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Case Series

A CASE SERIES ON INTEGRATED MANAGEMENT OF ANAL CONDYLOMA ACUMINATA

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ABSTRACT

Anal Condyloma acuminata is a viral disease caused by Human Papilloma Virus (HPV) which is distinct from virus of the common wart. It is usually associated to other veneral diseases and immune-compromised state. Certain strains of HPV are associated to dysplasia and progression to cancer usually squamous cell carcinoma of the anus. Patient usually present with mass per anum, itching and false odour rarely, relentless growth results in giant condylomata (Buschke Löwenstein tumour), which may obliterate the anal orifice. **Method:** Five patients of anal condyloma acuminata were managed by excision with electrocauterization and the excised masses were sent for histopathological examination to rule out any malignancy. In the post-operative period dressing was done with *Jatyadi Taila* and also Ayurvedic oral medicines were prescribed to enhance wound healing. **Result:** All the patients were cured without recurrences till the date. No patients had significant post-operative adverse events. Histopathological examination turned out to be non-malignant for all the patients. The treatment was well tolerated and was affordable to all the patients. **Discussion:** There are various methods for managing condyloma acuminata, out of which electrocoagulation is considered as best strategy of management where first or at most second degree of burn is created. For larger mass, base can be transfixed and ligated using *Ksharasutra* which sloughs on its own as a result of vessels strangulation. Post-operative care should be done efficiently to enhance timely healing and prevent recurrences. Immune-compromised state, sexual history should always be taken into consideration and malignancy should always be ruled out.

INTRODUCTION

Condyloma acuminata is a viral disease caused by Human Papilloma Virus (HPV), a double-stranded DNA virus that is a member of the Papovavirus group and is antigenically, biochemically, and immunologically distinct from the virus of the common wart, verruca vulgaris.[1] It may be found in association with other diseases, such as gonorrhea, lymphogranuloma venereum, and syphilis, especially in those who have had homosexual contact but can also be found in heterosexual male and female too.[2] Viral subtypes, such as HPV-6 and HPV-11, are found more commonly in benign warts, whereas HPV-16 and HPV-18 tend to be aggressive and are associated with dysplasia and progression to cancer. [3]

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HPV forms the etiological basis of anal and perianal warts, anal intraepithelial neoplasia (AIN) and squamous cell carcinoma of the anus. [4] Condyloma acuminata is related to sexual activity and also immune-compromised state (e.g. HIV infected and transplant recipient) of the patient. Clinical presentation may vary according to the patients and strains of the viruses those are involved. The condition has also been reported in a child with HIV infection [5] because there is such a strong association; all patients who are observed to have anal condylomata should undergo appropriate blood testing for HIV. The reported incidence of squamous cell carcinoma of the anus in patients with anal condyloma is 3–4% and is likely to increase with the increasing prevalence of HPV infection in immunosuppressed human immunodeficiency virus (HIV) positive patients. [6,7]

Patient may have different kinds of symptoms like mass in perianal region, pruritus, discharge, bleeding, foul odour and some may feel tenesmus too. Pain is rare in such cases but may occur in some chronic cases. Some patients may think it's a

haemorrhoid and may take medications without prescription. Rarely, relentless growth results in giant condylomata (Buschke Löwenstein tumour), which may obliterate the anal orifice. [4]

The diagnosis is obvious with clinical examination but anal examination with proctoscopy and vaginal examination in female should be carried out mandatorily to see if internal parts are affected too. Patients are examined for veneral diseases and also diseases causing immune-compromised condition should also be ruled out. In addition, sexual partners are at risk for contracting the disease and should also undergo evaluation and treatment. The excised mass after surgery should invariably sent for histopathological examination to differentiate it from malignancy.

There are various treatment options are available in the management of condyloma acuminata.

Topical agents, surgical excision, electrocoagulation, laser therapy, cryosurgery, immunotherapy, chemotherapy are the treatments usually done. Among them electrocoagulation with excision of a portion of the specimen to submit for pathologic examination is the "gold standard" for the management of anal canal condylomata. [8] Treatment should be pursued with lesions that persist for more than two years if the lesions are symptomatic or for cosmetic purposes.[9] Management of condyloma acuminata should be done as soon as possible compulsorily when there are signs of malignant changes. Concerning signs for malignant transformation include bleeding, irregular pigmentation, ulceration, and lesions with palpable dermal infiltration. [10] Buschke-Lowenstein tumors are a known complication of condyloma acuminata. [11]

Some cases which have been treated in government and private hospitals of Nepal are taken for the study, which were treated with electrocauterization, excision, daily dressing with *Jatyadi Taila* (medicated Ayurvedic oil) and oral Ayurvedic medicines *Triphala Guggulu* and *Gandhaka Rasayana* along with a 7 days course of oral antibiotics and analgesics.

Case 1

A 34 years married male patient, Army by Profession presented as mass per anum with itching and discharge peri-anal region for 2 years. The mass was gradually increasing in size which later became too large that affected his defecation process too. Itching was mild initially and later became intractable. There was no history of rectal bleeding, weight loss and loss of appetite.

He didn't have any significant past medical and surgical history. He denied sexual partners other than his wife and his wife didn't have similar condition. He was non-alcoholic and non-smoker. His general examination revealed no any abnormalities. Per rectal examination revealed a bunch of condyloma around the anal verge which where red to grayish in colour, without any discharge and tenderness. The mass was not fixed to deeper structures and bleed on touch was absent. The mass was seen to be distal to Hilton's line and digital and anoscopic examination revealed no internal masses. There was no inguinal lymphadenopathy.

The investigations of the patient turned out to be normal where HIV/HBsAg/HCV/TPHA all came as non-reactive. After all pre-operative preparations patient was taken for surgery. Patient was operated by excision by electrocauterization under local anaesthesia and excised mass was sent for histopathological examination which turned out to be non-malignant. In post-operative period, patient was treated with oral antibiotics for 7 days and oral analgesics SOS. *Triphala Guggulu* and *Gandhaka Rasayana* were given orally from the day of surgery till wound healed and also dressing was done with *Jatyadi Taila* from first operative day till wound healed. Patient was advised to take sitz bath twice a day with boiled lukewarm water. It took 35 days for wound to heal after the surgery without any significant post-operative adverse events. There is no history of recurrence till the date after surgery.



Case 1: Figure 1: Pre-operative image of the peri-anal region showing large anal condyloma which is present circumferentially around the anal verge



Case 2: Figure 2: Post-operative image of the patient showing the peri-anal area after excision of the masses using electrocautery

Case 2

A 26 years unmarried male student patient presented as mass per anum since 6 months. Mass was small initially and was increasing gradually. He didn't have any associated symptoms. There was no history of rectal bleeding, weight loss and loss of appetite. He didn't have any significant past medical and surgical history. He didn't have any sexual partners till that time. He was non-alcoholic and non-smoker and had good bladder and bowel habit. His general examination revealed no any abnormalities. Per rectal examination revealed a bunch of condyloma around the anal verge which where blackish to grayish in colour, without any discharge and tenderness. There was no bleed on touch and fixity to deeper part was absent too. The mass was seen to be distal to Hilton's line and digital and anoscopic examination revealed no internal masses. There was no inguinal lymphadenopathy. The pre-operative investigations and management was similar to previous case. The wound healed in 25 days without any post-operative adverse events. There is no history of recurrence till the date after surgery.



Case 2: Figure 1: Pre-operative image of the peri-anal region showing anal condyloma which is present circumferentially around the anal verge



Case 2: Figure 2: Post-operative image of the patient showing the peri-anal area after excision of the masses using electrocautery.

Case 3

A 41 years married male shopkeeper patient presented as mass per anum since 1 and half years associated with itching and discharge peri-anal region. Mass was rapidly increasing in size and had severe itching sensation with whitish water like discharge in peri-anal region. He didn't have history of bleeding per rectum and there was no history of loss of weight, loss of appetite. He was known hypertensive since years and was taking Tablet Amlodipine 5 mg OD. He didn't have any surgical history. He didn't have sexual partner other than his wife and wife didn't have similar condition. He was non-smoker and social drinker and had good bowel and bladder habits. General examinations revealed no abnormalities. Per rectal examination revealed bunch of condyloma to right and left side of the anal verge which was whitish to reddish in colour, no obvious discharge was seen, marked erythema was present around the anal verge. The mass was non tender and was not fixed to deeper structures. Digital and anoscopic examination showed no mass inside the anal cavity. There was no inguinal lymphadenopathy. The pre-operative investigations and management was similar to previous case. The wound healed in 30 days without any post-operative adverse events. There is no history of recurrence till the date after surgery.



Case 3: Figure 1: Pre-operative image of the peri-anal region showing anal condyloma which is present circumferentially around the anal verge



Case 3: Figure 2: Post-operative image of the patient showing the peri-anal area after excision of the masses using electrocautery

Case 4

A 29 years old male married patient working as a labourer patient presented as mass per anum for 3 years. He also complained about discharge and itching in peri-anal region. The mass was small in size initially and was increasing gradually. He took some ointment there but size didn't decrease but discharge and itching had started. He had difficulty in defecation and later on mild pain while defecating was present. He didn't have history of bleeding per rectum and there was no history of loss of weight, loss of appetite. He didn't have any surgical history. He didn't have sexual partner other than his wife and wife didn't have similar condition. He was alcoholic and is smoker and had good bladder and bowel habit. His general examination revealed thin body built other than that he didn't have any other abnormalities. Per rectal examination revealed a large condymata to the left side of the anal verge and other small to medium sized masses present circumferentially in anal verge. The mass was grayish and reddish in colour. There was no any discharge present. The mass didn't show bleed on touch and was not fixed to deeper structures. Tenderness was absent and mild skin erythema was there. The mass was distal to anal canal and digital & anoscopic examination revealed no internal masses. There was no obvious inguinal lymphadenopathy.

The pre-operative investigations and management was similar to previous case except the larger mass present at left side, due to its larger base was transfixed and ligated by *Ksharasuta* (Ayurvedic medicines coated surgical thread) at the base which sloughed off along with mass after 10 days. The wound healed in 40 days without any post-operative adverse events. There is no history of recurrence till the date after surgery.



Case 4: Figure 1: Pre-operative image of the peri-anal region showing large anal condyloma which is present circumferentially around the anal verge obliterating the anal opening



Case 4: Figure 2: Post-operative image of the patient showing the peri-anal area after excision of the masses using electrocautery. For the larger mass Ksharasutra is transfixed and ligated at the base

Case 5

A 23 years unmarried bank officer female patient presented as mass around peri-anal and vaginal region for about 1 year. Her sole complain was mass and other associated complaints were absent. Mass was initially one in number later many such masses were observed that compelled her to take medical consultation. There was no any history of bleeding, discharge or itching. According to her she was not sexually active then, in past too. She didn't have any kind of addiction and her bladder and bowel habits were normal. Her general examination revealed no significant abnormalities. Inspection of peri-anal and vaginal region revealed multiple small to medium sized condyloma present around the anal region circumferentially and around the labia majora of vagina. One mass on perineal region was larger than others. The mass was not fixed to deeper structures and bleed on touch was absent. Tenderness was absent and inguinal lymphadenopathy was absent. Digital examination and anoscopic examination revealed no mass internally in anal cavity. Per-vaginal examination with per-speculum examination revealed no mass internally in vaginal cavity.

The pre-operative investigations and management was similar to previous case. The wound healed in 25 days without any post-operative adverse events. There is no history of recurrence till the date after surgery.



Case 5: Figure 1: Pre-operative image of the peri-anal region and genital area showing condyloma acuminata



Case 5: Figure 2: Post-operative image of the patient showing the peri-anal and genital area after excision of the masses, using electrocautery

DISCUSSION

Among the five cases 4 were male and 1 was female which is suggestive of the fact that male are affected more in comparison to female. Their ages may suggest the fact that people of young age are affected more. All of them had mass per anum as chief complaint and most of them had itching as associated complaint where few had anal discharge too. In these cases, malignant changes were not found and association with sexual history couldn't be correlated.

There are various methods for managing condyloma acuminata, out of which electrocoagulation is considered as best strategy of management where first or at most second degree of burn is created.[8] Electro-coagulation is used to destroy and excise abnormal tissues and also to stop bleeding. It is always advised to send the excised mass for histopathological examination. Here in electrocoagulation electric energy is changed into heat energy which acts upon the local tissues, similar therapy using heat has been explained in Sushruta Samhita is known as *Agnikarma* and by doing *Agnikarma* it is said that disease recurrence does not occur.[12] Recurrence can occur in some cases of immune-compromised patients like in cases of HIV/AIDS and transplant recipient patients [13] so recurrent cases should be evaluated and treated properly. It should always be considered that skin should be preserved around the anus and tissue damage is as less as possible to prevent anal stenosis post-operatively because deep burn may lead to anal stenosis which further complicates the scenario.[1]

One of the above cases was treated with *Ksharasutra* transfixation and ligation for a big mass along with electrocauterization of other small masses. The *Ksharasutra* mechanically strangulates the blood vessels[14] which causes necrosis of the mass and hence mass fell after 8 days. *Ksharasutra* is coated with three Ayurveda medicines which are *Haridra* (turmeric powder), *Snuhiksheera* (latex of *Euphorbia Neriifolia)* and *Apamarga Kshara* (alkaline substance prepared from water soluble ash of plant *Achyranthes aspera)*.[15] These components make *Ksharasutra* to have anti-septic, proteolytic, wound healing properties and also cause necrosis of infected tissues. [16,17,18]

Oral antibiotics and analgesics were prescribed for the patients for duration of 1 week afterwards antimicrobial and anti-inflammatory control was achieved by daily dressing with *Jatyadi Taila,*[19] sitz bath,[20] *Triphala Guggulu*,[21] and *Gandhaka Rasayana*[22] which were prescribed till the wound healed completely.

CONCLUSION

Condyloma acuminata is a viral disease caused by HPV can be best treated with electrocauterized excision of the mass followed by histopathological examination. Bigger masses can be transfixed and ligated using *Ksharasutra.* Daily sitz bath and dressing with *Jatyadi Taila* are vital in post-operative care along with oral medications like *Triphala Guggulu* and *Gandhaka Rasayana* to bring down microbial load and enhance healing as well to reduce inflammation and pain. This treatment was well tolerable and affordable to the patients and has no or very less recurrences after the surgery. Hence, it can be considered for managing condyloma acuminata associated to HPV. Malignancy should be ruled out in every cases and sexual history of the patient should be taken in details.

Limitations of the study

This study was carried out in five patients and needs a large-scale Study for further generalization.

Sexual history might have been concealed by some patients.

Patient consent

Written surgical consents were taken from the patients for the surgery and for this study.

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