and may be burdened by a number of complications, including dermatitis, infection, fistulization to neighboring organs, necrosis, anal stenosis and hemorrhage [17,18]. Malignant transformation is one of the most feared evolutionary risks [1,19,16,20]. It has been reported in 30% to 56% of cases [1]. Buschke-Lowenstein tumors pose the problem of differential diagnosis with other pathologies, notably certain tumoral lesions (squamous cell carcinomas) or infectious lesions (secondary syphilis, verrucous and vegetative tuberculosis) [3,16,21]. Treatment of TBL is often difficult, even when histology confirms benignity [3,8,16,17]. Surgery remains the treatment of choice for the majority of authors [3,17,21]. It must be sufficiently large, or even mutilating, to rule out the risk of recurrence and hope for a definitive cure. We performed excision of the condyloma, partially removing the labia majora and minora of the vulva (Fig. 2), followed by haemostatic suturing of the resection slices and insertion of an indwelling catheter (Fig. 3). The post- operative course was straightforward, with good healing and no recurrence (Image 4). Recurrence is one of the characteristics of this tumor and is the direct consequence of a surgical procedure that is too limited [3,19,22]. The risk of recurrence after excision is 60 to 66% [22].

Conclusion

Buschke-Lowenstein tumor (or giant condyloma acuminata) is a rare tumor requiring early and extensive surgical treatment, with regular post-surgical, clinical andhistological surveillance. The functional and vital prognosis can be compromised, hence the importance of STI prevention through protected intercourse and sex education for young people.

***Correspondence**

Konate Moussa

konate08@yahoo.fr

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1 : Commune VI reference health center in the Bamako district
2 : Bamako dermatology hospital
3 : General surgery department, Hôpital mère-enfants le Luxembourg
4 : General surgery department of CHU Gabriel Touré
5 : Urology department at CHU Point G
6 : Bamako district commune I reference health center
7 : Bamako district commune III reference health center

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