CR15 Approach to Buschke-Löwenstein tumor associated with malignant transformation

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KEYWORDS: Buschke-Löwenstein tumor; Condylomata acuminata; Squamous cell carcinoma

INTRODUCTION/OBJECTIVES: Buschke-Löwenstein tumor (BLT) or giant condyloma is a verrucous infiltrating lesion, due to a sexually transmitted human papilloma virus. It appears benign histologically. Excision surgery with a broad incision is the preferred treatment. The aim of this paper is to report on a possibility of malignant transformation and treatment in such case.
CASE PRESENTATION: We present a 49-year-old man who had several verrucous condylomata acuminata on his penis shaft and a big verrucous growth in his right inguinal region that was clinically and histologically consistent with a Buschke-Löwenstein tumor, HPV type 6 and 8 positive. The diagnosis was made sixteen years ago and the patient had no history of any internal disease or medication that suppresses the immune system . He received electrocauterization treatment for genital warts on the penis shaft before being referred to a surgeon for additional care. The patient elected to disregard the growing mass, which then persisted for an additional decade. A deep biopsy was performed which was consistent with a diagnosis of verrucous squamous cell carcinoma. A computed tomography scan of the abdomen and pelvis revealed no local invasion, and there was no sign of inguinal lymphadenopathy. A wide local excision of the tumor mass was performed. As of now the patient had no recurrence.
CONCLUSION: BLT must be characterized as a condyloma acuminate-derived low grade in situ epithelial carcinoma. Since recurrences and potential recurring malignant transformation are a possibility, surgery is now the recommended course of action, with a focus on regular follow-ups.

CR16 Arthritis as a presentation of paraneoplastic syndrome: A case report

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KEYWORDS: adenocarcinoma; arthritis; paraneoplastic syndrome

INTRODUCTION/OBJECTIVES: Paraneoplastic syndrome includes symptoms that occur far from the primary tumor, and despite unclear pathogenesis, these conditions are thought to be caused by substances secreted by the neoplasm or by the effect of antibodies directed at the tumor, which cross- react with other tissues.
CASE PRESENTATION: We present a 70-year-old patient who was referred to the Emergency department by a dermatologist for skin changes and additional examination. For the past three months, she has had papules, papulopustules and ulcerations that itch, especially at night, and are visible on both lower legs, arms and torso; swelling of both ankles was also present. She complains of musculoskeletal pain in the whole body for the past year and says she noticed 10 kilograms weight loss in the last few months. Patient wasn't febrile, denied nausea, vomiting and abdominal pain. Vasculitis was suspected and the patient was admitted to the Department of rheumatology, clinical immunology and allergology. At the time of admission, laboratory findings verified microcytic anemia with elevated inflammatory parameters (erythrocytes 3.62[x1012/L], hemoglobin 80[g/L], MCV 76.2[fL], CRP(s) 18.8[mg/L]), because of which the patient received two doses of erythrocyte concentrate. Due to microcytic anemia, gastroscopy was indicated, during which an infiltrating process suspicious for a neoplasm was seen in the cardia, which extends to the gastroesophageal junction. A biopsy was performed and the pathohistological results showed adenocarcinoma.
CONCLUSION: Malignant diseases can have unusual clinical presentation. In elderly patients without a family history of rheumatological diseases, with new-onset arthritis and symptoms suggestive of malignancy, additional treatment should be performed.