Photo Quiz

Chronic extensive warty eruptions on the genital, pubic, crural, and perianal region

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Case Report

A 58-year-old promiscuous bisexual male presented to our outpatient department for the evaluation of asymptomatic nonscaly, warty lesions for the past 2 decades over phallus, pubic region, left thigh, and around the anus. He reported receptive and insertive anal intercourse with known and unknown male partners. No history of genital ulcer or discharge. A history of smoking cigarettes and cigars for 35 years was present. No other systemic comorbidities. The patient did not seek treatment till recently; gradual increase in size and number for 3 months, prompted him to obtain care. No color change or ulceration or bleeding from the lesions. No significant family history. Clinical examination revealed multiple hyperpigmented verrucous papules and plaques over phallus, pubic region, left thigh, bilateral inguinal region, and perianal region [Figure 1a and b]. No similar lesions elsewhere in the body and no regional adenopathy. Routine investigations including screening for sexually transmitted infections (STIs) yielded negative results. Excisional biopsy of a small lesion was conclusive with characteristic histopathological features [Figure 2].

What is your diagnosis?

Figure 1: (a and b) Multiple hyperpigmented verrucous papules and plaques over phallus, pubic region, left thigh, bilateral inguinal region, and perianal region

Discussion

Differential diagnoses considered were bowenoid papulosis, condyloma acuminata, seborrhoeic keratosis, genital porokeratosis, and common warts due to autoinoculation. Bowenoid papulosis may manifest as solitary or multiple well-demarcated hyperpigmented or skin-colored papules in the genital and perigenital region. Other extra genital sites include the mouth, face/neck (within beard).[1] It is now renamed as a vulval or penile high-grade squamous intraepithelial lesion and "Bowenoid papulosis" is no longer used by pathologists in the WHO Classification of Tumours, 2020, 5th edition.[2] Condyloma acuminata commonly appear as raised, skin-colored, and fleshy papules. They are usually broad and flat, pedicled, or occasionally have a cauliflower-like appearance. If a large warty mass engulfs the entire anogenital region, Buschke–Lowenstein tumor should be the fore most diagnosis.[3]

Seborrheic keratoses have a dull, waxy, uneven surface resulting in the characteristic "Stuck on" appearance. The color and number of these lesions can vary widely, and can generally occur anywhere on the body sparing the palms, soles, and mucous membranes.[4] Porokeratosis presents as keratotic papules or annular plaques that expand centrifugally with an elevated keratotic border and central atrophy. The lesions can present with itching and maybe there for yeomen years before diagnosis. Porokeratosis can occur in the face, genitourinary region, and scrotum.[5] The

Access this article online

Quick Response Code:

Website: www.ijstd.org

DOI: 10.4103/ijstd.ijstd_103_23

How to cite this article: Vedhanayagam M, Rajagopalan R, Revathi K, Balamurugan BR, Srinivasahan KG, Damodaran D. Chronic extensive warty eruptions on the genital, pubic, crural, and perianal region. Indian J Sex Transm Dis 2023;44:193-4.

Submitted: 01-Nov-2023 **Revised:** 08-Nov-2023
Accepted: 08-Nov-2023 **Published:** 06-Dec-2023

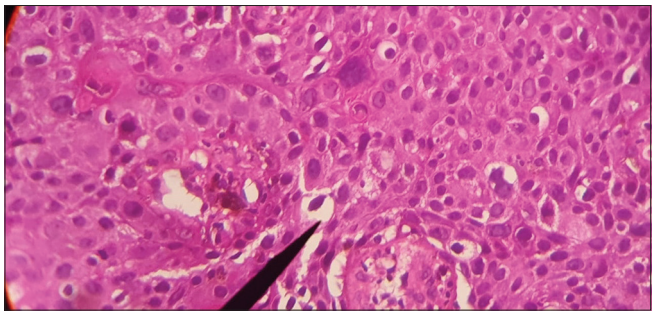

Figure 2: Full-thickness epidermal dysplasia, multiple metaphase mitoses in suprabasal layer with scattered dyskeratotic and multinucleated keratinocytes with pleiomorphism, basal cell degeneration and dermal superficial lymphocytic infiltrate with perivascular accentuation

majority of common warts are seen on the lower and upper extremities.[6] Unusually, they can be observed in genital and perigenital areas due to autoinoculation raising suspicion of sexual abuse, especially in female children, human papillomavirus (HPV) typing helps in differentiation.[7]

Excision biopsy of a papule was done. Full-thickness epidermal dysplasia (acanthosis, parakeratosis, and hypergranulosis), multiple metaphase mitoses in suprabasal layer with scattered dyskeratotic and multinucleated keratinocytes with pleiomorphism, basal cell degeneration and dermal superficial lymphocytic infiltrate with perivascular accentuation were observed under H and E stain. Thereby, we confirmed the diagnosis of bowenoid papulosis. Staining with an antibody to p16 protein which is confirmatory was not done.

The aim of our treatment is to avoid malignant transformation and to preserve the normal tissue and function. The available treatment modalities were topical such as 0.05% tazarotene, 5-fluorouracil and 5% imiquimod cream, photodynamic therapy with 5-aminolevulinic acid, carbon dioxide laser vaporization, cryotherapy, electrocoagulation, and excision.[8-11] We treated him with 5% imiquimod cream thrice a week at bed time for nearly 16 weeks with no improvement. The patient was not willing for electro surgery or cryotherapy or excision. Without treatment, it may regress only to appear elsewhere.

We advised the patient to practice safer sex,[12] cessation of smoking to reduce the recurrences, partner evaluation, and prophylactic HPV vaccine. Bowenoid papulosis, a rare STI is commonly due to HPV 16, though infrequently HPV 18, 31, 33, 34, 35, 39, 42, 48, 51, 52, 53, and 54 are also implicated. We could not do HPV typing to identify oncogenic strains due to monetary constraints.

Conclusion

Bowenoid papulosis, a rare, asymptomatic, slow-growing warty papules, STI, commonly occurs in young people and it frequently remits spontaneously. The management is generally conservative. Follow-up is mandatory.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understands that his name and initials will not be published and due efforts will be made to conceal his identity, but anonymity cannot be guaranteed.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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