# Genital Warts

## Introduction

### Aetiology and Epidemiology

- **Caused by Human Papilloma Virus (HPV)** genital types of which there are ~ 38
- Visible genital warts usually type 6 and 11
- Main high risk types 16 and 18 are found in pre-malignant conditions such as cervical intraepithelial neoplasia (CIN) and vulval intraepithelial neoplasia (VIN), and in sub-clinical cervical and vulval infection
- **Lifetime risk of infection ~ 80%**
- **Prevalence** of infection in **young sexually active people <25 is ~ 20%** – however clinical genital warts are much less common
- **Average duration of HPV infection = ~ 18 – 24 months** but may be significantly longer, and long term latent infection is possible
- Infection with multiple different types over time is possible
- Transmission is via skin contact – condoms are not fully protective

## Symptoms and Signs

### Symptoms

- Genital lumps (in **women** commonly **vulval or perianal**, in **men** commonly **glans penis, coronal sulcus, shaft, scrotum, or perianal**)
- May be itchy or painful, may bleed

### Signs

- Condylomata acuminata 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**

# Management

## General

**The goal of treatment is cosmetic rather than curative**, therefore non-treatment 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.

## Vaginal Warts

Treatment options should be discussed with the patient – since vaginal warts are not generally evident to the patient, non-treatment is an option if the warts are not extensive.

**Vaginal warts should only be treated with Cryotherapy.**

## Cervical Warts

All women with cervical warts require follow-up although many will resolve spontaneously. Referral can be made to either a colposcopist or sexual health specialist depending on the age of the patient, symptoms and cervical screening history.

Women with genital warts should have cervical smears as recommended by the National Cervical Screening Programme guidelines and do not require more frequent screening.

## Anal Warts

Patients with **perianal warts who have anorectal** symptoms should have **anoscopic evaluation and treatment of anorectal warts if necessary**.

# Treatment Options

## Provider Applied

- **Cryotherapy** using liquid nitrogen or CO2

## Patient Applied

- **Podophyllotoxin (Condyline™) bd 3 consecutive days per week for 5 weeks**
- **Imiquimod (Aldara™) od 3 x weekly for up to 16 weeks.** Clinicians can make a Special Authority application for subsidy ( see Pharmac website)

## Pregnancy

- **Cryotherapy** using liquid nitrogen or CO2 only
- **Imiquimod and podophyllotoxin are not safe for use in pregnancy**

### Specialist Only

- **Hyfrecation**
- **Laser**

**Notes:**

**1. Podophyllotoxin:**

- Use with caution as a patient applied treatment in women as visualisation of warts may be difficult
- **Not generally effective for highly keratinised** warts
- Suitable for small numbers of exophytic warts on keratinised skin

**2. Imiquimod:**

- Suitable for **women and men with early infection and minimally keratinised warts** (e.g. introital, perianal, subpreputial)

**3. Side Effects:**

Both imiquimod and podophyllotoxin can cause erythema, irritation, erosions or ulcerations. If mild side effects occur it is reasonable to treat through these, but if moderate or severe side effects occur it is recommended that a break from treatment be taken, and that therapy be reintroduced slowly with a reduction in dosing frequency if necessary.

### Pregnancy

- podophylloxin is not safe and is contraindicated in pregnancy
- imiquimod is not recommended because of insufficient information. If there has been inadvertent exposure, there is a low risk of harm to the fetus

## Contact Tracing

**Not required**, but it is **suggested that sexual partners have a sexual health screen**.

## Referral Guidelines

**Referral to a Specialist Sexual Health Service is recommended for:**

- Management of warts if clinician wishes
- Management of cervical warts
- Management of genital warts in pregnancy, immunosuppression, diabetes
- Management of extensive genital warts likely to require hyfrecation/laser
- HIV positive clients

# Further Information

**A prophylactic HPV vaccine is now available in New Zealand:**

**Gardasil™** is a quadrivalent prophylactic vaccine for **HPV 6, 11, 16, and 18** and is licensed for administration to females from the ages of 9 to 26 and males from the ages of 9 to 15.

Current recommendations are for the vaccination of girls and young women preferably prior to sexual debut, although benefit has been shown up to the age of 26.

The vaccination schedule is 3 doses spread over 6 months – 0, 2 and 6 months.

Gardasil™ is currently funded by the MOH through the National Immunisation Schedule for girls aged school year 8 ( or age 12 if not delivered in a school based programme) with a phased catchup programme available for girls born on or after 1st January 1990.

For further information the following websites are useful:
**www.medsafe.govt.nz**
**www.gardasil.co.nz**

**Note:** An in-depth guideline for the management of genital HVP has been produced by the Professional Advisory Board of the Australian and New Zealand HPV Project. **www.hpv.org.nz**

This best Practice Guide has been produced as a collaborative project by Counties Manukau District Health Board and Auckland Sexual Health Service, and has been adapted for use by NZSHS as a National Guide for the Diagnosis and Treatment of Sexually Transmitted Infections. Updated – 2009.