

A MULTIDISCIPLINARY APPROACH TO A CASE OF CONDYLOMA ACUMINATA IN AN ADOLESCENT FEMALE FOLLOWING SEXUAL ABUSE – CASE REPORT

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CASE REPORT

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ABSTRACT

Introduction: Condyloma acuminata (CA) is a sexually transmitted disease caused by human papillomavirus (HPV) and typically presents as exophytic, verrucous lesions on moist mucocutaneous surfaces, including the anogenital region. The infection is highly transmissible and may occur as solitary or multiple lesions of varying sizes. In pediatric and adolescent populations, the identification of sexually transmitted infections may represent an early clinical indicator of sexual abuse. The aim of this report to highlight the role of a multidisciplinary approach in comprehensive patient management.

Methods: A 15-year-old female presented with genital warty lesions. Dermatovenereological examination revealed multiple skin-colored verrucous papules involving the labia majora and minora, without tenderness or bleeding. Detailed anamnesis obtained from the patient and her caregiver disclosed a history of sexual abuse. The clinical diagnosis was confirmed by histopathological examination of biopsied lesions.

Results: The patient was diagnosed with condyloma acuminata associated with HPV infection in the context of sexual abuse. Management involved collaboration among dermatovenereologists, pediatricians, psychiatrists, and pediatric surgeons to address both medical conditions and psychological trauma.

Discuss: Management of this patient required a multidisciplinary approach involving pediatrics for underlying aplastic anemia, dermatovenereology for genital warts, psychiatry for psychological trauma, and pediatric surgery for definitive lesion management. Such coordinated care was essential to address both the medical and psychosocial complexities associated with condyloma acuminata following adolescent sexual abuse.

Conclusion: The presence of condyloma acuminata in children or adolescents should prompt careful evaluation for possible sexual abuse. Early diagnosis and coordinated multidisciplinary management are crucial to achieving optimal medical treatment and psychological recovery.

Keywords: pseudobulbar affect, stroke, antidepressant.

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INTRODUCTION

Condyloma acuminatum (CA) is a sexually transmitted infection (STI) caused by Human Papillomavirus (HPV) that manifests as hyperplastic lesions of the skin and mucosa, most commonly affecting the anogenital region. HPV is primarily transmitted through sexual contact, including genitogenital, oro-genital, and genito-anal exposure.¹ To date, more than 100 HPV subtypes have been identified, with low-risk subtypes 6 and 11 most frequently associated with condyloma acuminata,

while high-risk subtypes such as 16 and 18 possess oncogenic potential and are linked to malignant transformation.²

Epidemiological data indicate that condyloma acuminata remains a significant global health concern. A worldwide study reported an annual incidence ranging from 160 to 289 cases per 100,000 individuals. In the United States, the Centers for Disease Control and Prevention (CDC) estimates approximately 19.7 million new STI cases each year, with HPV accounting for about 14.1 million of these infections.³ In Indonesia, the prevalence of CA in the general population is

reported to range between 5% and 19%, with an estimated prevalence of approximately 1% among sexually active individuals. Data collected by the Indonesian Sexually Transmitted Infection Study Group from 13 dermatovenereology teaching hospitals between 2007 and 2011 demonstrated a rising proportion of anogenital condyloma acuminata cases over five consecutive years.^{4–6} The condition most commonly affects individuals in early adulthood, with peak incidence around age 20, whereas cases in children and adolescents remain relatively uncommon.⁷

Child sexual abuse constitutes a serious component of the broader spectrum of child maltreatment. Although numerous legal and academic definitions of child abuse have been proposed, no single universally accepted definition exists. Variability in definitions is influenced by social norms, cultural child-rearing practices, political frameworks, and religious beliefs. In addition, ongoing challenges remain in understanding the contextual and situational aspects of abuse, professional perspectives in assessment, the long-term psychological and physical consequences for victims, and the effectiveness of available interventions.⁸

Physicians play a pivotal role in recognizing and identifying clinical findings that may be associated with sexual abuse, including the presence of sexually transmitted infections. The detection of an STI in a child or adolescent may represent an important indicator of abuse and warrants careful clinical, psychological, and ethical consideration. Therefore, this paper reports a case of condyloma acuminata in an adolescent female with a documented history of sexual abuse and emphasizes the importance of a multidisciplinary approach in management. The novelty of this case lies in the complex interplay between dermatovenereological findings, underlying comorbid medical conditions, and significant psychological trauma, highlighting the challenges and value of coordinated multidisciplinary care in addressing both medical and psychosocial aspects of adolescent sexual abuse.

METHOD

Ethical Considerations

Written informed consent for publication was obtained from the patient's legal guardian after a full explanation of the purpose and scope of this case report. Ethical clearance for this case report was granted by the Health Research Ethics Committee of Dr. Saiful Anwar General Hospital, with the patient's informed consent documented in the form of an informed consent letter. All procedures involving the patient were conducted in accordance with the ethical standards of the institutional research committee and the principles outlined in the Declaration of Helsinki. Special attention was given to patient confidentiality, anonymity, and psychological safety due to the sensitive nature of the case involving sexual abuse.

Case Presentation

A 15-year-old female patient was admitted to Dr. Saiful Anwar Hospital (RSSA) and managed by the Department of Pediatrics with a diagnosis of aplastic anemia. She was referred to the Department of Dermatology, Venereology, and Aesthetics (DVE) due to genital warts suspected to be related to sexual abuse. The lesions had been present for approximately four months, initially appearing as a single small lesion that gradually enlarged and increased in number. The warts were painless but accompanied by pruritus with a Visual Analog Scale (VAS) score of 4/10. There was no history of easy bleeding or friability.

The patient denied any previous history of genital warts. She had been diagnosed with aplastic anemia seven years earlier by a pediatric specialist at RSSA. There was no history of genital wounds, aphthous ulcers, malodorous or pruritic vaginal discharge, fever, chronic cough, chronic diarrhea, or significant weight loss. She also denied illicit drug use, needle sharing, tattooing, or blood transfusions. No oral or topical self-treatment had been attempted.

The patient was a junior high school student, unmarried, and living with her grandmother. She reported a history of rape by an acquaintance met through social media six months prior to presentation. The assault involved forced sexual intercourse with genital and anal contact. She denied any prior sexual activity and described physical restraint during the incident, including having her mouth covered. Information regarding the perpetrator's medical history or risk behaviors was unavailable.

On general examination, the patient appeared moderately ill but was fully conscious (*compos mentis*). Vital signs were stable, with blood pressure of 112/77 mmHg, pulse rate of 93 beats per minute, respiratory rate of 22 breaths per minute, and axillary temperature of 36.7°C. No cervical, axillary, or inguinal lymphadenopathy was detected.

Dermatovenereological examination of the labia majora, labia minora, perineum, and anus revealed multiple skin-colored verrucous masses that were non-tender and non-friable (Figure 1). The acetowhite test was positive, showing characteristic white discoloration. Immunoserological screening for sexually transmitted infections, including Venereal Disease Research Laboratory (VDRL), *Treponema pallidum* Hemagglutination Assay (TPHA), and rapid anti-HIV testing, yielded non-reactive results. Histopathological examination demonstrated hyperkeratotic and parakeratotic stratified squamous epithelium with hyperplasia and subtle papillary architecture surrounding a fibrovascular core. Koilocytes with raisinoid nuclei, eosinophilic cytoplasm, and perinuclear halos were identified, confirming the diagnosis of condyloma acuminata.



Figure 1. Dermatovenereological status: masses were visible on the labia majora, minora, and anus, which were multiple, skin-colored, and had a verrucous surface.

RESULT

Based on the clinical history, physical examination, and supporting investigations, the patient was diagnosed with condyloma acuminata. The DVE Department planned outpatient management with electrodesiccation and recommended consultation with the Surgery Department. The Pediatrics Department planned further evaluation, including abdominal ultrasonography and assessment for bone marrow puncture, pending stabilization of the patient's hematological condition.

A forensic consultation for visum et repertum was considered; however, it was not pursued because physical signs of sexual abuse were no longer detectable due to the six-month interval since the reported assault. Psychiatric evaluation was conducted, resulting in a diagnosis of preoccupation disorder accompanied by significant psychological distress. The patient and her mother received psychoeducation and supportive psychotherapy.

Follow-up and Subsequent Management

One week after hospital discharge, the patient returned for follow-up and was again referred from the Pediatrics Department to the DVE Department. She reported a marked increase in the size and number of genital warts over the preceding two weeks, accompanied by worsening pruritus (VAS 5/10) and persistent pain during walking and sitting. Given the patient's history of trauma related to genital examination, the DVE team recommended surgical management with wide excision under general anesthesia to minimize psychological distress.

However, during the follow-up visit, the patient required readmission to RSSA for severe anemia (hemoglobin 3.9 g/dL), which led to a temporary postponement of the planned procedure. Two weeks after re-admission, she returned to the pediatric outpatient clinic and was re-consulted to the DVE Department. Subsequently, a consultation with the Pediatric Surgery Department was made, and urgent surgical excision of the condyloma acuminata was scheduled.

Psychiatric and Psychological Considerations

The patient underwent a psychiatric evaluation due to psychological distress following the reported sexual abuse. The diagnosis was established based on clinical assessment consistent with trauma-related psychological responses, including persistent fear, emotional distress, and preoccupation with the traumatic event. Psychiatric intervention consisted of supportive psychotherapy and psychoeducation aimed at improving emotional regulation, coping strategies, and treatment adherence. Mental health involvement played a crucial role in facilitating multidisciplinary coordination, reducing examination-related anxiety, and supporting the patient's readiness for further medical and surgical interventions.

DISCUSS

Child sexual abuse constitutes a serious form of child maltreatment and represents a complex medical, legal, and social issue. Various definitions of child abuse have been proposed in legal statutes and scientific literature; however, a universally accepted definition has not been established. According to the Federal Child Abuse Prevention and Treatment Act (CAPTA), a child is defined as an individual younger than 18 years, or, except in cases of sexual abuse, the age specified under state child protection laws.⁸ Definitions of child sexual abuse differ across jurisdictions and professional disciplines. CAPTA describes sexual abuse as the involvement of a child in sexually explicit conduct, whether through coercion, persuasion, enticement, or force, including rape, molestation, statutory rape, sexual exploitation, prostitution, or incest, particularly in cases involving caregivers or familial relationships.⁸

Key elements commonly considered in defining child sexual abuse include the age difference between the victim and the perpetrator, the nature of the sexual act, and the relationship between the child and the offender. Many jurisdictions exclude consensual sexual activities between peers with a small age

gap, typically less than five years, particularly when neither party has reached early adolescence. In contrast, acts involving coercion, violence, threats, fear, or abuse of authority are regarded as significant indicators of sexual abuse.⁸ Criminal statutes related to offenses against minors encompass a wide range of acts, including penetrative sexual contact, forced sexual activity for gratification, exposure to adult sexual behavior, involvement in pornography or prostitution, and other acts that endanger a child's physical or moral well-being.⁸

Sexual offenses perpetrated by caregivers are generally classified as abuse, whereas acts committed by non-caregivers are often categorized under broader legal terms such as assault or rape, similar to those applied to adult victims. From a medical perspective, however, the clinical consequences of abuse and assault in children share many similarities, although legal responses may differ.⁸

The medical evaluation of a child suspected of sexual abuse requires a structured and multidisciplinary approach. Essential components include coordination of care, collection of relevant documentation from involved services, interviews with caregivers and the child, thorough physical examination—including general, genital, and anal assessments—appropriate laboratory investigations, and multidisciplinary case review.⁸ Although investigative interviews are ideally conducted by trained social or legal professionals, physicians remain responsible for obtaining comprehensive medical histories, including prior injuries, menstrual and sexual history in adolescents, and relevant psychosocial information. Such information is critical for determining appropriate diagnostic tests, interpreting findings, and planning medical and psychological interventions.⁸

Physical examination should be performed by experienced healthcare providers to minimize further physical or emotional trauma. When appropriate and with the child's consent, the presence of a trusted adult or trained advocate during examination is recommended. Careful documentation of findings and patient responses is essential, as disclosure of abuse may occur during the clinical encounter.⁸ The primary objectives of medical assessment include evaluating the child's overall health and development, identifying injuries or neglected conditions, screening for sexually transmitted infections (STIs), assessing pregnancy risk, documenting findings with potential forensic relevance, and collecting evidence when indicated.⁸

Urgent examination is warranted when abuse is suspected to have occurred within 72 hours, when acute trauma or pregnancy risk exists, or when the child is considered unsafe. In cases where more than 72 hours have elapsed and no acute injuries are present, examination may be scheduled at a time that prioritizes the child's comfort and psychological well-being. Forensic evidence collection is most effective within the initial 72-hour window, as delayed sampling—particularly body swabs in prepubertal children—has limited diagnostic yield, with clothing and linens often providing more useful forensic evidence.⁸

In the present case, interviews with the patient and her family revealed a history of forced sexual intercourse perpetrated by a male acquaintance met through social media. The patient exhibited psychological distress following the incident, including social withdrawal and emotional confusion, as reported by her grandmother. Due to the six-month delay between the assault and presentation, physical signs of acute genital injury were absent. Moreover, a complete genital and

anal examination was limited by the patient's psychological trauma, and evaluation for additional signs of abuse was constrained by the elapsed time since the event. Laboratory investigations were performed as clinically indicated, although forensic testing was no longer feasible because the recommended time frame had passed.⁸

Assessment for STIs remains a crucial component of medical evaluation in suspected sexual abuse cases, as these infections may not only affect physical health but also serve as indicators of victimization requiring further protection.⁸ Comprehensive STI screening is particularly important in post-pubertal adolescents, given the prevalence of asymptomatic infections in this group. Testing strategies should be individualized based on patient history, suspected exposure sites, and epidemiological considerations.^{8,9}

In this patient, Gram stain examination showed no evidence of other STIs. Serological testing for HIV, VDRL, and TPHA yielded non-reactive results. However, multiple anogenital warts were identified, prompting further evaluation by the dermatovenereology team. Additional microbiological testing was deferred due to ongoing hospitalization and was planned following clinical stabilization.⁸

Genital HPV infection commonly presents as classic anogenital warts or flat mucosal lesions affecting areas such as the genitalia, anus, oral cavity, or urethra. Diagnosis is typically clinical, although cytological examination or biopsy may be required in atypical or rapidly progressive cases. Anogenital warts may be symptomatic or asymptomatic, and previous studies have reported their presence in approximately 1.8% of children evaluated for suspected sexual abuse.^{8,10,11}

The incubation period for HPV ranges from one to twenty months, with a potential latent phase extending beyond two years. While vertical transmission and autoinoculation are possible, current evidence suggests that anogenital warts appearing after the age of two are more likely associated with sexual transmission. Diagnostic uncertainty may persist in younger or non-verbal children, complicating determination of the exact mode of transmission.^{8,10,11}

Condyloma acuminata is primarily diagnosed through history and physical examination. The acetowhite test using 3–5% acetic acid may assist in identifying subclinical lesions, while anoscopy or colposcopy can aid visualization. Biopsy is reserved for lesions with atypical features, suspicion of malignancy, rapid growth, or lack of response to treatment.^{12,13} In this case, the acetowhite test was positive, and histopathological examination was performed due to rapid lesion progression and concern for malignant transformation. Typical histopathological features of condyloma acuminata include acanthosis, papillomatosis, hyperkeratosis, and the presence of koilocytes—mature squamous cells characterized by perinuclear clearing. Langerhans cells may be reduced in number and exhibit degenerative changes, suggesting impaired immune function within the lesion.^{14,15} The biopsy findings in this patient were consistent with these characteristics, confirming the diagnosis of condyloma acuminata.

Several studies have reported a strong association between condyloma acuminata in children and sexual abuse, with reported abuse rates ranging widely from 10% to 90%, depending on investigative methods. The long-term consequences of sexual abuse are multifactorial and influenced by factors such as age at last exposure, duration and frequency of abuse, family support, and social validation of the victim's experience. Early psychological manifestations may include

anxiety, nightmares, heightened stress responses, and behavioral changes suggestive of trauma.⁷

In this case, the patient reported significant emotional distress following the assault, including fear, helplessness, and reduced self-confidence. Psychiatric consultation resulted in a diagnosis of significant mental distress, and the patient received supportive psychotherapy, psychoeducation, and psychopharmacological support. The rapid progression of genital warts, combined with the patient's fear of genital examination, necessitated consideration of surgical excision under general anesthesia to minimize further psychological harm. However, this intervention was temporarily delayed due to severe anemia.

CONCLUSION

This case report describes an unmarried 15-year-old adolescent female who developed genital condyloma acuminata following sexual abuse perpetrated by a male acquaintance met through social media. The diagnosis of condyloma acuminata in this patient underscores the importance of considering sexual abuse in adolescents presenting with anogenital warts. Management required a comprehensive multidisciplinary approach involving pediatrics for underlying aplastic anemia, dermatovenereology for diagnosis and treatment of genital lesions, psychiatry for psychological trauma, and pediatric surgery for definitive management. Coordinated multidisciplinary care was essential to address both the medical and psychosocial complexities of this case and to optimize overall patient outcomes. From a clinical perspective, this case highlights the need for a high index of suspicion, trauma-informed care, and early multidisciplinary collaboration when managing adolescents with sexually transmitted infections. Integrating medical, surgical, and mental health services is crucial not only for effective disease management but also for minimizing re-traumatization, improving treatment adherence, and supporting long-term psychological recovery, particularly in vulnerable pediatric populations.

Management of this patient required a multidisciplinary approach involving pediatrics for underlying aplastic anemia, dermatovenereology for genital warts, psychiatry for psychological trauma, and pediatric surgery for definitive lesion management. Such coordinated care was essential to address both the medical and psychosocial complexities associated with condyloma acuminata following adolescent sexual abuse.

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