Unusual Clinical Presentation of Giant Extragenital Condyloma

Dear editor,

Condylomata accuminatum (CA) is a human papillomavirus (HPV) related sexually transmitted infection (STI), clinically characterized by solitary or even clustered dark red or pink lesions solely affecting the anogenital area (1). CA involving the extragenital, non-mucosal skin has been sporadically reported (2-4). Diagnosis of CA is usually straightforward when the lesions are located on the anogenital area. However, involvement of extragenital skin may pose a diagnostic challenge. Herein, we report a rare case of giant linear extragenital CA without coexisting genital lesions, diagnosed with a synergic intervention of dermatoscopy and clinics.

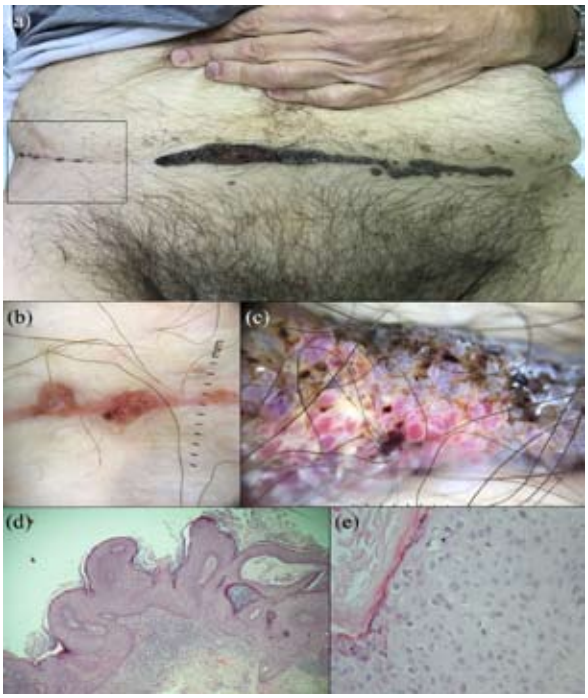

Figure 1. Clinical, dermoscopic and histological findings. (a) Linear giant verrucous plaque with small solitary papules (square). (b) Mosaic pattern with glomerular vessels. (c) Fingerlike pattern with glomerular and hairpin vessels. (d) Papillomatosis, parakeratosis and acanthosis seen in the epidermis (Hematoxylin-eosin stain; original magnification x 4). (e) Koilocyte (arrow) in the spinous layer (Hematoxylin-eosin stain; original magnification x 40).

A 70-year-old Caucasian man was referred to our department for an atypical asymptomatic seborrheic keratosis presenting as a linear verrucous plaque (20 × 2 cm) with few solitary reddish satellite papules on the abdomen (Figure 1, a). No similar lesions were present in both cutaneous and mucosal districts. Medical history was unremarkable, and the patient denied having recent sexual intercourse or any history of condylomas. Remarkably, the patient underwent a diet in the last 8 months that resulted in a loss of 30 kg. We employed dermatoscopy to further assess the lesions, highlighting a finger-like pattern on the main lesion (Figure 1, c), while satellite lesions presented a mosaic pattern (Figure 1, b). The clinical appearance and these dermatoscopic findings were suggestive of condyloma acuminatum (CA), but due to its extraordinary presentation we also performed an incisional biopsy. Histopathological examination reviled features compatible with the diagnosis of CA (Figure 1, d, e). To better characterized the HPV genotype (high-risk and low-risk HPV) a polymerase chain reaction (PCR) from lesional tissue sample was performed and found HPV type 6 positivity. The lesions were successfully removed by electrosurgery. Regular follow-up was scheduled. Sexually transmitted infections (STIs) were also screened, namely syphilis, gonorrhea, chlamydia trachomatis, and HIV status. In addition, laboratory tests and imaging examinations (radiography of the chest and ultrasound examination of the abdomen) revealed no pathological findings.

CA involving the extragenital skin has been reported within intertriginous areas, including the inframammary fold, the groin, and the axillary vault, as well as mucosal surface such as intraoral and conjunctival mucosa (1-5). In most cases, extragenital CA coexisted with genital lesions. Staples *et al*. reported three obese patients with extragenital CA on the skin of the abdominal pannus (3). However, all of the patients had involvement of the inguinal folds, from where the CA had extended. Generally, CA is acquired by genital, oral, or anal sexual contact. Among the wide spectrum

of HPV genotypes, types 6 and 11 are responsible of 90% of CA (1). Our paradigmatic case allows us reflect on the concept of transitory immune dysregulation due to a significant amount of weight loss, and the position of the lesions in particular seems to suggest that frictional triggers may disrupt the barrier integrity, leading to higher probability of infection.

Dermoscopy is a noninvasive diagnostic tool with a significant role in the assessment of melanocytic and non-melanocytic skin tumors. Furthermore, the utility of dermatoscopy has expanded to the field of inflammatory and infectious skin disease, where dermoscopy enhances the differential diagnosis between them. Seborrheic keratosis, as the most common benign epithelial tumor, can occur anywhere in the skin excluding the palms, soles, and mucosa (6). In the anogenital area, seborrheic keratosis usually resembles CA. However, dermatoscopically, seborrheic keratosis can be immediately identified by the presence of milia-like cysts, comedo-like openings, fissures, finger-print structures, and sharply demarcated borders (6). In contrast, reports of CA dermoscopy suggested four different dermoscopic patterns: fingerlike, mosaic, knoblike, and the most commonly, an unspecific pattern (7). Our case showed that dermoscopy of extragenital CA presented a mosaic pattern in an early stage of CA, while fully developed lesions revealed a fingerlike pattern, as has previously been reported by Dong *et al*. (7), where two different stages of clinical development of CA exhibit distinctive dermoscopic patterns, which correlates with our case. We did not observe the typical dermoscopic features of seborrheic keratosis.

CA arising in an extragenital area is very rare and perhaps also underestimated. Thus, dermatologists should be aware of this unusual presentation even in the absence of genital HPV involvement. Moreover, dermoscopy may facilitate CA recognition in a such uncommon location. To our knowledge, this is the first report of extragenital condyloma acuminatum documented dermoscopically.

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