CASE REPORT

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FLORID ANOGENITAL CONDYLOMA ACUMINATA IN A MALE AFRICAN: A CASE REPORT

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ABSTRACT

Condyloma acuminate are commonly transmitted through sexual intercourse among those in the age bracket of 15 to 49 years. Florid lesions occur in those with immunosuppression, debilitating illness or pregnancy. Clinical diagnosis is often used in Nigeria. Their prevalence among HIV Seropositive patients is unknown. Lesions are often treated with 25% Podophyllin hydrochloride solution or ointments in other combinations. Occasionally surgery is used in giant and obstructive types. This is a case of 34 year old male homosexual that is HIV positive presenting with a Florid Anogenital Condyloma Acuminata. He was undergoing treatment with *HAART* (Nevirapine, Starudine and Lamivudine). He did well clinically before coming down with this condition. He also responded well to podophyllin treatment without surgery but was lost to follow-up. Clinicians should watch out for similar resentations.

KEY WORDS: Condyloma Acuminata, Warts, Human Papilloma Virus, anogenital.

INTRODUCTION:

Genital warts or Condyloma acuminata are found in approximately 7 to 20% of the general population, with the highest frequency in the early teenage years. Autoinoculation of virus to contiguous or distant sites is frequent (1). Condyloma acuminata are one of the most common sexually transmitted infections. They are hyperplastic, sessile or pedunculated neoformations, red or pink, sometimes forming soft exuberant masses, strangulated at their base. The human papilloma virus (HPV) (1,2,3,4) causes them. In men, they occur most commonly in the preputial area, on the coronal sulcus and

the urethral meatus, rarely on the scrotum and anus. In women, they predominate on the posterior vestibule and the vulva, the vagina, the urethra, the perineum and the uterine cervix. Certain clinical conditions such as pregnancy, diabetes and immunodeficiency states accelerate their growth. Warts reoccur frequently and are quite contagious. Systematic histologic examination of excised pieces is necessary to confirm their sero-types (subtypes). We hereby present a peculiar case of florid anogenital warts in a young male adult homosexual of African descent living with HIV/AIDS.

CASE REPORT

A 34-year-old male presented to our clinic with a history of weight loss diarrhoea and fever of more than one-month duration. He had visited many herbalists, chemist shops and private hospitals without significant improvement in his clinical status. However, when the symptoms worsened and associated with weakness and tiredness, he was referred to STD/RVD clinic for HIV antibody testing and further management.

History revealed a high risk activity in his sexual orientation (homosexuality) which is uncommon in the general population. His educational, social and occupational history was not significant. Medical history was also not significant until these presenting complaints of the last few months that broght him to our clinic. No previous history of admissions, surgery or significant illness.

Physical examination revealed a young, male, African patient of 1.75metre in height, weighing 50kg while height, pale++, ill looking, weak, emaciated, febrile to touch and generalized lymphoadenpathy. He was well oriented in time, place and person. His chest was clinically clear. Cardiovascular system, abdomen, musculoskeletal system and urogenitals were intact.

HIV screening by double ELISA as well as confirmatory tests by Westernblot were reactive. The follow up tests revealed the following: HbsAg was non-reactive, PCV 26%, WBC of 3,200, blood film was normocytic and normochronic, urea and electrolytes, Liver function test, lipid profile and Serum amylase were all within normal range with only slight derangement. His CD_4 cell count was however low at 290 cells/L. He was then placed on ***HAART*** comprising Nevirapine, Stamdine and Lamivudine apart from cotrimoxazole prophylaxis, analgesic and antidiarrhoea. Reviews were carried out at one month, three months and six months respectively. At one month, he was slightly better than before following control of fever, diarrhea and tiredness. His weight had increased to 52kg. At three months, his confidence had been regained, his weight appreciated to 56kg while his CD_4 count had risen to 320 cells/L. No more fever, tiredness, weakness and loss of appetite were reported. At six months, he now came down with florid anogenital warts with some difficulty in moving bowels. There was no fever, pain, itching or other complaints. He was actually looking much better and stronger. He had visited several surgeous in private hospitals where he was charged exhorbitantly. Since he could not afford it, he decided to consult us at the Sexual Transmitted Disease/Retroviral Disease (STD/RVD) clinic.

We then examined him, evaluating him for optimal treatment and concluded that he could benefit from podophyllin application following a clean bill of a histology report following biopsy of one of the lesions. The lesions were benign. His weight had increased to 60 kg by this time and he was looking much better. The CD_4 cell count was then 400 cells /mm^3.

Physical examination revealed: large perianal condyloma acuminata above and below the anal orifice. Other smaller lesions were seen at the buttocks, urethral meatus and penile coronal areas (figures I and II). They were soft, fleshy, slightly mobile but not tender. Normal skin colour was observed in some of them while others were hypopigmented. Much smaller ones were flat, discrete and fleshy. His treatment was 25% podophyllin hydrochloride applied thrice a week. After two months most lesions were gone without scars.

Fig 1: **Verucose Warts in the anal region and buttocks**

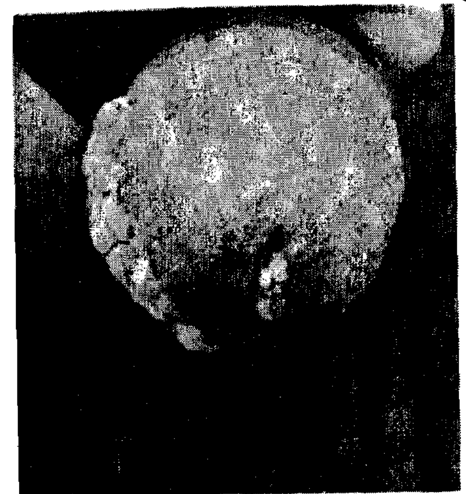

Fig 2: **Verucose Warts on the Urethral Meatus and Coronal Sulcus**

DISCUSSION

Mucosal Human Papilloma Viruses (HPVs) infect primarily the anogenital tract epithelium, but these HPV types can also be found in the oral mucosa, conjunctiva, and respiratory tract. Genital tract HPV infection is thought to be the most common viral sexually transmitted disease (STD) in the United States of America (5). Such data do not exist in Nigeria but current evidence suggests that over 50% of sexually active adults have been infected with an HPV associated with genital infection (6). Our case is a young adult of African descent who was HIV positive, already on therapy ***(HAART)*** but was still active with homosexual activity inspite of his serostatus. The reason why the warts became florid after months of antiHIV treatment is unknown to us. This has occurred inspite of the fact that the young man had appreciated in weight, CD_4 cell count, physical and psychological well being. The prevalence of HPV infection in the genital tract is not well defined. Estimates have varied with the diagnostic method used. What is clear is that as with other sexually transmitted diseases, evidence of current infection is most frequently detected among sexually active young people (7, 8). In the early 1990s, it was estimated that

about 1% of men and women in the United States between 15 and 49 years of age had clinically evident genital warts

Our case report is a single case out of the 605 patients that were attending the clinic since 2003. Florid cases like this are uncommon by our experience. Clinicians are therefore encouraged to watch out for such cases. Local 25% podophyllin application was able to virtually clear all the lesions before the patient got lost to follow up.

This should be encouraged instead of radical surgical interventions. Reoccurence is common even with surgical excision. However, healing may be slow. With podophyllin, those prolonged healing time in a HIV seropositive person, scars that may result, pain and financial pressures on the patient may be reduced substantially

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