Extensive Condylomata with Malignant Transformation Complicated by Compounding Socioeconomic Barriers

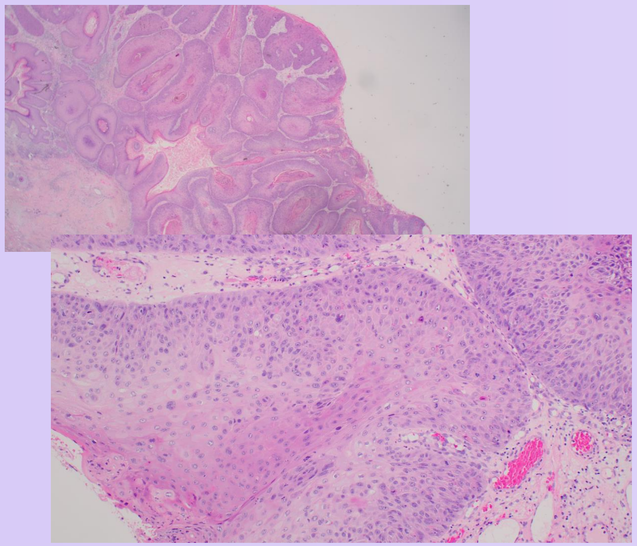
Muhamad Fauzi SM, O'Riordan R. Infectious Disease Department, University Hospital Waterford

CASE PRESENTATION

A 46 year old male presented to ED with a worsening growth in his perianal area for the past 2 years. There are no significant comorbidities. He is a smoker with 30-pack year history and had significant alcohol consumption with 140 units a week. There was an element of self neglect as reported by family.

He had lost 25kg in the past 2 years. He reports dyschezia, with loose bowel motions mixed with clots. There was no family history of malignancy. He is not sexually active for the past 10 years at least and denies sexual intercourse with men.

He was cachectic and had significant pallor. BMI was 16. There was a large ulcerating, malodorous condylomatous mass covering the majority of his perianal and bilateral buttock area including his perineum and medial thigh area which was extremely tender. There were patches of erythema and necrosis.



WORKUP AND COURSE

Investigations revealed a significant anaemia; of Hb 3 g/dl. Viral hepatitis serology, HIV and syphilis screen were negative. PCR swabs from the lesion for HSV 1, 2 & VZV were also negative. MRI pelvis and CTTAP revealed an extensive locally invasive tumor in the perianal and perineal regions extending into muscles of the pelvic floor with no distant metastases. A decision was made for defunctioning loop ileostomy.

Histology revealed high grade AIN (HGAIN). The patient was discussed at the colorectal MDM. There was no surgical treatment option for this patient as he had extensive disease which was deemed unresectable. As there is no histologic confirmation of invasive disease, medical and radiation oncology were hesitant to offer treatment.

He absconded during his inpatient stay. He was booked for follow up and repeat imaging, however he had reduced engagement with the healthcare services. He represented 6 months after with a deterioration in his status. He was found confused and wandering,

A repeat biopsy at this point demonstrated invasive SCC. However, the patient was too frail at this point for any systemic therapy. He declined rapidly and was made palliative. He passed away 3 months afterwards in hospice care.

DISCUSSION

❖ When does HPV become malignant ?

This case represents the spectrum of disease that can present in a patient with HPV infection.
Most HPV infections are transient with >90% clearing within 2 years.

There is evidence showing that benign HPV infections can initiate a growth process that can develop into a malignant phenotype due to chronic epithelial irritation, promoting co-infection of different HPV subtypes. The chronic inflammatory immune response might favour malignant transformation as well

At present, cure for HGAIN is radical excision or topical therapy. Systemic treatment outcomes for metastatic disease remains poor. Thus, prevention of anal cancer holds the best potential for reducing disease burden.

❖ Screening for AIN ?

Screening for AIN has been recommended due to success for cervical screening programme with HPV as well. However, there are significant differences that needs to be considered.

Cytological screening has been suggested for HGAIN, especially for high risk population, however it is only 83% sensitive and 38% specific.

ACPGBI does recommend a six-monthly follow-up for high risk patients for at least 5 years, with an aim of early identification and treatment of HGAIN. However there is a high recurrence rates at 60-66%.

In Ireland there are recommendations for baseline and annual anal cytology in HIV-positive MSM

CONCLUSION

In this patient, he only presented to a healthcare setting after having the condylomata for 2 years. The condylomata was chronically, persistently irritated and was likely further irritated with poor personal hygiene. The persistent growth, compounding with his immunosuppression secondary to significant alcohol intake would have contributed to development of a malignant transformation.

There was reduced engagement with health care services and an element of self-neglect as well. This might have further exacerbated his ongoing issue.

If he presented sooner, would this been identified earlier with better control ? He did not meet the criteria for high risk population screening. However, his abscondment and reduced engagement with the health service likely contributed to his poor outcome due to reduced monitoring.

REFERENCES

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2. Brogden, Danielle R L et al. "Comparing and contrasting clinical consensus and guidelines for anal intraepithelial neoplasia in different geographical regions." *Updates in surgery* vol. 73,6 (2021): 2047-2058. doi:10.1007/s13304-021-01156-7