

Two-stage approach for circumferential condylomatous lesion in the anus and perianal area

Abordagem em dois tempos para lesão condilomatosa circunferencial em canal anal e perianal

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PALAVRAS-CHAVE: Condiloma acuminado. Cirurgia. Pós-operatório.

INTRODUCTION

Condyloma acuminata is a skin and/or mucosal lesion caused by the human papillomavirus (HPV). They commonly manifest as soft papules or plaques on the external genitalia, perineum, perianal region, or groin.

There are more than 200 subtypes of HPV, more than 40 of which can infect the anogenital tract. There are low-risk subtypes, especially 6 and 11, and high-risk subtypes, notably subtypes 16 and 18.¹ Approximately 90% of condylomatous lesions have subtypes 6 and 11, with an important prevalence in infected individuals, where different studies in the literature have shown a prevalence above 50% in follow-ups of 24 and 36 months.^{2,3} In addition to the sex vector, the infection can also be transmitted vertically.

Among the risk factors, the following can be highlighted: sexual activity, especially when with skin-to-skin contact with the lesions, immunodeficiency, smoking, co-infection with HIV and HTLV-I. Circumcision, in turn, is a protective factor against HPV infection.

The lesions can have different shapes or colors. They are usually asymptomatic but can cause itching. To a lesser extent, other symptoms may occur, such as pain or local infections, as well as obstructions, urethral bleeding or discomfort when defecating. In addition, the psychosocial impact plays an important role due to the stigmatization of the patient. Social isolation, depression, and anxiety are reported in the literature.⁴

Anal stenosis, in turn, has as its main cause iatrogenic due to anorectal surgical procedures, notably hemorrhoidectomy, and, also, from electrocautery of extensive condylomatous lesions of the anal canal. Examples of other possible causes are anorectal masses,

inflammatory diseases, trauma, and congenital. The condition is characterized by deformity of the anal canal, decreased elasticity and diameter culminating in evacuatory difficulty and discomfort, and may also be associated with the presence of fissures, where there is commonly pain, important evacuatory effort, bleeding and thinning of the stool.^{5,6}

Highlighting the surgical cause, several factors can be listed: lack of sufficient mucosal bridges, dissection above the necessary culminating in low vascularization of the mucosal bridges, circumferential approach, depth of resection, amplitude culminating in narrow bridges, inadvertent intraoperative lesions and postoperative sphincter spasm.

The objective of this study was to report the case of a patient with a circumferential condylomatous lesion in the anal canal and perianal region, as was the case with the management in an attempt to avoid anal stenosis.

CASE REPORT

A 65-year-old woman came to the service complaining of "skin in the anus" (Figure 1A) without itching or pain, without discomfort to evacuate, with a history of chronic occasional constipation in April 2024. Condylomatous lesions were examined and promptly identified. On painless touch, it was noticed that the sphincter normotonia was observed, with no hemorrhoidal disease, no lesions in the low rectum, but with large lesions in the anal canal. Due to her age and because she had never had a colonoscopy (Figure 1B), she was performed and guidelines for excision of the lesions were initiated. Together with the patient, the pros and cons of the therapeutic modalities were presented,

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and it was decided to resect the lesions; however, due to its circumferential nature, it would occur in 2 stages, aiming to protect mucosal bridges and trying to reduce or even not allow the development of anal stenosis resulting from the approaches. Only the biopsy would be awaited for histopathological confirmation.

She returned in June to show preoperative exams and evaluation of the result of a colonoscopy performed with the result of: "sigmoid polyp, sessile, pink, 7 mm, polypectomy performed; diverticula in the left colon with no signs of inflammation; elevated lesions of various sizes, soft, grayish, in the perianal region and external anal border that extend through the anal canal, occupying about 80% of the circumference, biopsies were performed" (Figure 2). Histopathological examination confirmed condyloma acuminatum with no signs of malignancy.

During the consultation, she denied other symptoms, such as pain, bleeding, stool thinning, tenesmus, feeling of heaviness or others. She referred to "a procedure through the vagina to burn the cervix years before". She denied the practice of anal sex, as well as the use of illicit drugs, smoking, alcoholism or an active sex life. As a comorbidity, she reported hypertension controlled with the use of 2 medications. The proctological physical examination was again painless. Sphincter normotonia was observed, with no involvement of the lower rectum, but with ample involvement of the anal canal, estimating 80% of involvement, in agreement with previous colonoscopy, preserving only part of the posterior portion. In the perianal region, characteristic lesions were also observed, as well as a suspicious lesion on the lower vulvar border.

The first procedure was performed on July 2, and the mucosal grafts were maintained in the posterior, left lateral and right anterolateral walls, the latter with a remaining lesion (Figure 3A). In this first procedure, all perianal lesions and lesions in the lower vulvar border were resected. Histopathological studies confirmed condyloma acuminata in all lesions, with the exception of the vulvar, where lichenoid dermatitis was found.

At 2 weeks, there was the first return visit, showing good healing evolution. The patient reported mild discomfort to evacuate and post-evacuatory burning that could be sustained without the need for analgesia, without fecal deformity, evacuatory effort or bleeding. She continued with the plan of sitz baths 3 times a day with warm water, in addition to symptomatic laxatives, laxative diet and topical treatment with calcium channel blocker for sphincter relaxation. At that moment, the digital rectal examination was still bothersome, but without bleeding. After 4 weeks, she no longer had complaints when defecating, also denying incontinence (Figure 2).

The second return visit took place at 8 weeks postoperatively, where stability was observed in the remaining lesions, both in number and size, with no new perianal lesions. There was no distortion of the anorectal anatomy, apart from a satisfactory, painless digital rectal examination, with sphincter normotonia. The occurrence of the second operative time was discussed, requesting preparations.

The third return visit occurred 1 month after the last visit. In a new physical examination, the findings of the previous examination were maintained, but a new lesion in the perianal region, posterolateral left, appeared (Figure 3A). The new approach was performed 1 week after the resection of the remaining lesions (Figure 3B), after a thorough anoscopy under narcosis. Using anesthesia, the correct diameter of the anal canal could be measured, which was approximately 5 cm. The histopathological examination of the second procedure resulted in "anal canal condylomatosis" and "perianal condylomatosis".

Currently, the patient denies any complaints related to the anal canal. She denies post-evacuatory discomfort, bleeding, difficulty in evacuating or thinning of stools. On palpation of the site, she denied hardening or tissues suggestive of fibrosis (Figure 3C). She was released for outpatient control.

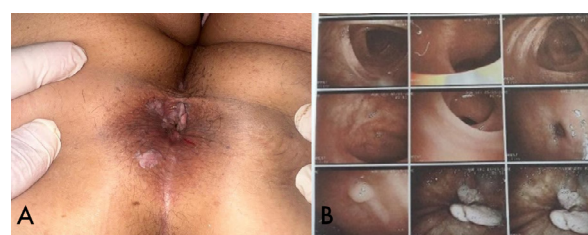


FIGURE 1 — Macroscopic appearance before the first procedure (May/2024): A) suspicious perianal lesions, in the anal canal and on the lower border of the vaginal canal (not visible in the image); B) preoperative colonoscopy and anatomopathological examination identified: "hyperplastic polyp and squamous papilloma, presence of alterations suggestive of viral cytopathic effect"

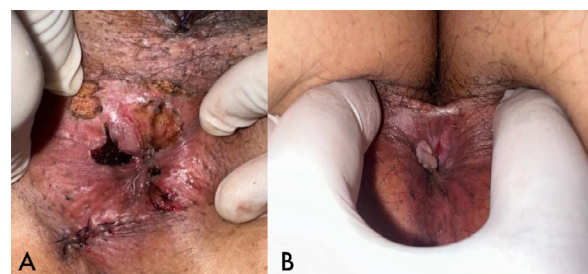


FIGURE 2 — A) POI aspect of the first procedure (July/2024); B) with 4 weeks of evolution (August/2024)

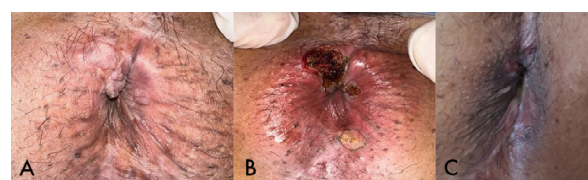


FIGURE 3 — Evolution at 12 weeks after the first procedure: A) a new lesion is noted on the left lateral wall (3 h October/2024); B) POI aspect of the second procedure (October/2024); C) evolution at 2 weeks after the second surgical procedure

DISCUSSION

Authors point out that different therapies can be used for condyloma acuminata, and the following are available: immunomodulatory – imiquimod and

sinecatechins, antiproliferative – podophyllin and ablative – cryotherapy, trichloroacetic acid and surgical excision (excision, electrocautery or laser).^{7,8}

The literature, however, does not present a consensus regarding the superiority of one technique over the other, and several factors have to be taken into account: location of the lesions, size, patient characteristics (immunity, ability to adhere to therapy, socioeconomic and educational level, pregnancy), availability of resources and expertise of the attending physician. Surgical excision, for example, is routinely indicated in extensive or refractory cases.^{9,10}

According to the studies, in the case of the patient in question, the following difficulties were made for drug therapy: living far from medical centers, requiring more definitive therapies and making it difficult to return periodically, the low level of education, the fact that she lived alone making it difficult to administer topical therapy, the location of lesions near mucosal areas preventing the use of imiquimod, in addition to the patient's own choice of the surgical method, having been performed.

The biggest challenge in the case, always passed on to the patient, would be to avoid or at least minimize anal stenosis due to the circumferential nature of the lesions. Therefore, following the established guidelines, what was tried was to preserve mucosal bridges, although in the first procedure one of them – right anterolateral – did not reach the recommended 2 cm, in addition to the resection of only the epidermis and superficial dermis, without reaching deep planes. This was followed, as recommended, by resection first with scissors and the use of electrocautery only for bed hemostasis.^{5,6}

Subsequently, an interval of at least 8-12 weeks was also completed between one procedure and the other, where the vascularization of the anal canal and scar accommodation would already be more appropriate for a new intervention.

As a final message, the case corroborates the line that condyloma acuminata, when located in the anal canal, should be thoroughly evaluated and the therapeutic plan should be drawn up together with the patient. In

the case of extensive lesions, especially circumferential lesions, the excisional approach in 2 times, with adequate interval, can reduce the incidence of anorectal stenosis by preserving mucosal bridges

Authors' contributions

Mário Fernando Dantas Gomes – Conceptualization, Writing (original draft)

Ana Catarina Dantas Gomes – Methodology, Writing (proofreading and editing)

Jurandir Marcondes Ribas Filho – Project Administration

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