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BUSHKE-LOWENSTEIN TUMOR-A CASE REPORT

KEYWORDS

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My case is a 37 year old male presented with ulceroproliferative growth over penis clinically appearing as involving prepuce and infiltrating glans penis.biopsy was taken from the leision ,features s/o Giant CondylomaAccuminatum/ Bushke-Lowenstein Tumor.

Back ground :First described by Buschke and Löwenstein in 1925, the giant condyloma of Buschke and Löwenstein (GCBL) is a slow-growing, locally destructive verrucous plaque that typically appears on the penis but may occur elsewhere in the anogenital region. It most commonly is considered to be a regional variant of verrucous carcinoma.

Pathophysiology:GCBL is slow growing, highly destructive to contiguous tissue, and seldom metastasizes. Most commonly located on the glans penis, GCBL can be found on any anogenital mucosal surface, including the vulva, vagina, rectum,scrotum,andbladder.Co-localization with human papillomavirus (HPV) types 6 and 11 ; occasionally HPV types 16 and 18.

Epidemiology: Most cases of GCBL occur in males on the glans penis. This condition is more common in malewhoareuncircumcised. The male-to-female ratio is 3.5:1. Two thirds of cases of GCBL occur in persons younger than 50 years.

CLINICAL:GCBL typically starts on the prepuce as a keratotic plaque and slowly expands into a cauliflowerlike mass, as large as 15 cm. The lesion may ulcerate or form a penile horn and typically is associated with a foul odor. Expansion to the corpus cavernosum and urethra may occur, with subsequent fistulation. Regional lymphadenopathy is common, primarily due to secondary infection, not metastases. Similar slow progression is noted on perianal lesions. Presenting symptoms of perirectal GCBL include perianal mass, fistula or abscess and bleeding.

CAUSES: Chronicphimosis and poor penile hygiene have been postulated as inciting or contributing events. This may account for the higher incidence in males who are uncircumcised. Populations with a higher incidence circumcision have a lower rate of GCBL.. Immunosuppression-secondary to HIV disease or due to immunosuppressive medication may be a predisposing factor. Other risk factors for GCBL are low socioeconomic status, drug abuse, use of oral contraceptives, presence of other sexually transmitted diseases.

Imaging Studies:GCBL has shown mild, heterogenous enhancement with gadolinium-diethylenetriaminepentaacetic acid (DTPA) contrast on MRI. This study may be useful in delineating the expansion of the lesion when planning for removal.

Procedures: Biopsy is the diagnostic procedure necessary for evaluation. It must be sufficiently deep and generous to evaluate for possible foci of SCC because lesions with these changes have been shown to have a higher recurrence rate and to metastasize. Vacuolar change is not a reliable differentiator between GCBL and condyloma, and visualizing the base of the lesion and the characteristic broad, blunt, deeply penetrating rete pegs is necessary to make the diagnosis.

Histologic Findings:GCBL characteristically has massive epidermal hyperplasia, hyperkeratosis, and parakeratosis and is markedly exophytic. Granular vacuolization may be present, and individual keratinocytes have large cytoplasm and a nucleus with prominentnucleoli.Giantcondylomaacuminatum is differentiated histologically from ordinary condylomaacuminata by its thicker stratum corneum and the presence of an endophyticdowngrowth, along with a tendency to invade deeper.

Medical Care: The treatment of choice for GCBL is wide surgical excision. Surgery alone has resulted in a disease-free status in 45.5% of patients.

Topical therapy alone, such as with 5-fluorouracil, podophyllin, or interferon (IFN), are generally insufficient to control disease or prevent progression of the giant lesions.

Surgical Care Surgical excision is the treatment of choice. Its main advantage is the ability to histologically examine the entire specimen to ensure clear margins and to evaluate for foci of SCC. As a drawback, it typically requires at least a partial penectomy, but one series successfully used glansectomy only, with excellent functional and therapeutic results.

Carbon dioxide,argon lasers and cryosurgery are used for

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relapsing cases or as an alternative first-line therapy.

Deterrence/Prevention: Condom use would probably be effective in decreasing the incidence of GCBL. The HPV vaccine (Gardasil) is indicated for the prevention of condylomaacuminata due to HPV types 6 and 11 in boys, men, girls, and women aged 9-26 years. The vaccine is administered as 3 separate doses adminstered at 0, 2, and 6 months.

Conclusion: As the tumor cilincally appeared penetrating glanspenis ,partial penectomy was planned.incision given close to the corona so as to proceed with glansectomy if possible. But on table tumor, could be easily separated from the glans and only circumcision sufficed.patient was followed up for 1 year and there is no recurrence.