DOI: 10.7860/JCDR/2026/86074.24545

Clinical Image of Giant Lobulated Exophytic Perianal Mass

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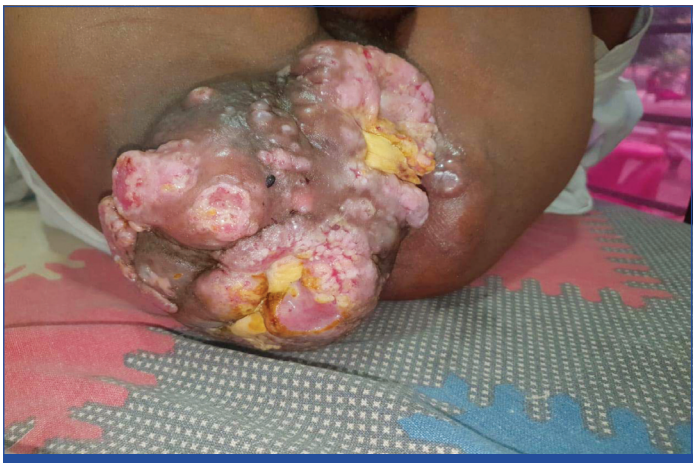
Keywords: Anal fistula, Growth, Malignancy, Necrotic, Rectal

A 40-year-old male presented to the Department of *Shalyatantra* with the chief complaint of a progressively enlarging growth in the perianal region for the past one year, associated with pain, foul-smelling discharge, occasional bleeding, and difficulty in sitting. The patient had a history of fistula-in-ano for the last 10 years, for which the patient had received intermittent conservative treatment, but no definitive surgical intervention. There was no history of tuberculosis, inflammatory bowel disease, radiation exposure, or immunosuppression. No history of tobacco or alcohol use was identified for the patient. There was no history of occupational exposures to chemicals, radiation, or other known cancer-causing agents. No family history of cancer was noted for the patient, including colorectal or anal cancer. On further questioning, the patient reported having an irregular bowel pattern characterised by occasional constipation and pain with defecation; however, there is no reported incidence of faecal incontinence. On local examination, a large, irregular, exophytic, cauliflower-like proliferative growth was noted in the perianal region, extending circumferentially around the anal verge, as shown in [Table/Fig-1]. The surface of the lesion appeared ulcerated, nodular, and friable, with areas of yellowish necrotic slough and purulent discharge. Multiple nodular and indurated areas were noted at the periphery, with depressions suggestive of possible fistulous openings. The surrounding skin showed induration and hyperpigmentation. There was no clinical evidence of any regional lymphadenopathy (enlarged lymph nodes). The examination of the patient's rectum with a digital exam was limited because of the degree of pain and mass effect present; nevertheless, the examining finger could be inserted partially into the anal canal. The anal canal mucosa was noted to be irregular and hardened (indurated) at the anal verge, but there was no obvious intraluminal mass detected beyond the lower anal canal. No active bleeding was noted at the time of the examination. Based on clinical information, it was suspected that the perianal tissues were also affected; however, involvement of the internal anal sphincter could not be definitively confirmed on physical examination due to the patient's soreness and discomfort. No proctoscopy or sigmoidoscopy was done at the time of the patient's initial presentation due to significant pain and obstructive symptoms from the size of the perianal mass. Histopathological confirmation could not be obtained because the patient was unwilling to undergo biopsy and did not return for follow-up.

In 1931, Rossier first described six cases of chronic fistula in ano with the subsequent development of cancer [1]. Buschke-Löwenstein tumour (giant condyloma acuminatum) is a significant



[Table/Fig-1]: Large exophytic, ulceroproliferative, cauliflower-like perianal growth.

differential, as it presents as a very large, verrucous, cauliflower-like lesion in the anal region and is locally aggressive yet has limited metastatic potential compared with Squamous Cell Carcinoma (SCC) [2]. Another differential diagnosis is verrucous carcinoma, a well-differentiated form of SCC. It presents as a slow-growing, warty vegetation that extends from the skin and forms a mass around the anal area. In clinical practice, it can be confused with giant condyloma, but the pathology shows a pushing margin and has fewer cytological abnormalities than SCC [3].

Long standing fistula-in-ano is an uncommon but recognised risk factor for the development of malignancy. However, several benign and malignant conditions, including Buschke-Löwenstein tumour, verrucous carcinoma, and SCC, may present as large exophytic perianal masses with overlapping clinical features. In the absence of histopathological confirmation, a definitive diagnosis could not be established in the present case.

Clinical appearance alone cannot reliably differentiate malignant from benign exophytic perianal lesions; therefore, histopathological evaluation remains the diagnostic gold standard.

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PLAGIARISM CHECKING METHODS: [Jain H et al.]
- Plagiarism X-checker: Jan 06, 2026
- Manual Googling: Jul 04, 2026
- iThenticate Software: Jul 07, 2026 (6%)

ETYMOLOGY: Author Origin

EMENDATIONS: 6

AUTHOR DECLARATION:
- Financial or Other Competing Interests: None
- Was informed consent obtained from the subjects involved in the study? Yes
- For any images presented appropriate consent has been obtained from the subjects. Yes

Date of Submission: **Jan 05, 2026**
Date of Peer Review: **Feb 23, 2026**
Date of Acceptance: **Jul 09, 2026**
Date of Publishing: **Oct 01, 2026**