Clinical Guideline

MANAGEMENT OF GENITAL WARTS

SETTING **Unity Sexual Health**
This clinical guideline has been developed primarily for the use of clinicians working in Unity level 3 sexual health services. For clinicians working in Unity non-level 3 settings, there is a separate section at the end of the guideline which highlights any major differences in the recommendations for practice within your setting.

FOR STAFF Clinical Staff

PATIENTS For patients presenting with genital warts

Genital warts are a common condition seen in sexual health services. Evidence shows that following a treatment protocol improves management of genital warts. These flow charts have been developed to guide management for patients diagnosed with genital warts.

Diagnosis:
Diagnosis is clinical and made by the typical appearance of warts.
If there is diagnostic uncertainty, patients can be referred to sexual health services
If the appearance is atypical e.g. pigmentation then refer for a skin biopsy prior to initiating treatment.

Assessment of lesion

- **Examine** the external anogenital and surrounding skin under good illumination.
- **Females**: Offer speculum examination
- **Both sexes**: Proctoscopy may be indicated if there is a history of anal receptive sex, rectal symptoms or following clearance of perianal warts.
- **Recording of lesions**: Approximate number, distribution, morphology (keratinised/fleshy, pedunculated, broad-based, pigmented).
- **Extra-genital sites** (e.g. oral cavity) to be examined if clinically indicated.

Management
General

- Explanation of condition, and also suitable written information
- Condom usage is advisable, though data is conflicting. There is some limited evidence to suggest condoms are protective against Human Papilloma Virus (HPV) and genital wart acquisition; when both partners are infected, condom use may minimise re-exposure to virus.
- Consider referral to Health Advisor if the patient is distressed.
- Smoking cessation advice: Smokers respond less well to treatment than non-smokers
- General advice on safer sex
- Ensure females up to date with cervical smears (however more frequent/earlier smears are not indicated, *see flow chart*).
- For eligible MSM, ensure they are up to date with routine HPV vaccination. This may reduce the risk of acquiring HPV again in the future.

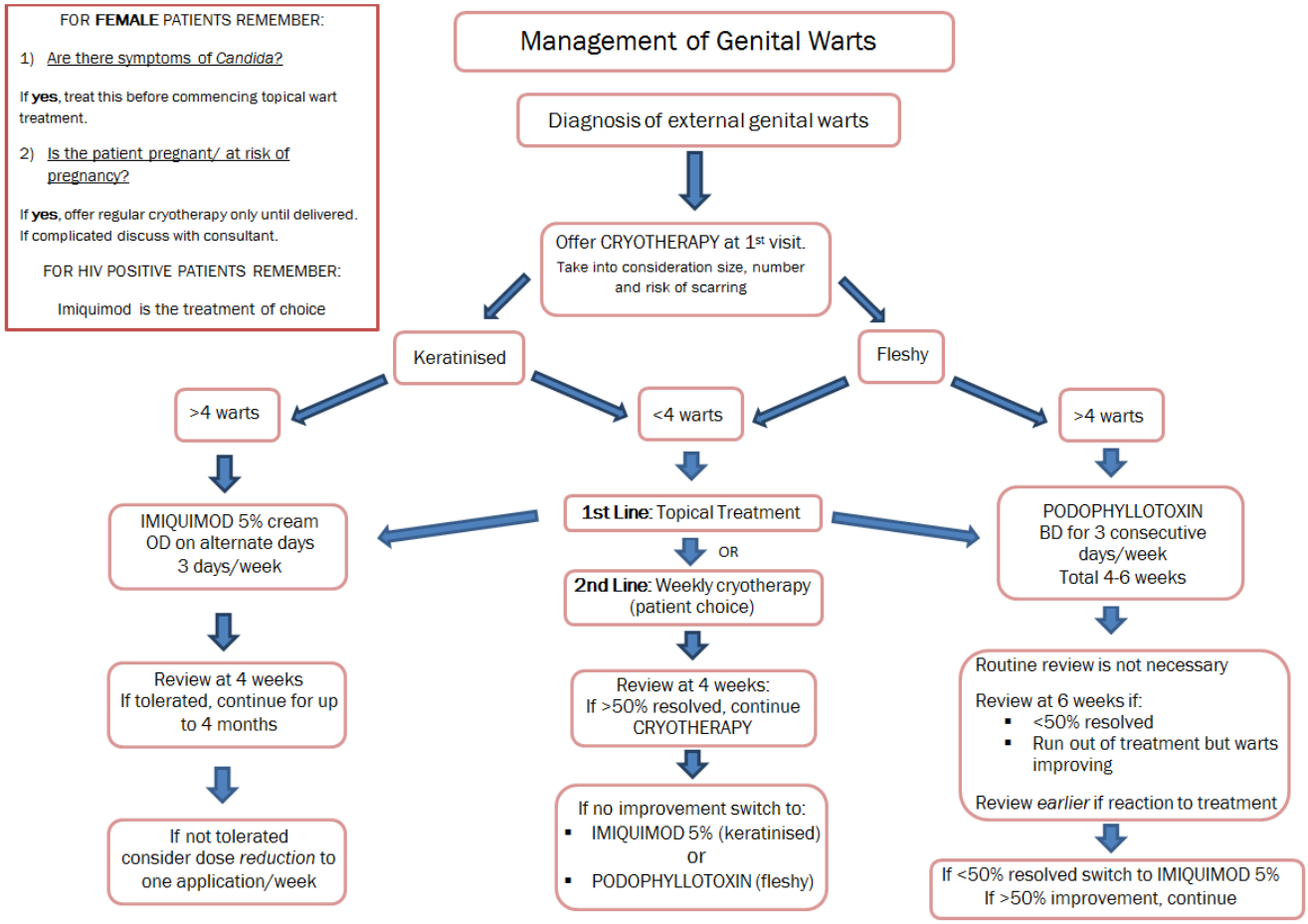
Further screening
Offer full STI screen including NAAT for chlamydia/gonorrhoea, and bloods for HIV/syphilis

Treatment *(see flow charts for further detail)*

- All treatments have significant failure and relapse rates.

- Treatment may depend on size, morphology, number and distribution of warts.
- Treatment of external warts may cause spontaneous regression of internal lesions.
- No treatment is an option at any site, and may apply particularly to warts in the vaginal and anal canal, as well as the cervix.
- Urethral warts should be treated with cryotherapy using a cryoprobe.
- Intractable or extensive warts, or cases with multiple co-morbidities should be reviewed by a senior clinician.

Further information can be found in the BASHH Guideline on Anogenital Warts
http://www.bashh.org/documents/86/86.pdf



UNITY NON-LEVEL 3 SETTINGS

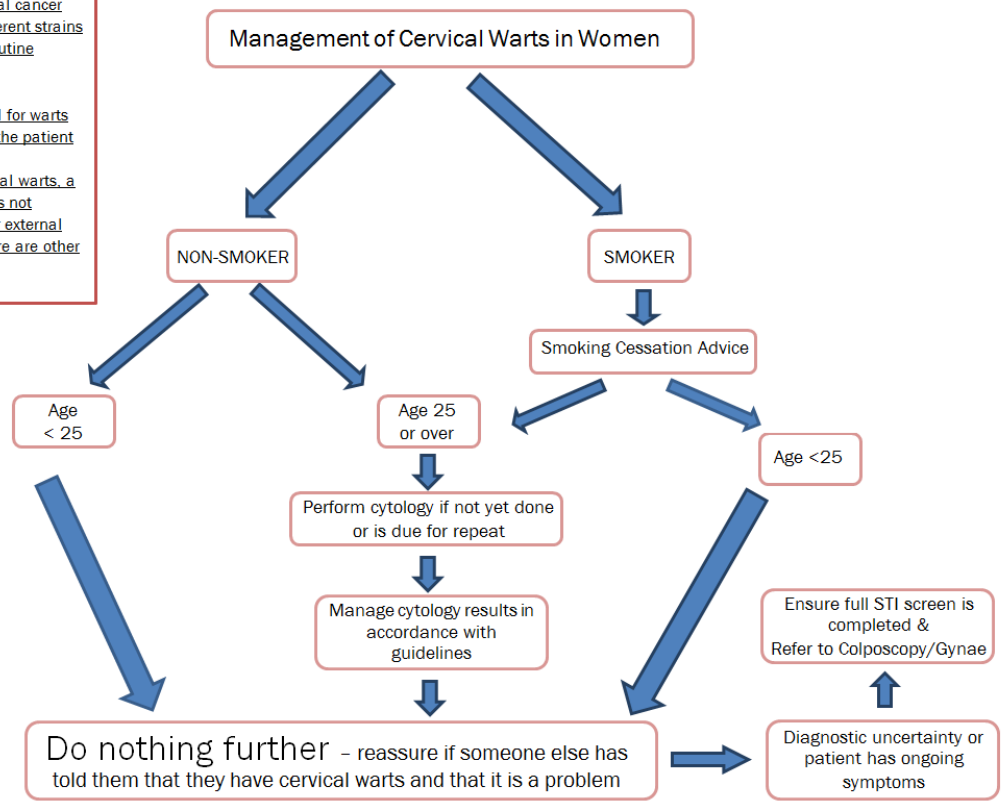
See separate flow chart on managing genital warts in non-level 3 settings
For any queries please discuss with on-call doctor at Unity Sexual Health

REMEMBER

1) Genital warts and cervical cancer are associated with different strains of HPV - no change to routine screening is indicated

2) No treatment is required for warts which are not visible to the patient

3) As we do not treat cervical warts, a speculum examination is not necessarily indicated for external genital warts unless there are other indications



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PODOPHYLLOXTOXIN

- Options include *Warticon* cream or *Condyline* solution
- Apply BD for 3 consecutive days of the week for 4 weeks (solution) or 5 weeks (cream).
- The cream may be easier for many patients to apply, especially for perianal lesions.
- It is not suitable for areas >4cm²
- If there are significant side effects (e.g. soreness, ulceration), discontinue.
- Unprotected sexual contact should be avoided soon after application because of a possible irritant effect on the partner

IMIQUIMOD 5% cream

- Common brand name is *Aldara*
- Apply at night and wash of 6-10 hours later
- Apply only 3 nights spread across the week e.g. Mon, Weds, Fri
- Use in 4 week cycles up to maximum 16 weeks
- Unprotected sexual contact should be avoided soon after application because of a possible irritant effect on the partner.
- Latex condoms may be weakened if in contact with imiquimod.

FOR **FEMALE** PATIENTS REMEMBER:

1) Are there symptoms of *Candida*?

If **yes**, treat this before commencing topical wart treatment.

2) Is the patient pregnant/ at risk of pregnancy?

If **yes**, podophyllotoxin and imiquimod are contraindicated.

In this situation, advise attending BSHC for regular cryotherapy. If complicated discuss with consultant. Remember warts are likely to improve spontaneously once they have delivered.

If you are concerned about the patient then either discuss with consultant or refer to BSHC for review.

Examples include:

- The diagnosis is unclear
- The lesions appear atypical
- They are not responding to treatment
- The patient may be suitable for cryotherapy

RELATED DOCUMENTS	BASHH Guideline on Anogenital Warts http://www.bashh.org/documents/86/86.pdf
SAFETY	Podophylloxtoxin is teratogenic and should not be used if there is a risk of pregnancy. Imiquimod is not licensed for use in pregnancy.
QUERIES	Please contact Dr Helen Wheeler, Clinical Lead. Unity Sexual Health