Hirsutoid Papillomas of Vulvae

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Hirsutoid papillomas of vulvae present as smooth or filiform papules located on the inner surfaces of the labia minora. This disease is usually considered as anatomical variants of the vestibular mucosa. Differentiation from condyloma acuminata is important to avoid unnecessary treatment.

Herein we report a case of hirsutoid papillomas of vulvae in a 21-year-old female who complained of pruritic papules on the vulva of one year’s duration. Papules were located on the inner surfaces of the left labia minora and vestibule of the vulva. Clinically, they were quite similar to condyloma acuminata. Histologically, however, the epithelium was devoid of features of human papillomavirus(HPV) infections such as koilocytosis, double nucleation, and dyskeratosis. (Ann Dermatol 12(1) 38–40, 2000).

Key Words: Hirsutoid papillomas of vulvae

Hirsutoid papillomas of vulvae were first reported by Altmeyer et al.1 in 1982 as pseudocondyloma of the vulva. The lesions usually are symmetrically located on the inner surfaces of both labia minora. They are small, smooth, flesh-colored, white or pink, dome-shaped or filiform papules. Clinically they are quite often misinterpreted as condyloma acuminata.

The etiology of hirsutoid papillomas of vulvae is unknown. Some authors believe that this condition is a developmental malformation, a counterpart of pearly penile papules1 occurring on the coronal margin of a glans penis in males and others believe chronic irritants and inflammation may play an important role in the pathogenesis2-3.

Herein we report a case of hirsutoid papillomas of vulvae. To our knowledge, this is the first reported case in Korean dermatologic literature.

CASE REPORT

A 21-year-old woman complained of pruritic papules on the vulva of one year’s duration. The patient stated that the lesions were intermittently pruritic. They were located on the inner surfaces of the left labia minora and vestibule of the vulva. Papules were smooth, flesh-colored and dome-shaped, approximately 1-3mm in diameter, and 3-5mm in length(Fig. 1). She had no history of sexual contact and she was in good health until this episode. VDRL test was negative.

In a biopsy specimen, the most prominent finding was vascular proliferations covered with mature squamous epithelium. The squamous epithelium was characterized by cells with a clear perinuclear halo, mimicking koilocytes. However, the lack of clear-cut nuclear atypia did not permit the identification of these cells as koilocytes. Perivascular infiltration of lymphocytes and histiocytes was noted in the dermis(Fig. 2). We examined the biopsy specimen for the presence of human papillomavirus(HPV) DNA using polymerase chain reaction(PCR). To amplify DNA, we used consensus primers MY09 (5’-CGTCCMARRGGAWACTGATC-3’) and MY11 (5’-GCMCAGGGWCATAAYATGG-3’), which are capable of am-

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plifying more than 25 types of HPV that infect the anogenital tract. But the specimen tested did not contain HPV DNA sequences.

The lesions were excised at the patient's request and there was no evidence of recurrence after 12 months of follow up.

**DISCUSSION**

These small, smooth projections found on the vulva mucosa have been reported under a variety of different names including vestibular papillae, 

vulvar squamous papillomatosis, 

benign squamous papillomatosis, and 

pruritic vulvar squamous papillomatosis as well as a number of other names. The abundance of names reflects the uncertain origin of this condition. Although the published literature on hirsutoid papillomas of vulvae is sparse, this condition is believed to be not rare.

The lesions are usually located on the inner surfaces of both labia minora, vulva vestibule and/or introitus. They are small, smooth, flesh-colored or pink, dome-shaped or filiform papules. Although it may resemble acuminate warts, it can be distin-

guished from condyloma acuminata because it is more diffuse, is generally symmetrical, and does not have the typical clustered appearance associated with the isolated, clinically more pleomorphic lesions that characterize classical condylomata.

Histologically, many cells were vacuolated in the upper stratum malpighii in reported cases. They were of normal size without atypical changes, such as cytologic atypia, multinucleated cells, or koilocytes. Dermal changes included rich vascular network, and perivascular infiltrate in which lymphocytes and histiocytes were often prominent. Generally speaking, they are considered as asymptomatic, normal variants of vestibular architecture.

The etiology of hirsutoid papillomas of vulvae is not clear. Altmeyer et al. reported the first case, and interpreted the structures as atavistic malformation without functional significance. Ackerman and Kornberg assumed that they were similar to pearly penile papules occurring on the coronal margin of a glans penis in males. Embryologically, the coronal margin of the glans penis arises from the
anterior portion of the genital folds which is also the origin of the labia minora. Bergeron et al. suggested that chronic irritants and inflammation may play a role in the pathogenesis of this disease, based on the observation that significant proportion of these lesions will regress spontaneously if left untreated. Some authors believe that the lesions are human papillomavirus (HPV) associated and may be the source of vulvar symptoms. However, a recent study of 34 cases of hirsutoid papillomas of vulvae using HPV DNA hybridization techniques demonstrated this diseases is unrelated to HPV, which is in agreement with the previous studies.

From a therapeutic standpoint, it is important to distinguish this lesion from lesions that are associated with HPV infection to avoid unnecessary treatment. Perhaps the most reasonable approach to evaluation of these questionable lesions would be to proceed with routine biopsy to look for histologic evidence of HPV infection.

REFERENCES