

VULVOVAGINAL CONDYLOMA ACUMINATA AND PREGNANCY: ABOUT TWO CASES

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ABSTRACT

Vaginal condylomata acuminata linked to papillomavirus infection are frequent during pregnancy, with a low risk of fetal transmission at the time of delivery. Diagnosis of genital Condylomata is primarily clinical, with lesions visible to the naked eye or requiring macroscopic examination (colposcopy). Pregnancy favors extensive, multifocal lesions. The aim of treatment is to eliminate visible lesions. No effective antiviral treatment is available. They may regress spontaneously in 20% to 30% of cases. However, in the post-partum period, low-grade lesions most potentially regress. Vaccination could significantly reduce the impact of this pathology, but cannot eradicate it. We report 2 cases of condyloma acuminata discovered at the end of the 3rd trimester, caesarean section was indicated for the risk hemorrhagic of lesions, the evolution was marked by spontaneous regression.

KEYWORDS: Condyloma; condylomata acuminata; Pregnancy; delivery.**INTRODUCTION**

Condylomas are benign tumors of the malpighian epithelium. Their location varies widely, from the vulva, vagina and cervix, to the urethra, perineum and anal region. These lesions are induced by certain human papilloma viruses (HPV).^[1] Viral transmission is essentially sexual, with only 1-3% of women, depending on the series, actually developing condylomas.^[2] Pregnancy favors the appearance and growth of condylomata, which are 3 times more frequent during gestation than outside it, and are mainly acuminated in the vagina and vulva.^[3] Diagnosis is generally clinical, aided, if necessary, by colposcopy.^[1] The therapeutic arsenal has broadened, from abstention and treatment of physical or chemical tricks to immune stimulation.

In two cases of vulvovaginal condyloma and pregnancy, we discuss the pathophysiological, clinical, therapeutic and preventive aspects.

Observation n1

Mrs AZ. 27 years old, pregnant at 38 weeks' gestation, primigravida with no previous history, consulted the obstetrical emergency department for abdominal pain and vulvar gene, clinical examination revealed a conscious patient with blood pressure at 114/64 mmHg, heart rate at 78bpm, afebrile, examination of the external genitalia showed the presence of multiple fine, diffuse vegetations pearly white with raspberry base throughout the vagina and urethral meat (Figure 1), vaginal touch

was impossible due to pain and risk of bleeding, fetal heart rate recording and tocograph objectified the presence of uterine contractions. cesarean section indicated for risk of hemorrhage, post-partum evolution was marked by spontaneous regression of lesions, and the newborn was progressing well.

Observation n2

Mrs WN. 34 years old, pregnant at 39 weeks' gestation, primigravida with no previous history, consulted an obstetrical emergency department for premature rupture of membranes at term. Clinical examination revealed a conscious patient with blood pressure 120/60 mmHg, heart rate 86bpm, afebrile, obstetrical examination revealed multiple fine, diffuse, spiculated lesions pearly white in the labia minora and vagina (Figure 2); vaginal touch to appreciate the cervix was impossible due to narrowing of the vulvar orifice by these lesions; amniotic fluid was clear. assessment of fetal well-being was normal. cesarean section was indicated in view of vulvovaginal lesions constituting a previa obstacle and risk of hemorrhage. post-partum evolution was marked by spontaneous regression of lesions, and the newborn was progressing well.

DISCUSSION

Condylomas are squamous epithelium benign tumors. They can be found in a wide range of places, including the urethra, perineum, anal area, vulva, vagina, and cervix.

More than 90% of these lesions are caused by certain human papillomavirus (HPV) types 6 and 11.^[4] The fundamental mechanism of viral transmission is sexual contact, which causes mucosal micro-abrasions that enable the viruses to invade the basal layers of the epithelium. Maternal-fetal or perinatal transmission and self-inoculation from cutaneous warts happen far less frequently.^[1] According to estimates, 10-15% of sexually active people are HPV positive, although only 1-3% of these women really present with condylomata.^[2] Men and women can both be impacted by condylomata. 3 to 5% of the population will develop clinical lesions^[5], and between 2.6 and 10% asymptomatic latent infections.^[6]

Prolonged oral contraception, smoking, multiple sexual partners, multiparity, co-infection with other STDs, and immunosuppression are risk factors for chronic HPV infection. Pregnancy also increases viral virulence, probably as a result of externalization of the cervical junction zone between squamous and cubic epithelium, and a reduction in immunity. Condoms and circumcision are protective factors against infection, although this protection is not absolute.^[7] Our pregnant women have no risk factors.

Lesions typically show up two to three months after infection, although there may be longer incubation times (months or even years). A person may have the virus for the duration of her life, putting herself at risk for late-stage clinical symptoms or recurrences. After a few months or years, the majority of these lesions appear to spontaneously resolve following local antiviral immune responses.^[4] The vulva, perineum, small and large labia, and perianal area are the most frequently encountered sites.^[8]

In the majority of cases, condylomata do not cause any symptoms, or may cause pruritus, the discomfort is represented by the raised forms, which the woman can see or palpate to the touch. Cervical and vaginal localization are revealed by smears. Leucorrhoea or post-coital bleeding will only be found in raised condylomas due to maceration and superinfection.^[1]

There are three primary varieties of condylomas that are described like the lesions presented^[1,3,8]

- Acuminate forms: these consist of one or more digitations that are centered on a vessel; they should not be confused with physiological papillae found on the inside face of inner lips. They typically reside in wet mucosal regions.
- Popular forms: elevated, smooth, pinkish, well-circumscribed lesions that can be found alone or in sheets; they are typically found on dry skin.
- Flat forms: more challenging to find on the vulva, they become visible only after acetic acid is applied.

Diagnosis of genital condylomas is essentially clinical. A biopsy should be used in atypical forms where dysplasia may be suspected.^[8]

It should be supplemented by a speculum examination, smear test, assessment of sexually transmitted infections (STIs) and systematic colposcopy, in view of the possibility of mixed infections, associating low-risk and high-risk HPV. The STI work-up consists of: VDRL/TPHA, HIV, hepatitis B and C depending on the context; a search for gonorrhoea and chlamydia.^[3]

For our patients, after spontaneous regression of the lesions, the speculum examination and cervico-vaginal smear were normal, and the STI test was negative.

Genital condylomatosis acuminata is not a rare pathology in pregnant women, with prevalence estimated at between 0.5% and 5%, depending on the author.^[9]

There is an increase in viral lesions during pregnancy, from an incidence of 21% in the first trimester to 41% in the third (versus 17% in the post-partum period).^[10]

Maternal complications of condylomata are rare and primarily related to the size of the tumor. They include defecation troubles, fragility of perineal tissues, local superinfection, dysuria, and obstruction of the genital canal, as in the cases reported. Extremely uncommon fetal consequences include abortion, fetal death in utero, premature membrane rupture (observation N 2), chorioamnionitis, or fetal contamination from inhaling HPV during delivery (juvenile laryngeal papillomatosis).^[11]

During pregnancy, the principal objective of treatment is to reduce the extent of lesions to limit the risk of mother/child transmission and avoid a preventive caesarean section by normalization of the perineum for the birth period.

In a matter of months, more than 20–30% of condylomata may spontaneously regress.^[6]

We advise therapy because of their psychological and cosmetic unacceptability, as well as the fact that it breaks the chain of contamination and stops autoinoculation from spreading.

With anesthesia, cryocoagulation, laser vaporization, and trichloroacetic acid are the most common methods suggested during the pregnancy between 28 and 32 weeks of amenorrhoea.^[1]

Podophyllotoxin and Fluorouracil are not recommended due to their teratogenicity and possible hyperabsorption-related maternal toxicity. Furthermore, the acute condition's immune system deficit precludes the use of interferon. In the case of limited lesions, however, treatment is not necessary.^[1,3,10]

Modification of the obstetrical attitude is indicated in the case of florid lesions forming voluminous condylomatous tumours which are a source of obstacle

prævia or haemorrhagic risks, as in the two cases presented.^[1]

Vaccination strategies can be proposed, essentially for prophylactic and therapeutic prevention.^[7,12]

CONCLUSION

Genital condyloma acuminata caused by HPV infection are common during pregnancy, with a low risk of transmission during delivery. Condylomatous lesions may regress spontaneously after delivery, or they may persist and require specific management. Caesarean section is not routinely performed, but may be required depending on size and location.



Figure 1: Vulvo-vaginal condyloma acuminata during pregnancy (observation N 1).



Figure 2: Vulvo-vaginal condyloma acuminata during pregnancy (observation N 2).

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