

Images in Infectious Diseases

Buschke-Lowenstein tumor in a woman living with HIV/AIDS

Paulo Sérgio Ramos de Araújo^{[1],[2]}, Carlos Eduardo Guimarães Padilha^[1] and Melina Ferraz Soares^[1]

[1]. Serviço de Doenças Infecciosas e Parasitárias, Hospital de Clínicas, Universidade Federal de Pernambuco, Recife, PE, Brasil.

[2]. Laboratório de Doenças Transmissíveis, Centro de Pesquisas Aggeu Magalhães, Fundação Oswaldo Cruz, Recife, PE, Brasil.

A 32-year-old woman presented with an 8-month history of verrucous and suppurative skin lesions on the anogenital area. She was diagnosed with human immunodeficiency virus (HIV) infection 18 months before and was receiving antiretroviral therapy thereafter. She underwent excision and experienced recurrence of perineal warts since the age of 28 years. Clinical examination showed oval hyperchromic keratotic plaques on the perineum, and extensive verrucous masses located on the left buttock that were painful to touch, friable, and foul-smelling, with some bleeding and purulent exudate on the surface (**Figure A**). The cluster of differentiation 4 (CD4) count was 219 cells/mm³ and the HIV viral load was undetectable. Pelvic magnetic resonance revealed confluent fluid collections, with edema of the gluteal muscles and fistulous communication between collections and the intersphincteric region of the anal canal. Deep biopsy of one of the multiple exophytic lesions was performed. Microscopic examination revealed a verrucous architecture, papillomatosis, parakeratosis, hyperkeratosis, and koilocytotic changes with an intact basement membrane. These findings were consistent with verrucous carcinoma (VC) or a Buschke-Lowenstein tumor (BLT). BLT is a rare disease triggered by HPV, usually subtypes 6/11. Clinical manifestations typically include a palpable mass, pain, bleeding, fistulas, or pruritus⁽¹⁾. Immunodeficiency is a significant risk factor, and the histological features of BLT are very similar to those of VC; some authors do not differentiate between these diseases^{(2),(3)}. Although locally aggressive and destructive in appearance, BLT has low metastatic potential⁽³⁾.



FIGURE A - Vegetative formations that are erythematous, exophytic, and friable in the left buttock.

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Universidade Federal de Pernambuco, Hospital de Clínicas.

Corresponding author: Prof. Paulo Sérgio Ramos de Araújo.

e-mail: psergiora@gmail.com

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