

Pedunculated Verrucous Tumor on the Buttock

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A 40-year-old man presented to our dermatology clinic with a growth on the left buttock of more than 22 years' duration that progressively increased in size. He was otherwise in good health and reported no ongoing medical problems. Physical examination revealed a 19×12-cm, flesh-colored, pedunculated, verrucous tumor with a central stalk. The patient underwent an excisional removal, and the specimen was sent for histopathologic evaluation.

WHAT'S YOUR DIAGNOSIS?

- giant acrochordon
- giant condylomata acuminata (Buschke-Löwenstein tumor)
- neurofibroma
- nodular melanoma
- squamous cell carcinoma

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THE DIAGNOSIS: Giant Acrochordon

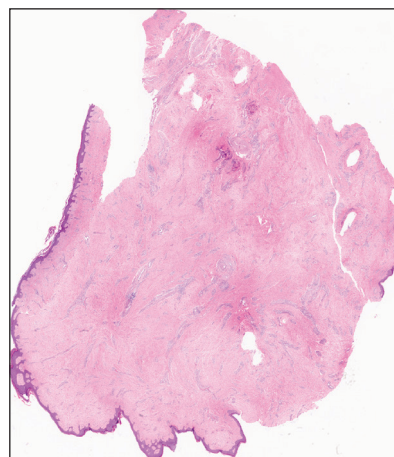
Based on the clinical and histologic findings, our patient was diagnosed with a giant acrochordon. Acrochordons (also known as fibroepithelial polyps or skin tags) are among the most commonly identified skin lesions and are believed to affect up to 46% of the general population.^{1,2} These benign growths typically appear after middle age in men and women alike and are believed to be of ectodermal and mesenchymal origin.³ The most common locations include the axillae, neck, and inguinal folds. They generally are small, measuring only a few millimeters, and frequently present as multiple lesions that are called *giant acrochordons* when their size exceeds 5 cm in length.² Acrochordons are benign lesions with only rare reports of the presence of basal or squamous cell carcinoma within the lesion on pathology.⁴ In addition to being cosmetically unsightly, patients with acrochordons often report pruritus. These lesions are easily removed in an outpatient setting via snip excision, cryosurgery, or electrodesiccation. Once removed, recurrence is unlikely. Despite the prevalence of fibroepithelial polyps worldwide, reports of giant acrochordons are limited. The histopathology of giant acrochordons is similar to smaller acrochordons, with features including epidermal acanthosis and a central core of fibrovascular tissue without adnexal structures (Figure).⁴

The differential diagnosis of giant acrochordon includes neurofibroma, nodular melanoma, squamous cell carcinoma, and giant condylomata acuminata (Buschke-Löwenstein tumor).¹ It is important to consider the clinical presentation and histopathologic findings to differentiate giant acrochordons from these other entities.

Neurofibromas typically present as multiple flesh-colored to brown nodules that invaginate into the skin when minimal external pressure is applied.⁵ Histopathology demonstrates a discrete, nonencapsulated, dermal collection of small nerve fibers and loosely arranged spindle cells. In contrast, giant acrochordons typically present as large, flesh-colored, pedunculated, verrucous tumors with a central stalk. Histopathology reveals epidermal acanthosis and a central core of fibrovascular tissue without adnexal structures.

Nodular melanomas usually are blue to black and grow rapidly over the course of several months.⁶ They have signs of hemorrhagic crust, and histopathology reveals atypical melanocytes, frequent mitoses, pleomorphic tumor cells, and irregular clumping of chromatin within the nuclei. Giant acrochordons are flesh colored, benign, and do not have these malignant features.

Squamous cell carcinoma often presents as an erythematous scaly patch or red plaque on sun-exposed areas of the skin.¹ Histopathology of squamous cell carcinoma shows atypical keratinocytes with an invasive growth pattern; giant acrochordon does not show keratinocytic atypia or invasive epidermal growth.



Histopathology revealed fibrovascular tissue with loose and dense collagen fibers and mild epidermal acanthosis characteristic of giant acrochordon (H&E, original magnification $\times 10$).

Giant condylomata acuminata (Buschke-Löwenstein tumor) is a locally destructive verrucous plaque that typically appears on the penis but can occur elsewhere in the anogenital region.⁷ Histopathologic features include epidermal hyperplasia, papillomatosis, and koilocytes. In contrast, giant acrochordons typically are located on the buttocks and do not present with these epidermal changes.

Based on the clinical and histologic findings, our patient was diagnosed with a giant acrochordon, a rare variant of the common skin lesion. Excisional removal was critical for both diagnostic and treatment purposes. By considering the clinical presentation and histopathologic features of other conditions in the differential, giant acrochordons can be distinguished from other similar entities. Diagnosis and prompt surgical removal are important for management of these neoplasms and prevention of misdiagnosis.

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