EXTERNAL ANOGENITAL WARTS

Whats new

Cryotherapy is a treatment and does NOT need to be prescribed. It can be administered by staff with relevant competency/experience.

Introduction

The UK National Guideline for the Management of Anogenital Warts (2015) can be found at www.bashh.org

Summary checklist for patients diagnosed with genital warts

Discussion points

- HPV infection; high population prevalence, variable incubation period and transmission issues
- Natural history of warts – 90% caused by HPV types 6 and 11
- Outcome of HPV infection – eradication unlikely
- Low risk for cervical cancer – different from “high risk” HPV types
- Several treatment attempts may be required before warts subside

Offer testing to identify concurrent STIs

Treatment options

- Discuss objectives of treatment - removal of visible warts to achieve acceptable cosmetic outcome and limit unnecessary tissue damage
- Discuss methods of treatment – home therapies best unless contraindicated

Written information should be offered and documented.

If psychological distress is apparent, onward referral may be indicated.

Clinical Aspects

- Warts are diagnosed by visible inspection under good illumination.
- The differential diagnosis of warts includes physiological features, dermatoses and other infections such as molluscum contagiosum. If uncertain, get an opinion from a senior doctor at the time of presentation. Proctoscopy is not routinely performed in patients with external genital warts at Sandyford, unless there are ano-rectal symptoms or the upper limit of wart area cannot be visualised at the anal margin. Intra-anal warts should only be treated if symptomatic. If uncertain, discuss with a senior doctor.
- Females should have a vaginal speculum examination as part of their initial assessment but this is not required at follow up if no internal warts are found. Intravaginal/cervical warts do not require treatment unless symptomatic.

- Intrameatal warts that cannot be fully visualised should be referred to urology for urethroscopy.
- Most anogenital warts are benign and caused by HPV 6 and 11, which are of low oncogenicity. Women with warts (or whose partners have warts) should be advised to have regular cervical screening at the usual 3 year interval or as directed by preceding cytology result. Annual cytology is not required.
- 10-20% of patients with warts at Sandyford will have other STIs. STI testing: HIV, syphilis and Chlamydia/gonococcal NAAT test is recommended when a patient presents with warts for the first time. Testing should be reoffered if there are new risks.
- Application of 5% Acetic Acid to reveal subclinical or latent infection is not recommended.
- Warts can appear or increase in size during pregnancy.

Wart Assessment at Sandyford

The following factors should be documented in the patient record.

1. Site(s) and distribution warts (vulva, urethral meatus, glans penis etc.).
2. Approximate number (single or multiple) and area of warts (more than $4cm^2$).
3. Morphology: keratinised or non-keratinised (those on moist, soft non-hair bearing tissue tend **not** to have a layer of keratin);
4. Any other notable features (e.g pigmentation).
5. Patient factors influencing therapy (e.g pregnancy, ability to re-attend).

Information giving

- Before information is given, an assessment must be made of the patient's existing preconceptions and concerns.
- Information should cover epidemiology, transmission, natural history, treatment, partner issues. The order and pace of information delivery may need to be varied to suit the needs of the patient.
- Written information should be offered and documented.

Epidemiology

- Visible warts represent only "the tip of the iceberg" (1-2%) of all individuals infected with HPV. Studies of HPV prevalence generally report much higher infection rates in young sexually active populations. PCR-based studies typically reporting prevalence values of 30-50%.
- HPV DNA is rarely detected in the genital tract of individuals who have never had sex. Risk of HPV acquisition rises with increasing numbers of sexual partners. However, prevalence in women with only one lifelong partner is as high as 20%.
- Prevalence of molecular evidence of HPV infection declines with increasing age.
- Smoking, hormonal factors (such as pregnancy) and immunosuppression are associated with an increased likelihood of HPV infection.

- Persistent infection (particularly with "high risk" types of HPV, such as HPV-16) is a key risk factor for HPV-related neoplasia.

Transmission

Transmission of HPV occurs by direct skin-to-skin contact. Transmission studies in patients with visible genital warts have shown male to female transmission rates of 50% and female to male transmission rates of 70%.

- The high population prevalence of HPV infection and studies which show type-specific concordance between partners suggest high rates of sexual transmission, even when visible genital warts are absent.
- Consistent condom use has been shown to reduce the acquisition of HPV infection and genital warts (by 30 – 60%) and their use is advisable, particularly in a new relationship

Natural History

- The majority of individuals infected with HPV have no visible clinical abnormalities. However, warts may become clinically manifest at any time after infection, especially if there is immunosuppression (eg in pregnancy, with HIV co infection and in smokers).
- The location of visible lesions does not accurately reflect the original site of inoculation. (e.g. the presence of perianal warts does not imply anal intercourse has occurred)
- Treatment of sexual partners makes no significant impact on the natural history of genital warts.
- Smokers may respond less well to treatment than non-smokers.

Partner Notification

There is no reason to routinely see partners for visual inspection to exclude warts. Partners should attend if they have concerns about their sexual health or wish to have sexual health screening.

Management

See end of document for male and female treatment algorithms

The objective of treatment is the removal of visible warts (to achieve an acceptable genital cosmetic appearance without causing unnecessary tissue damage). All treatments have significant failure and recurrence rates. Eradication of HPV is not an achievable goal with current therapies and treatment has no measurable effect on transmission rates between partners. Most patients seek treatment because of the psychological impact of visible wart lesions.

Treatment Notes

- **Podophyllotoxin (Warticon/Condyline)** is a purified extract of podophyllin. It is suitable for patients to self-administer and is available in both a 0.5% alcoholic solution (both brands and is more effective) and a 0.15% cream formulation (Warticon only in this form). The latter is easier to use. Treatment cycles consist of twice daily application for 3 days followed by 4 days rest for

4 cycles. Supervision by medical staff is needed when treatment area is greater than 4cm^2. Use for perianal lesions is "off licence". Treatment should be discontinued if significant side effects develop (eg. soreness, ulceration). Sexual contact should be avoided soon after treatment because of possible irritant effect on the partner. Response rates at 4-6 weeks are generally in the region of 40-70%, but subsequent recurrence of lesions is common. Podophyllotoxin should never be used in pregnancy or on broken skin.

- **Imiquimod** (Aldara) is an immune response modifier. It is used for refractory warts which have failed to respond to other treatments, or warts which have been assessed by a senior doctor and are thought likely to be refractory to treatment (e.g. extensive carpet warts). Wart recurrence rates are lower with imiquimod, but it is currently reserved as a second line therapy (except for refractory warts) owing to its cost which is 2-3 times greater than podophyllotoxin.

  It should be applied 3 times per week (eg Monday, Wednesday, Friday) prior to normal sleeping hours and should remain on the skin for 6 – 10 hours. Use should continue until the clearance of visible genital or perianal warts or for a maximum of 16 weeks per episode of warts with 4 weekly review. Sexual contact should be avoided soon after treatment because of possible irritant effect on the partner. It should not be used in pregnancy or if having unprotected sex with a pregnant partner. Skin reactions are common, including erythema (61%), erosion (30%) and oedema (14%). Treatment should be discontinued if these are severe. Less severe reactions may subside with a treatment break. Rarely an intense local inflammatory reaction can occur after a few applications.

- **Cryotherapy** is the treatment of choice for intrameatal warts, and in pregnancy. It is labour intensive for the patient and service so should only be used when self-taken treatments are not possible. Treatment should be applied until a halo of freezing has been established a few millimetres around the treated lesion. A freeze, thaw, freeze technique should be used and the lesion held frozen for 10-30 seconds, depending on size. Response rates depend on size and chronicity of the lesions. This is not suitable for large warts and large clusters of warts unless other therapies are contra-indicated. See references relating to safety issues for use and storage of liquid gases. Product subject to risk assessment review. Cryotherapy is a treatment and does NOT need to be prescribed. It can be administered by staff with relevant competency/experience.

- **Cataphen** *(Camellia sinensis*, folium (green tea leaf))

  An alternative second line treatment for warts unresponsive to Condyline is Cataphen. This should be applied three times per day to all external genital and perianal warts, for no longer than 16 weeks in total. Some irritation to treated areas can be expected. Application into the vagina, urethra or anus must be avoided. It is not necessary to wash off the ointment from the treated area prior to the next application. It should be washed off the treated area before sexual activity. It should not be used in pregnancy or breastfeeding. Effectiveness and recurrence rates appear to be similar to other topical treatments.

- **Biopsy/ removal** may be necessary in some cases e.g. unusual appearance or failing to respond to treatment.

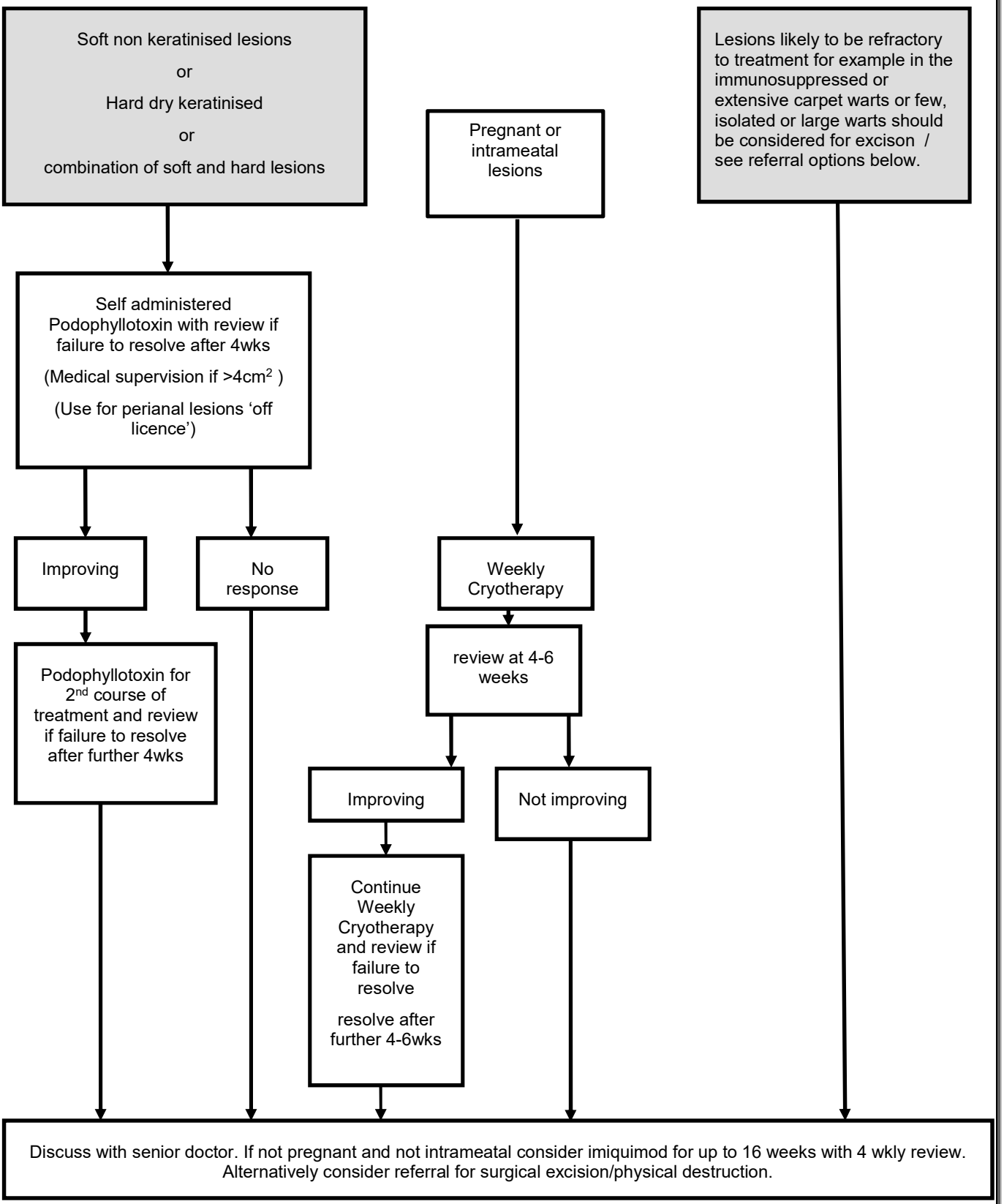
- **Other therapies**.
  - Internal referral options include:

- Electrocautery and/or excision (refer females with vulval lesions to Med Gyn)
- TCA treatment (refer to GUM complex for vetting)

- External surgical referral remains an option for large volume lesions and those unresponsive to medical therapies.

References

The UK National Guidelines on the Management of Ano-genital warts 2015. [http://www.bashh.org/documents/UK%20national%20guideline%20on%20Warts%202015%20FINAL.pdf] [accessed online September 2020]


Soft non keratinised lesions
or
Hard dry keratinised
or
combination of soft and hard lesions
Pregnant or intrameatal lesions
Lesions likely to be refractory to treatment for example in the immunosuppressed or extensive carpet warts or few, isolated or large warts should be considered for excison / see referral options below.
Self administered Podophyllotoxin with review if failure to resolve after 4wks
(Medical supervision if >4cm2)
(Use for perianal lesions 'off licence')
Improving
No response
Weekly Cryotherapy
Podophyllotoxin for 2nd course of treatment and review if failure to resolve after further 4wks
review at 4-6 weeks
Improving
Not improving
Continue Weekly Cryotherapy and review if failure to resolve
resolve after further 4-6wks
Discuss with senior doctor. If not pregnant and not intrameatal consider imiquimod for up to 16 weeks with 4 wkly review.
Alternatively consider referral for surgical excision/physical destruction.