Bowenoid papulosis (BP), Bowen’s disease (BD) and erythroplasia of Queyrat (EQ) are distinct clinical entities with similar histological findings of intraepithelial neoplasia, but with different clinical behaviour and different risks of progression to invasive squamous cell carcinoma (SCC). In the anogenital region, BP presents grey-brown or skin-coloured elevated papules with a maximum diameter of 1 cm, BD shows larger well-demarcated plaques, and EQ appears as a well-margined erythematous velvety patch or plaque, mainly on the glans penis (1). BP is rarely invasive and may even regress spontaneously, thus conservative treatments are often adequate. In contrast BD and especially EQ, should be treated relatively more aggressively. Human papillomavirus infection (HPV) may play a causative critical role, with variable risk of progression to invasive SCC (2, 3). It has been suggested that the management of high-risk HPV-associated lesions is best if tailor-made with a multidisciplinary approach. We report here the case of a sexually active woman affected by a dramatic and disabling HPV16-related anogenital BP and BD, with focal progression into invasive SCC.

CASE REPORT

A 42-year-old Caucasian woman was referred to our Dermatology Department with a 20-year history of asymptomatic, smooth, brownish, velvety surface macules and plaques in the anogenital region, labia minora and majora, fourchette, perianal region and groin. Lymphocyte count, including total CD3, CD4 and CD8, natural killer (NK)-cell and B-cell counts, as well as serum immunoglobulins were all within normal ranges. Tests for HHV-1, HIV-2, HTLV-1 and HTLV-2 were negative and she had no history of immunodepression or immunosuppressant drugs intake. She had smoked 40 cigarettes a day for 14 years. Her gynaecological history included menarche at the age of 13 years with regular menstrual cycles and sexarche at the age of 18 years and obstetric history included menarche at the age of 13 years with regular menstrual cycles and sexarche at the age of 18 years and obstetric history included menarche at the age of 13 years with regular menstrual cycles and sexarche at the age of 18 years and obstetric history included menarche at the age of 13 years with regular menstrual cycles and sexarche at the age of 18 years. Especially younger women tend to have multicentric disease. According to some studies, women who are heavy smokers are more likely to have persistent vulvar disease (7). An additional risk factor which might have influenced her clinical course is smoking. It has been shown that women who are heavy smokers are more likely to have multicentric disease. According to some studies, women who continue to smoke after treatment are 30 times more likely to have persistent vulvar disease (7).

Surgical excision, electrocoagulation, cryotherapy, CO₂ laser therapy, and photodynamic therapy, are recommended treatment modalities, but they are not always completely successful, because of the multifocal distribution of the BP lesions (10). Alternatives are chemotherapeutics including 5-fluorouracil, podophyllin, cidofovir, imiquimod, and either systemic or local...
retinoids (10, 11). A randomized placebo-controlled trial has demonstrated the role of oral isotretinoin in the treatment of recalcitrant cervix condylomata (12). Several pathways have been proposed to explain how retinoids can control viral replication. They can down-regulate the expression of HPV messenger-RNA or indirectly induce transforming growth factor-β, which inhibits cell proliferation and transcription of E6/E7 genes in cervical epithelial cells (13, 14).

Brachytherapy is a recently patented skin-focused superficial and selective form of radiotherapy, demonstrated to be effective in non-melanoma skin cancers (15). A synthetic resin containing a radioactive β-emitting isotope is applied to the lesion to perform a selective β-irradiation treatment, reducing the radiation exposure of the surrounding healthy tissues. We speculated that brachytherapy in combination with isotretinoin could cooperate to clear the Bowenoid field and prevent recurrences, and in our patient this was acutally the case.

In conclusion, this case emphasizes the insidious evolution of high-risk, HPV-related anogenital lesions, featuring as BP, BD and invasive SCC, in a young sexually active patient, and describes a successful therapy able to achieve healing of the lesions, chemoprevention and improvement in quality of life.

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REFERENCES