Genital Warts

MANAGEMENT SUMMARY

ASSESS IF:

- Symptoms of lumps in genital region
- Having a sexual health check (male and female)
- Having an assessment of genital symptoms

DIAGNOSIS AND TESTING BY CLINICAL EXAMINATION

- Document findings
- Speculum examination in women and genital and perianal examination in both genders
- Distinguish from normal anatomical variants e.g. pearly penile papules (coronal papillae), vestibular papillomatosis, Fordyce glands etc., and from Molluscum contagiosum
- If benign appearance and diagnosis uncertain, observe and arrange follow-up review
- Offer screening for other STIs including serology for HIV and syphilis (see Sexual Health Check guideline www.nzshs.org/guidelines)

ASSESSMENT FOR TREATMENT MODALITY

- Decision made on case-by-case basis on discussion with patient
- Consider:
  - Gender
  - Pregnancy
  - Site of lesions
  - Size and number of lesions and degree of keratinisation
  - Patient preference and social circumstances

TREATMENT OPTIONS (see Management Guidelines below for details)

None: Treatment is largely cosmetic and a decision not to treat is an option.

Cryotherapy: For treatment of small numbers of warts.

Patient applied:
- Podophyllotoxin solution 0.5% twice daily 3 consecutive days per week for 5 weeks – for men only, for use on lesions which can be visualised by patient
- Imiquimod cream 5% once daily 3 x weekly for up to 16 weeks in persons over 18 years, for warts not responsive to podophyllotoxin or in areas not easily visualised. (Fully subsidised – Special Authority not required from February 2015.)

Specialist settings: Diathermy, laser or surgery.

Combination: Cryotherapy plus podophyllotoxin or imiquimod.

Other management:
- Lignocaine 2% gel pre- or post-treatment
- Counselling and education

Special situations:

Pregnancy: Cryotherapy is the only recommended treatment option.

Children: Refer to paediatrician.

Specialist referral:
- Atypical warts (including pigmented lesions)
- For treatment on clinician request
- Management of cervical warts (or discuss with specialist)
- Pregnancy, immunosuppression, diabetes.
- Management of extensive anogenital warts
- HIV positive patients

PARTNER MANAGEMENT

- Contact tracing not required
- Partners should be offered a sexual health check and education

FOLLOW-UP

- Follow-up at end of course of treatment is recommended to confirm treatment response

PREVENTION

- Quadrivalent vaccine, currently on schedule for year 8 girls
- Funded and recommended for transplant patients and HIV positive persons under 26 years
- The vaccine is recommended but not funded for immune compromised individuals, MSM, boys and young men under 20 years

Further guideline information – www.nzshs.org or www.hpv.org.nz or phone local sexual health service.

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Introduction

- **Caused by human papilloma virus (HPV)** – greater than 40 genital types.
- Visible genital warts usually due to types 6 and 11.
- Main high risk types 16 and 18 are found in pre-malignant conditions such as cervical intraepithelial neoplasia (CIN), vulval intraepithelial neoplasia (VIN), anal intraepithelial neoplasis (AIN) and in sub-clinical cervical, vulval and anal infection.
- **Lifetime risk of HPV infection ~80%.**
- **Prevalence** of asymptomatic infection in **young sexually active people aged under 25 is ~20%**, however clinical genital warts are much less common.
- Average duration of HPV infection is approximately 18-24 months but may be significantly longer and long term latent infection is possible.
- Infection with multiple different HPV types is possible.
- Transmission is mainly via genital skin contact – condoms are not fully protective.

Symptoms and signs

Symptoms

- Genital lumps – in women commonly vulval or perianal; in men commonly penile shaft, glans penis, coronal sulcus, or perianal.
- Often asymptomatic but may be itchy or painful or may bleed.

Signs

- Genital lumps on examination – may also involve vagina and cervix in women.

Note: The presence of perianal lesions is not necessarily associated with anal intercourse.

Diagnosis

- **Diagnosis** is made on **clinical grounds**.
- Distinguish from anatomical variants, e.g. pearly penile papules (coronal papillae), vestibular papillomatosis, Fordyce glands etc., and from Molluscum contagiosum.

Management

- **The goal of treatment is cosmetic rather than curative** therefore the decision not to treat is an option at any stage.
- Genital warts can cause significant emotional distress due to fear of social stigmatisation and lesions can be of aesthetic concern.
- Women with genital warts should have cervical smears as recommended by the National Cervical Screening Programme guidelines.
- Regular review is recommended to ensure treatment efficacy and tolerability.
- All patients with genital warts should be offered a sexual health check (see Sexual Health Check guideline www.nzshs.org/guidelines).

Vaginal warts

- Treatment options should be discussed with the patient – since vaginal warts are not generally evident to the patient, a decision not to treat may be taken if the warts are not extensive.
- Consider specialist referral to sexual health clinic or gynaecology clinic if extensive.

Cervical warts

- All women with cervical warts require follow-up to ensure resolution and should be discussed with a gynaecologist or sexual health physician.
- Women with abnormal cervical smears should be managed according to the National Cervical Screening Programme guidelines www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/cervical-screening-guidelines.

Anal warts

- Patients with **perianal warts who have anorectal** symptoms, e.g. rectal bleeding or pain, should be referred for specialist review.

Treatment regimens

Patient applied

Podophyllotoxin (Condyline™) solution 0.5% twice daily 3 consecutive days per week for 5 weeks.

- For men only, for use on warts which can be visualized by patient.
- To be used with caution – can cause significant ulceration if not applied appropriately. Vaseline can be used to protect surrounding skin.
- Suitable for small numbers of warts on keratinized skin.
- In general, podophyllotoxin is not suitable for women or for perianal warts.
- If significant irritation therapy should be interrupted – but may be resumed with caution once skin healing has occurred.
- Must not be used in pregnancy.

Imiquimod (Aldara™) cream 5% once daily 3 times weekly for up to 16 weeks.

- Fully subsidised on Special Authority (not required from February 2015) for warts that are not easily visualised or warts not responding to podophyllotoxin (see www.pharmac.govt.nz/PharmaceuticalSchedule/SAForms).
- Suitable for **women and men with minimally keratinised warts** (e.g. introital, perianal, subpreputial).
- Can cause erythema, irritation and ulceration. Mild effects are common. If moderate to severe side effects occur, it is recommended that a break from treatment is taken, with gradual reintroduction.
- Not recommended in pregnancy.

Clinician applied

Cryotherapy using liquid nitrogen or CO_2 to produce an 'ice ball' on visible lesions.

- Offer lignocaine gel 2% for pre- or post-treatment discomfort.
- Repeat weekly up to 6 weeks.
- Review treatment plan if persistent warts after 6 treatments.

Specialist level treatment

Consider in management of more extensive warts – higher risk of morbidity.

- **Diathermy.**
- **Laser.**
- **Surgery.**

Combination treatment

- More than one treatment may be used simultaneously or sequentially.
  - Podophyllotoxin 0.5% solution at the time of cryotherapy; or cryotherapy of larger lesions, followed by imiquimod cream 5%.
- There is some evidence to support combination treatments but monitoring of side effects is important.

Pregnancy

- Cryotherapy is the only recommended treatment modality in pregnancy.
- Extensive warts require specialist review.
- Podophylloxin and imiquimod are contraindicated in pregnancy.

Partner notification and management of sexual partners

- Not required, but it is recommended that sexual partners have a sexual health check and be given information on HPV infection.
- Advise patients that regular partners should be informed of the diagnosis.

Follow-up

- Follow-up until there are no visible warts may decrease the chance of recurrence.
- Relapses are treated as appropriate to site and size.

Prevention

- The quadrivalent HPV vaccine prevents 90% of anogenital warts if schedule is completed before sexual debut.
- It is included in the immunization schedule for girls in year 8 (12 years).
- The vaccine is funded and recommended for girls and young women aged under 20 years, HIV +ve individuals under 26 years and transplant patients.
- The vaccine is recommended but not funded for immune compromised individuals, MSM, boys and young men under 20 years.
- See www.health.govt.nz/system/files/documents/publications/immunisation-handbook-may14-v5_0.pdf for information.

Referral guidelines

Referral to a specialist sexual health service is recommended for:

- Management of warts if clinician wishes.
- Cervical warts (or discuss with specialist).
- Atypical warts (including pigmented lesions)
- Pregnancy, immunosuppression, diabetes.
- Extensive anogenital warts.
- HIV positive patients.

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