



External Genital Warts: Answering Patients' Questions



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In Canada, it has been estimated that there are 185,000 consultations per year for external genital warts (EGWs).¹ In 2005, the BC Cancer Agency estimated that the direct costs to the BC healthcare system arising from disease associated with the low risk subtypes HPV 6 and 11 (genital warts, recurrent respiratory papillomatosis and sinonasal papillomas) was 8.8 million dollars.² Providing accurate information to patients about EGWs may reduce the psychological burden associated with this disease. One study found that patients who received an educational leaflet about EGWs were four times less likely to develop recurrences than those who did not receive the leaflet.³ This article will address the common questions asked by patients with regards to EGWs.

How did I get them?

EGWs are the result of the skin being infected by HPV. Patients are exposed to HPV through hetero- or homosexual contact. The virus that causes EGWs cannot be spread to other parts of the body. Autoinoculation from hand warts has not been reported in adults. There is no evidence that transmission occurs via inanimate objects.

Patients feel stigmatized by the diagnosis of EGWs. In fact, the majority of North American sexually active adults have been exposed to HPV

Meet Melanie...

Melanie is a 22-year-old woman who presents with a 3 month history of external genital warts (EGWs).

She has been visiting her GP's office weekly for cryotherapy treatments. She has had 10 treatments so far. She is very upset because nothing seems to be working and the bumps do not seem to be going away.

Every time she comes in for an exam, the doctor discovers new warts. She is reluctant to have sex with her partner until all the bumps are gone.

Her last Pap smear was 4 months ago and was normal but she read on the internet that warts can cause cervical cancer and she would like to have another Pap smear done today.

She wonders if the new HPV vaccine will help get rid of the warts.

(60%), many carry the virus (14%) and only a minority develop EGWs (1%).⁴ Genital HPV infection is the most common STI worldwide.

The time period from exposure to disease ranges from weeks to months. The length of period that the virus may be in a subclinical phase is unknown. Thus, if the patient and/or her partner have had more than one sexual partner, it is difficult to identify the source of HPV.

Table 1**Common treatments for external genital warts**

Treatment	Mechanism of action	Course of treatment	Clearance rates ⁵	Recurrence rates ⁵
Podophyllotoxin*	Cytotoxic	Twice a day for 3 days on and 4 days off for 4-6 weeks	60%-90%	10%-40%
Podophyllin	Cytotoxic	Once per week for 4-5 weeks	60%-80%	20%-30%
Imiquimod*	Immunomodulation	3 times per week for up to 16 weeks	40%-60%	10%-20%
Trichloroacetic acid	Cytotoxic	Once per week for 3-4 weeks	70%-80%	30%-60%
Cryotherapy	Physical ablation	Repeat every 1-3 weeks for up to 3 months	40%-90%	30%-60%

*Patient-applied

► *Will they go away?*

Yes, if you do nothing the warts may go away. Spontaneous regression rates are low in the first few months. All treatments for EGWs have a high initial clearance rate. Regression of the warts, with or without treatment, does not necessarily mean clearance of the virus. Rates of recurrent disease from 25% to 67% have been reported within three months of wart “clearance.”⁵ Patients should be prepared to expect recurrent disease following initial treatment. Patients who have a large number of warts will require more treatments and take longer to clear the disease. Recurrent disease does not mean treatment failure. In healthy adults, after approximately 18 months, all EGWs disappear and there is no evidence of viral replication.⁶

► *What treatment do you recommend?*

Treatment for EGWs should be offered but not necessarily recommended. Most patients will request treatment. Treatment should not be more harmful than the disease. Most treatments are associated with side-effects (e.g., irritation, soreness and swelling of the skin). Over treatment of

sensitive areas (the vulvar vestibule, or the glans of the penis) may result in pain that lingers long after the warts have disappeared. Treatment may improve symptoms and cosmesis. Treatment does not eliminate infectivity. The specific treatment will depend on the type of wart, location of warts and bulk of disease. Patient characteristics (pregnant, immunocompromised) should also be considered when recommending treatment. In these two patient situations, a realistic goal of therapy is often reducing the bulk of the disease until the immune system recovers vs. total clearance of disease. In general, patient-applied treatments are an excellent first-line treatment option. They are just as, if not more effective, than physician provided treatments (Table 1).

► *Can I reduce the risk of recurrence after treatment?*

Cigarette smoking has been associated with HPV acquisition, persistence of HPV infection and progression of dysplasia to cancer.⁷ Patients should be counselled to quit smoking. Treatment with the immunomodulator imiquimod has been reported to result in lower recurrence rates.⁸

► Will I infect my sexual partner?

EGWs are highly contagious. There is no therapeutic way to shorten the contagious period. Abstaining from sex is the only way to eliminate the risk of infecting a sexual partner. Condoms may reduce but not eliminate this risk. Patients should be encouraged to use condoms to protect against infection from other HPV subtypes such as 16 and 18, that are responsible for high-grade squamous dysplasia of the cervix, vulva, vagina and anus.

► Will I get cancer?

The majority (> 90%) of genital wart lesions are associated with the HPV subtypes 6 and 11. The risk of developing cancer from these subtypes is negligible. Patients should participate in a Pap smear screening program. If their Pap smears are satisfactory and normal, they can be repeated according to local guidelines. Women with EGWs do not need to have Pap smears done more frequently, nor do they need to be referred on for colposcopy.

► Can I get pregnant?

Pregnancy is associated with recurrence of disease and increase in size and number of EGWs. Some treatments are contraindicated in pregnancy (podofilox, podophyllin). Surgical treatment should be reserved for EGWs that will obstruct delivery. Treatment will not eliminate



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Take-home message

1. Treat the patient, not just the warts
2. Patient-applied treatments are as effective as physician-applied treatments
3. Recurrence of disease does not represent treatment failure
4. Counsel patients to quit smoking and use condoms
5. The HPV vaccine is recommended for prevention of EGWs

the risk of HPV transmission to the baby. The risk of respiratory papillomatosis is extremely low. Performing a C-section does not eliminate this risk and thus maternal EGWs are not an indication for a C-section. Many EGWs will regress spontaneously in the postpartum period.

► Should I get the HPV vaccine?

The current HPV vaccine available is prophylactic and not meant for treatment of disease. It is a quadrivalent vaccine and protects against HPV 16, 18, 6 and 11. The vaccine is very effective in protection against HPV infection and related EGWs and cervical dysplasia. It will not influence the course of the disease in a woman with EGWs. A woman presenting with EGWs has already been infected with one of the low-risk HPV subtypes but not necessarily been infected with a high-risk subtype. Theoretically, she may be naive to the high-risk subtypes and therefore benefit from the vaccine. HPV testing for high-risk HPV subtypes is currently not available and or recommended in asymptomatic patients.



For references, please contact cme@sta.ca