PART 2L

Anogenital warts

R Maw, on behalf of the HPV Special Interest Group of BASHH

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Anogenital warts are caused by the human papilloma-virus (HPV). There have been more than 90 HPV types sequenced. The common types causing genital warts are types 6 and 11. These are usually referred to as low risk HPV types indicative of their low or absent oncogenic potential.¹ Both male and female patients independent of sexual orientation attending a genitourinary medicine clinic should have the anogenital skin examined under good light as part of a routine assessment. The presence of exophytic warts should be noted. Speculum examination of female patients is a routine component of female genitourinary examination and the presence of vaginal or cervical warts should be noted. Anogenital warts are essentially a cosmetic problem but often cause patients considerable psychological and psychosexual distress. They are therefore usually highly motivated to have warts detected and removed.

RECOMMENDED TESTS

Visual examination, which may be aided by a magnifying glass, is the only recommended test for routine diagnosis. There is no place for HPV typing in routine clinical practice (evidence level IV, recommendation grade C).²

If there is doubt as to the diagnosis, biopsy under local anaesthetic for histology is justifiable. Biopsy is indicated if there is a concern that a lesion may be dysplastic and may need a different management strategy from genital warts (evidence level IV, recommendation grade C).

The acetic acid test—that is, soaking the skin under examination with 5% acetic acid and examination for “aceto-white” lesions, is occasionally justifiable for lesions that may be dysplastic or may not be warts or for targeting biopsy. This test should be aided by the use of a colposcope. There is a high false positive rate with the “aceto-white” test³ and it should not be used for screening purposes (evidence level IIb, recommendation grade B).

Cervical cytology test is not recommended for women under 25 years of age and is not indicated for women who have kept their normal smear intervals (evidence level IV, recommendation grade C).⁴

RECOMMENDED SITES FOR TESTING

Examination of anogenital skin and speculum examination of the vagina and cervix.

FACTORS THAT ALTER TESTS RECOMMENDED OR SITES TESTED

Proctoscopy is not recommended except if the patient has symptoms such as bleeding from the anus or irritation. Warts identified in the anal canal during proctoscopy for other reasons should be discussed with the patient to determine if they want the warts to be treated.

Examination of the oral cavity is indicated if patients think they may have warty lesions at that site.

Risk groups

- Homosexual men (no alteration to standard recommendation)

- Sex workers (no alteration to standard recommendation)
- Young patients (no alteration to standard recommendation)
- HIV positive homosexual men. There is a high prevalence of anal intraepithelial neoplasia (AIN) in this group, and an increased incidence of anal carcinoma.^{5–6} A carcinoma would tend to present with a palpable lump, which to the patient might feel very similar to a wart. Patients presenting with lumps in the anal canal should therefore be offered definitive treatment, if necessary by surgical excision and biopsy.⁷

Other groups

- Pregnant women (no alteration to standard recommendation)
- Women with history of hysterectomy (no alteration to standard recommendation)
- Patients who are known contacts of the infection and are not found to have any exophytic genital warts should be advised as to self examination of the genitals and told to return for advice if they detect lesions. They should also be advised that most people developing warts as a result of recent contact do so within several months.⁸

RECOMMENDATION FOR FREQUENCY OF REPEAT TESTING IN AN ASYMPTOMATIC PATIENT

As noted above, patients should self refer if lesions appear.

Some patients may be reassured by a follow up examination in 3 months' time.

RECOMMENDATION FOR TEST OF CURE

Visual examination for clearance of warts is the only appropriate test of cure.

STAKEHOLDER INVOLVEMENT

MSSVD Human Papilloma Virus Special Interest Group (Raymond Maw, Chris Sonnex, Paul Fox).

No patient involvement has been undertaken.

RIGOUR OF DEVELOPMENT

This guideline was obtained by searching the Medline database from 1965 until August 2002 using the MeSH headings “genital warts, anogenital warts, diagnosis, guidelines”.

The recommendations of the UK National Guidelines for the management of anogenital warts, the European course on HPV associated pathology: guidelines for primary care physicians for the diagnosis and management of anogenital warts, and the CDC STI treatment guidelines of 2002.

Abbreviations: AIN, anal intraepithelial neoplasia; CIN, cervical intraepithelial neoplasia; HPV, human papillomavirus

APPLICABILITY

Personnel involved in the management of patients in genitourinary medicine clinics should be trained in identification of anogenital warts.

AUDITABLE OUTCOME MEASURES

All patients attending for genitourinary examination should have a documented adequate visual examination of the anogenital region.

Conflicts of interest: Dr Moore has acted as a consultant to 3M, Perstorp and Stiefel. Dr Sonnex has conducted clinical trials for 3M and Stiefel.

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