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## Condylomatous cell carcinoma of the penis associated human papillomavirus with multimetastatic

## Carcinoma escamocelular condilomatoso asociado al virus del papiloma humano multimetastásico

Dear Editor,

The incidence of penile cancer is currently low in industrialized countries (around 0.5–1 per 100,000 inhabitants), and moderate in developing or underdeveloped countries (20–25 per 100,000 inhabitants). There are several primary penis histological types; atypical histological types located in the penis, and penile metastasis of other carcinomas have also been described.

We present the case of a 67-year-old patient with a history of insulin-dependent diabetes mellitus, arterial hypertension, and dilated cardiomyopathy, who complained of an excrescent, ulcerated lesion on his penis and difficulty urinating for 5 months. The physical examination revealed a very large excrescent, friable, ulcerated lesion on the glans penis; no normal anatomical structures could be identified (fig. 1). Laboratory tests did not show any significant abnormalities. A CT scan of the abdomen and pelvis showed multiple retroperitoneal lymphadenopathies, a 1-cm node

in liver segment III, multiple hypoattenuated nodes in the spleen (fig. 2), a right adrenal node, interruptions on the wing of the right ilium, all of which were compatible with metastasis. The chest X-rays showed a node in the right pulmonary base compatible with metastasis. A total penectomy and perineal urethrostomy was performed. Seventy-two hours after surgery the patient presented with dysarthria and vertiginous syndrome; a brain CT scan showed multiple nodes compatible with metastasis. The histological report of the sample was squamous cell carcinoma of the condylomatous variety, positive for human papillomavirus type 16 antigen (T3N2M1). Palliative treatment was initiated; the patient died 20 days after surgery.

Squamous or epidermoid carcinoma is the most common malignant tumor of the penis; there are three histological grades according to cellular differentiation. Risk factors



Figure 1 – Excrescent and ulcerated lesion on the penis.

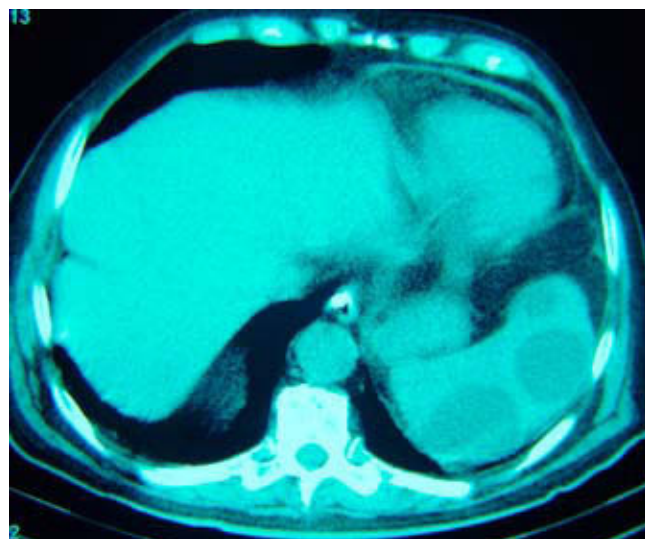


Figure 2 – CT scan: spleen nodes compatible with metastasis.

for this condition include poor hygiene, phimosis, and human papillomavirus infection<sup>1,2</sup>. Preventive factors include hygienic measures, circumcision, condom use, smoking cessation, and the treatment of chronic inflammatory lesions<sup>3</sup>. The diagnosis is mainly clinical; imaging tests (ultrasound or MRI) are necessary to assess the degree of local invasion<sup>4</sup>. If distant invasion is suspected, an abdomen and pelvis CT scan and a simple chest X-ray are indicated for assessing metastases<sup>1</sup>.

Typically, treatment is partial or total penectomy, depending on the degree of invasion. Over the past few years, it has been shown that lesions that do not invade the corpora cavernosa and the corpus spongiosum and which have a high degree of cell differentiation can be treated conservatively with cryotherapy, laser therapy, imiquimod 5%, fluoruracil, radiotherapy, brachytherapy, or photodynamic therapy<sup>[1 and 5]</sup>. For locally invasive tumors, a more radical surgery (total or partial penectomy) is indicated. In cases with distant invasion, treatment depends on the location of the metastases. If inguinal lymphadenopathies are palpable, the first-choice treatment is lymphadenectomy<sup>6</sup>; if no lymphadenopathies are found, there is controversy regarding the complementary treatment, which will depend on the degree of local invasion and the degree of cell differentiation. In cases with distant metastases, the indicated treatment is palliative or chemotherapy with cisplatin, methotrexate, and bleomycin, which has shown to be effective and to prolong survival when there is lymphatic involvement<sup>7</sup>, but not if there is organic dissemination of the tumor.

Prognosis depends on many factors. In a systematic review, Novara et al showed that a high histological grade, infiltration of the corpora cavernosa, infiltration of the corpus spongiosum, infiltration of the urethra, and the presence of lymphadenopathies are associated with reduced survival and worse prognosis<sup>8</sup>. Madeira Campos et al showed that a low E-cadherin immunoreactivity is associated with a high risk of lymph node metastasis and a poor prognosis, but this is not the case for MMP-2 and MMP-9 immunoreactivity for which no association with lymphatic involvement was found<sup>9</sup>. Zhu et al showed that p53 immunoreactivity is useful to establish the likelihood of lymph node involvement; it is also a good marker for prognosis and follow-up after treatment<sup>10</sup>.

We therefore currently consider penile cancer an aggressive cancer with a high rate of distant metastases, especially via the lymphatic system, whose most common

treatment is penectomy. In cases with multiple distant metastases such as the one presented here, at this time the only option is palliative treatment, since chemotherapy has high cytotoxicity and does not benefit patients.

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