

EDITORIAL**REPORT CASE OF EXCESSIVE GENITAL WARTS, WAD MADANI MATERNITY HOSPITAL**

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**INTRODUCTION**

Anogenital warts (condylomata acuminata) is the most common viral sexually transmitted disease in the United States. Although condylomata affect both genders, data from office visits for warts obtained from the 1994 to 1998 National Ambulatory Medical Care Survey showed that women accounted for 67 percent of the patient population (1).

Condyloma acuminatum is caused by human papilloma virus (HPV) infection. HPV encompasses a family of highly infectious and primarily sexually transmitted double-stranded DNA viruses. The incubation period after exposure ranges from three weeks to eight months. Most infections are transient and cleared within two years (2). Persistent infections in the setting of other clinical risk factors (such as infection with the human immunodeficiency virus) is associated with the development of squamous (3,4)

There are over 70 distinct HPV subtypes; approximately 35 types are specific for the anogenital epithelium and have varying potentials to cause malignant change, such as cervical or anal cancer (5).

,HPV serotypes 16 and 18 are most commonly associated with squamous cell carcinoma. HPV 6 and 11, do not integrate into the host genome and are most frequently

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associated with benign condylomas and low grade intraepithelial neoplasia. Intermediate risk subtypes can cause high grade dysplasia which persists but rarely progresses to the invasive stage.

Acquisition of condylomata is related to sexual activity. Digital/anal, oral/anal and digital/vaginal contact probably can also spread the virus, as may fomites (6). The disease is also more common in immunosuppressed individuals (7,8).

Disease in women is primarily caused by vaginal intercourse. Anal condylomata can occur by extension from vulvar or perineal infection or by receptive anal intercourse. The risk of disease increases with the number of sexual partners. A population-based case-control study including 94 women with incident and 55 women with recurrent condyloma found women with five or more partners within the previous five years were over seven times more likely to have incident condyloma and over 12 times more likely to have recurrent condyloma compared to women with only one sexual partner during the same time period (9). An increased risk of incident condyloma was also associated with a history of any sexually transmitted disease or oral herpes.

In men, the preputial cavity or penile shaft can be affected through heterosexual or homosexual activity. Perianal lesions may occur among heterosexual men, although most such lesions are observed among men who have sex with men. The risk of disease increases with the number of sexual partners (10), as described above for women.

HIV infected individuals — The prevalence of condyloma is higher in patients who are HIV positive or who have other forms of sexually transmitted diseases. In one retrospective series, 119 of 677 (18 percent) primarily male patients who were HIV positive were found to have anal condylomata, and 60 percent of these patients had another sexually transmitted disease (11). However, the data for the above study were collected between 1986 and 1988; since then, changing sexual practices among gay men are likely to have decreased the prevalence of the disease in the gay population.

By comparison, a prospective cohort study of the incidence of condylomata acuminata in 385 HIV-1 positive and 341 HIV-1 negative women reported incidences of 7 and 1 percent, respectively (12). Lower CD4 T lymphocyte count (<500 cells/ μ L) and frequent injection of drugs were also risk factors for development of vulvovaginal or perianal lesions. Similar results were reported in a subsequent study, which also noted that highly active antiretroviral therapy decreased the incidence (13).

Symptoms associated with condylomata acuminata vary depending upon the number of lesions and their location. Patients with a small number of warts are often asymptomatic. Other patients may have pruritus, bleeding, burning, tenderness, vaginal discharge (women), or pain.

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Condylomata can occasionally form large exophytic masses that can interfere with defecation, intercourse, or vaginal delivery. Lesions involving the proximal anal canal may also cause stricturing.

The diagnosis of condylomata can usually be made by visual inspection of the affected area. The lesions, which are skin-colored or pink, range from smooth flattened papules to a verrucous, papilliform appearance. The extent of involvement should be documented by anoscopy, sigmoidoscopy, colposcopy, and/or vulvovaginal examination, as appropriate. Application of 5 percent acetic acid causes lesions to turn white, which facilitates identification but is not specific. A biopsy can be considered when the diagnosis is uncertain, in those who do not respond to therapy, in immunocompromised patients, in those with large lesions, or in the presence of atypical features. Some authorities recommend a routine biopsy to search for dysplasia (14).

CASE REPORT

A single female, 17 years old, Timid and shy brought by her family to the private clinic with vague complaints. By clinical routine examination we discovered that she had an extensive vulval swelling extending to the left thigh. It was an ugly skin lesion and there was vaginal discharge. The lesion was pink with multiple black blotches, hard, verrucous and shiny edges. It was extending down to the mid thigh and involving the labias extensively. It was tender and hard on touch. The lesion extended to involve the perineum and the anus in a papilliform appearance. There was palpable inguinal lymph nodes. The lesion was smelly. The Diagnosis was made and complete haemogram vaginal swab for culture were ordered. Screening for HIV, Hepatitis B and C were negative. Speculum examination and proctoscopy excluded vaginal and anal involvement. The surgical treatment by cautery and excision was chosen instead of medical treatment due to the large size of the pathology. Excision was performed at the labial sites and cauterization at the site of thigh and perineum. The patient was kept for 15 days under antibiotics, daily dressing. Mobility was encouraged and epithelizer creams were daily and applied. She was discharged in a good condition to be seen 4 weeks later in a good health, happy and with little scarring.



DISCUSSION

Condyloma acuminatum should be distinguished from another form of condylomata (condyloma lata), which is caused by secondary syphilis infection. Lesions in condyloma lata appear flat and velvety.

Micropapillomatosis of the vulva is a normal variant. The papillary projections each arise from an individual base, in contrast to condyloma acuminatum where multiple papillae arise from a single base. Painful verrucous perianal lesions have been described in association with herpes simplex in patients with AIDS (15).

Squamous cell carcinoma of the anogenital area can exist concurrently with condylomata acuminata. Suspicious lesions (particularly those which are ulcerated) should be biopsied. Lesions that do not respond after three provider administered treatments or have not resolved after six months should be reevaluated with consideration of biopsy to confirm the diagnosis (16).

Additional conditions which should be considered include hymenal remnants and vulvar intraepithelial neoplasia (in women), molluscum contagiosum, and skin tags.

Treatment of condyloma acuminatum involves one of three major approaches: chemical or physical destruction, immunologic therapy, or surgical excision (show algorithm). Limited experience with topical antimicrobial therapy has also been reported. The preferred approach depends upon the number and extent of the lesions. In general, all therapies for genital warts are somewhat unsatisfactory due to recurrence rates of 30 to 70 percent within six months of treatment (17). However, spontaneous regression is also possible,

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and has been reported to occur within three months in 20 to 30 percent of cases.

There is no evidence to suggest that one treatment is significantly superior to another or appropriate for all patients and all types of warts (16). If a clinician has trichloroacetic acid or podophyllin available in their office practice, then it would be most efficient for the clinician to provide an initial treatment of the warts at the diagnostic visit, and then to prescribe home treatments (imiquimod or podofilox) or examine the patient in follow-up to see how the initial treatment worked. For clinicians without trichloroacetic acid or podophyllin in their office, the patient could first try home treatments (imiquimod or podofilox). However, we suggest initially referring patients with very large condylomata to a surgeon (gynecologist or anorectal surgeon) because surgical treatment is probably going to be needed.

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