SEXUALLY TRANSMITTED INFECTIONS

CONDYLOMATA ACUMINATA (GENITAL WARTS)

Keywords: Genital warts, sexually transmitted infection, STI, human papilloma virus, HPV

AIM

• To describe the diagnosis and management of genital warts.

BACKGROUND

Genital warts are caused by low risk strains of Human Papilloma Virus (HPV).¹ High risk strains of HPV may concurrently infect individuals with genital wart infection, therefore making them at increased risk of long term HPV related cancer should the high risk HPV infection persist.¹ Immunosuppressed individuals are at increased risk of HPV related cancers.

DIAGNOSIS

• Diagnosis of genital warts is clinical / by naked eye examination of the lesions.¹
• No confirmatory testing is required; however HPV DNA cervical testing at the time of a Pap smear may assist future management.¹ .
• The differential diagnosis includes normal anatomical variants, seborrhoeic keratoses and intraepithelial neoplasia.

EXAMINATION

1. Examine and test the woman for other STIs¹ which can be asymptomatic or be associated with inflammation, which can encourage wart proliferation.
2. Inspect the genitalia carefully- Examine the:
   • Crura
   • Mons pubis
   • Perineal area
   • Perihymenal area (stretch the skin)
   • Urethral meatus
   • Labia majora
   • Labia minora
3. Insert the speculum and observe the cervix. Offer and perform a Pap smear if required.²
4. On removing the speculum, look to see whether there are any lesions on the vaginal walls.
5. Ask about oral lesions.

MANAGEMENT

TREATMENT

Non Keratinised Warts

• Podophyllotoxin paint 0.5%, or cream 0.15% (self treatment).¹ Applied by the woman twice daily for 3 days, with a 4 day treatment free interval.¹ May be repeated up to 4 cycles.¹

Keratinised Lesions

• Liquid nitrogen applied weekly or ablation (hyfrecation or excision).¹ NB: Ensure warts are not condylomata lata (secondary syphilis) or donovanosis, as antibiotics are the treatment for these.¹

Alternative Treatments

• Trichloroacetic acid (85% TCA in 80% alcohol or water) applied weekly to the wart.
• Cryotherapy: freezing the warts once each week.¹ Patients should be warned that this procedure may cause some discomfort.
• Hyfrecation or laser – offered for solitary pedunculated lesions or warts that have been present for 6 weeks or longer with treatment. Laser is provided as a private service.
Imiquimod 5% cream, 3 nights per week (for up to 16 weeks), patient self applied\textsuperscript{1} at night.

**Determining Treatment Failure**

- It is essential that maps of the distribution of lesions are drawn with each treatment.
- If a lesion persists with treatment and then is still present after 6 weeks, this is called treatment failure and an alternative form of therapy must be found. Biopsy of atypical or persistent warts can assist in excluding dysplasia, particularly in HIV infected patients.\textsuperscript{1}
- If a new lesion appears this can be treated with the same treatment.
- New lesions do not imply treatment failure, but are representative of the proliferative nature of the infection. Up to 50\% can have recurrence in the first 6 months.\textsuperscript{1} If left, warts are highly infectious and may enlarge.\textsuperscript{1}

**PATIENT ADVICE**

- Advise patients to cease cigarette smoking. The risk of cervical cancer is increased in women who smoke cigarettes and also in women who have genital warts.
- Encourage women with (or who have partners with) genital warts to have regular Pap smears\textsuperscript{1}
- Counsel the woman about the condition and provide written information about the infection.
- Discuss safe sex practices.\textsuperscript{1}
- Advise the woman to use condoms until treatment completed\textsuperscript{1} or abstain from sexual intercourse until the lesions have resolved.\textsuperscript{2}
- Discourage the woman from shaving the area as this spreads the infection.\textsuperscript{1}
- Current sexual partners may require information, and assessment for undetected warts.\textsuperscript{1, 2}

**FOLLOW UP**

- Review at 3 weeks and follow up for 6 months.
- Assess response to treatment and re-test for other STI's.\textsuperscript{1}
- Suggested review schedule is: 3 weeks, 6 weeks, 3 months, and 6 months.

**REFERENCES (STANDARDS)**


**National Standards** – 1.8, 3.11, 3.13 & 4

**Legislation** - *Children and Community Services Act 2004; Freedom of Information Act 1992; Privacy Act 1988*

**Related Policies** –
- Department of Health WA: OD 0296/10: Interagency Management of Children Under 14 Years who are Diagnosed with a Sexually Transmitted Infection (STI) (2010); OD 0344/11: Mandatory Reporting of Sexual Abuse of Children Under 18 Years (2011).
- Other related documents – Clinical Guidelines Sexually Transmitted Infections
- Department of Health WA: Quick Reference to STI Management (2013); Genital Warts Fact Sheet

**RESPONSIBILITY**

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