

Genital Wart Treatment

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A thorough patient history is essential to risk stratify a patient with genital warts and determine the best method for treatment and disease surveillance. Herein, discussion points for patient visits and treatment approaches are provided.



What does your patient need to know?

When a patient presents with a history of genital warts (GWs), find out when and where the lesions started; where the lesions are currently located; what new lesions have developed; what treatments have been administered (eg, physician applied, prescription) and which one(s) worked; what side effects to treatments have been experienced and at what dose; does a partner(s) have similar lesions; is there a history of other sexually transmitted diseases or genital cancer; is he/she immunocompromised (eg, human immunodeficiency virus, transplant, medications); and what is his/her sexual orientation.

Once all of the information has been gathered and the entire anogenital region has been examined, a treatment plan can be formulated. If the patient is immunocompromised or is a man who has sex with men, the risk for anogenital malignancy due to human papillomavirus (HPV) is higher, and GWs, which can be coinfecting with oncogenic HPV types, should be treated more aggressively. If the patient is still getting new lesions, use of only a destructive method such as cryotherapy will likely lead to suboptimal results.

Any patients with GWs in the anal region but particularly those in high-risk groups such as men who have sex with men and human immunodeficiency virus-infected patients should have an anoscopy to evaluate for lesions on the anal mucosa and in the rectum.

What are your go-to treatments?

Prior treatments need to be taken into account; make sure to understand any side effects and how he/she applied the prior treatment before eliminating it as a viable option. Treatment usually depends on the number of lesions, surface area, anatomic locations involved, and size of the lesions. I start with a 2-pronged

approach—a debulking therapy and a patient-applied topical therapy—which allows me to physically remove some of the lesions, typically the larger ones, and then have the patient apply a topical medication at home that will treat the smaller lesions as well as help to clear or decrease the burden of HPV virus on the skin. I use cryotherapy as a debulking agent, but curettage or podophyllin 25% also can be used in the office. I use imiquimod cream 5% as a first-line topical agent at the recommended dose of 3 times weekly; however, if after the first 2 weeks the patient has little response or too much irritation, I titrate the dose so that the patient has mild inflammation on the skin. The dose ultimately can range from daily to once weekly. Some patients who can only tolerate imiquimod once or twice weekly may require zinc oxide paste for the inguinal folds and scrotum to protect from irritation. Alternate topical medications for GWs include sinecatechins ointment 15% or cidofovir ointment 2%.

How do you keep patients compliant?

Start the visit with open communication about the disease, where it came from, what the risks are if it is not treated, and how we can best treat it to make sure we minimize those risks. I explain all of the treatment options as well as our role in treating these lesions and minimizing the risk for disease progression.

What do you do if they refuse treatment?

Most patients with GWs are motivated to be treated. If pain is a concern, such as with cryotherapy, I recommend topical treatments.

What patient resources do you recommend?

The American Academy of Dermatology (<https://www.aad.org/public/diseases/contagious-skin-diseases/genital-warts>), Harvard Medical School patient education center (Boston, Massachusetts) (<http://www.patienteducationcenter.org/articles/genital-warts/>), and *American Family Physician* (<http://www.aafp.org/afp/2004/1215/p2345.html>) provide patient materials that I recommend.

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