Cartas al Director

Not only aondyloma acuminata of the anal canal: a rare case with coexisting adenocarcinoma

Key words: *Condyloma acuminata. Anal canal. Malignancy. Adenocarcinoma.*

Dear Editor,

A 38-year-old homosexual male presented to our hospital with a two-week history of foreign body and itching sensation in the anus. There were no changes in his appetite and body weight. In his medical history, there is no gastroduodenal ulcer or hematochezia. He was afebrile on admission, and physical examination of abdomen showed no palpable mass or tenderness. There were no palpable inguinal lymph nodes. Laboratory data showed no remarking findings and negative human immunodeficiency virus (HIV). Tumor markers revealed normal carcinoembryonic antigen (CEA) and carbohydrate antigen-199 (CA-199) levels. Digital examination showed multiple exophytic lesions over the anal canal. Anoscopy showed verrucous papules at the anorectal junction and all lesions in clusters of two or three were less than 1 cm in diameter. Excisional biopsy was performed. Histopathologic report indicated a diagnosis of co-existing condyloma acuminata and poorly-differentiated adenocarcinoma of the anal canal without stromal invasion (Fig. 1). In addition, the epithelium showed vacuolization or koilocytosis, characteristic of human papillomavirus (HPV) infection. Colonoscopy was performed without abnormal findings and the patient underwent wide excision. The postoperative course was unevenful, and the patient was discharged on the

4th postoperative day. He recovered well without further recurrence of anal cancer or condyloma acuminata at 12 months follow-up.

Discussion

Infection with human papillomavirus (HPV) may manifest as anal condyloma and cause clinical symptoms such as burning, itching, bleeding, and pain. In addition, it is a primary risk factor for dysplasia and may progress to squamous cell carcinoma (SCC) of the anus (1). The reported incidence of SCC of the anus in patients with anal condyloma is rare and accounts for only 3 to 4% in the literature (2). However, the natural history of progression from benign anal condyloma to anal squamous intraepithelial lesions and SCC is not well defined (3). Since anal cancer is only 2% of all colorectal malignancy, adenocarcinoma of anal canal is even rare and constitutes about 5% of anal malignancy (4). There are only few reports in correlation with adenocarcinoma of anal canal, including anal fistula, hemorrhoids, ulcerative colitis, or Crohn's disease (5-7). Although adenocarcinoma of the anal canal is rare with limited data regarding treatment and outcomes, Beal et al. (8) suggested that the abdomino-perineal resection (APR) for invasive adenocarcinoma of anal canal was a reasonable approach.

To the best of our knowledge, this case is not yet reported in the literature, especially with such presentation of co-existing adenocarcinoma and condyloma acuminata over the anal canal. For unknown lesions of anal canal, biopsy and histological examination are importantly required to prove the malignancy and grade dysplasia. In addition, further endoscopic studies are suggested for monitoring after operation.

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Fig. 1. A. Coexisting adenocarcinoma (arrowhead) and condyloma acuminata (arrow) of the anal canal. B. Poorly-differentiated adenocarcinoma of the anal canal (Hematoxylin- Eosin; 100X). C. Poorly-differentiated adenocarcinoma of the anal canal (Hematoxylin- Eosin, 400X). D. Condyloma acuminata of the anal canal. The epithelium shows vacuolization (koilocytosis), characteristic of human papillomavirus (HPV) infection.

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