Australian STI Management Guidelines for Use in Primary Care

Anogenital warts

Overview

- Human papillomavirus (HPV) transmission is from direct skin-to-skin contact with apparent or subclinical lesions and contact with genital secretions. Micro-abrasions in the recipient's skin allow viral access to the basal cells of the epithelium.
- Most HPV infections are asymptomatic.
- Most anogenital warts are caused by HPV types 6 and 11 and infection results in type-specific protection.
- The long latent period, just as with herpes, means that the presence of warts in only one partner does not necessarily imply recent infidelity.

Cause

- *Human papillomavirus*

Clinical presentation

Symptoms and Signs
• Warty growths in and around anogenital skin or mouth. Little discomfort (sometimes itchy) but often psychological distress is significant • Distorted urinary stream or bleeding with urethral lesions • Perianal itch • Rectal bleeding after passage of stools with anal lesions • Cervical lesions noted on vaginal examination should have cervical screening conducted as per national guidelines
Complications
• Malignancy (penile, anal, oropharynx) is possible with oncogenic HPV genotypes. • Malignancy (vulvar, vaginal, cervical, anal, oropharynx) is possible with oncogenic HPV genotypes.

See STI Atlas for images.

Special considerations

- Consider referral and biopsy of atypical lesions or new lesions in elderly people (to test for malignancy).
- Atypical lesions, lesions with variable pigmentation or raised plaque-like lesions should be biopsied to exclude pre-cancerous change especially in patients who are immunosuppressed or have human immunodeficiency virus (HIV)
- Warts can grow rapidly in pregnancy and can be treated during pregnancy with cryotherapy or diathermy.
- Pregnant people can undergo a normal vaginal delivery as the risk of transmission to the baby is extremely low.

Diagnosis

Diagnosis is usually based on visual appearance. If there are atypical lesions (e.g. variable pigmentation, raised plaque-like lesions or cervical warts), consider biopsy to exclude cancer.

Investigations

- A presentation with any STI provides an opportunity for comprehensive STI testing.
- HPV PCR testing is not used to diagnose Anogenital warts.

Management

Principal treatment options		
Situation	**Recommended**	**Alternative**

Treatment for genital warts	Patient applied podophyllotoxin paint topically applied, twice a day for 3 days, then 4 days off, repeated weekly for 4-6 cycles until resolution. OR Patient applied imiquimod 5% cream topically, 3 times per week at bedtime (wash after 6-10 hours) until resolution (up to 16 weeks).	Clinician initiated cryotherapy weekly. (Rarely may need excision under local anaesthetic or ablative therapy under general anaesthetic. Seek specialist advice.)

Treatment advice

- Treatment is cosmetic rather than curative.
- HIV infection: genital warts can have a poor response to treatment and may require longer cycles of treatment and are more likely to recur.

Other immediate management

- If warts are in the pubic region avoid shaving or waxing as this may facilitate local spread by autoinoculation of HPV into areas of microtrauma.
- Provide patient with factsheet.
- Offer HPV vaccination if not already vaccinated. Note that HPV vaccination is not a therapeutic vaccine but may protect people from future acquisition of other HPV types.
- Genital warts is not a notifiable condition.

Special Treatment Situations

Special considerations

- Consider seeking specialist advice before treating any complicated presentation.
- Consider other potential causes (e.g. syphilis presenting as condylomata lata).

Situation	Recommended
Complicated or disseminated infection	Consider referral for laser or diathermy. Persistent intra-anal lesions in people living with HIV should be considered for surgical excision and HPV DNA typing to inform follow-up.

Pregnancy	Cryotherapy can have a poor response. Lesions often resolve spontaneously postnatally when immune function returns to normal following delivery.

Special considerations:

- Meatal warts: treat with cryotherapy
- Intra-anal warts: treat with cryotherapy or refer for surgical management
- Cervical warts: initial cervical cytology and refer to gynaecologist for consideration of colposcopy, biopsy and treatment as indicated.

Contact Tracing

Not recommended. The majority of partners have probably acquired the infection subclinically.

Follow Up

Not required if symptoms resolve. Review if patient anxious or warts are difficult for patient to visualise**.**

Test of cure

Not applicable.

Retesting

Not required. Consider testing for other STIs, if not undertaken at first presentation, or retesting post the window period.

Auditable Outcomes

100% of patients diagnosed with genital warts are provided with information.

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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