Warts Do Not Always Indicate Recent Infection

Only 20% of new human papillomavirus infections produce lesions within the first few months.

BY JANE SALODOF MACNEIL
Contributing Writer

HOUSTON — Diagnosis of human papillomavirus infection in a genital wart should not trigger a rush to judgment regarding recent sexual transgression or child abuse, Peter J. Lynch, M.D., said at a conference on vulvovaginal diseases.

Only 20% of new human papillomavirus (HPV) infections produce lesions within the first few months. The average incubation period lasts 2 months to 2 years, after which the virus can remain latent for years or even a lifetime in the unsuspecting human host, said Dr. Lynch, a dermatologist in Sacramento.

He attributed 95% of adult infections to sexual transmission but said genital warts in children often result from infections transmitted by parents. Transmission not only can happen during vaginal delivery in a woman who is asymptomatic, but infections can also remain latent for years before a wart is detected, he said at the meeting, sponsored by Baylor College of Medicine.

The average HPV incubation period lasts 2 months to 2 years, after which the virus can remain latent for years or even a lifetime in the human host.

Theoretically, a parent infected with a finger or hand wart can transmit the virus innocuously when bathing a child. If a genital wart is the only evidence of child abuse, he advised against assuming the child was assaulted. "Vertical transmission occurs and, thus, not all childhood genital HPV infections are child abuse," he said. "Latency occurs, so that the appearance of active disease does not tell you anything about when the original infection was acquired."

Clinicians are unable to diagnose latent virus in the absence of discernable lesions, Dr. Lynch said, warning that acetic acid soaks have turned out to be misleading and should not be used. Conventional biopsy also can be misleading, he said; sometimes pathologists will misidentify clear cells as koilocytes.

The best test for identifying HPV type uses polymerase chain reaction, which is expensive and generally reserved for research. Simple inexpensive test kits have become available, but he predicted questions about their accuracy would prevent wide use until they are resolved.

Meanwhile, research in women with sexually transmitted diseases has shown 60% to be infected with HPV. In more typical populations of sexually active women, he estimated prevalence at 20%. Because cervical infections are more common than vulvar infections, he reckoned that 5%-10% of women have active or latent HPV infections of the vulva.

Sexual partners do not need to be examined after a woman is diagnosed with HPV. "The acquisition may not have been sexual. It may have occurred years ago and be latent," he said.

"How would you examine the partner anyway?" he asked, describing one test used in men as "neither accurate nor specific." Nonetheless, he added, men diagnosed with HPV should notify female sexual partners because of the risk of cervical and vulvar infection.

When anogenital warts are diagnosed in children, they are often best left alone; nearly 100% will resolve spontaneously within 2 years. If such warts are treated, he recommended home care with imiquimod (Aldara) or podofilox (Condylox) to minimize psychological and physical trauma. ■

Cancer Concerns, Patient Wishes Drive Genital Wart Tx

BY JANE SALODOF MACNEIL
Contributing Writer

HOUSTON — Whether to treat genital warts may seem like a no-brainer, but Peter J. Lynch, M.D., has a list of reasons for not trying to eradicate some vulvar lesions.

Many genital warts resolve spontaneously. The underlying cause, human papillomavirus (HPV), is "nearly universal," and destroying the lesion will not eradicate latent virus in the host, he said at a conference on vulvovaginal diseases sponsored by Baylor College of Medicine.

"There's a high rate of recurrence with all forms of treatment and a high cost for treatment, both economically and psychologically, with very little benefit," said Dr. Lynch, a dermatologist in Sacramento. Still, he included himself among the majority of clinicians who treat genital warts. Patient wishes, concerns about cancer risks, and legal vulnerability make genital warts difficult to ignore.

Vulvar warts must be characterized and the source of infection confirmed before they are treated. Vulvar lesions from HPV infection are highly variable, he said, listing the most common forms:

► Filiform warts (condyloma acuminata) are taller than they are wide. They are about a quarter-inch to a half an inch long and skin colored or slightly pink. The tip is a little thicker than the stalk and often consists of brush-like bristles.

► Papules or nodules are as wide as they are tall—usually about the size of a pencil eraser (but sometimes as large as a plum), and skin colored or light brown. They are usually smooth but can feel rough if located in dry anogenital tissue.

► Flat warts are small, bare-topped, barely elevated papules that are wider than they are tall. They are about a quarter-inch in diameter and skin colored, pink, tan, or dark brown. The most common type of wart in the vulva, flat warts can coalesce into flat-topped plaques.

Dr. Lynch recommended biopsy to make certain the cause is HPV infection and to rule out malignancy. Once vulvar HPV infection is established, other anogenital areas should be examined to rule out possible HPV infection there. The next step is to choose among these three therapeutic options:

► Home-based medical therapy, in which the patient applies a 5% cream of imiquimod (Aldara) or podofilox (Condylox). The weekly frequency might be every other day for imiquimod or 3 days in a row for podofilox. About a third of patients have complete clearance after 2 months of treatment, Dr. Lynch said.

► Office-based medical therapy lets the clinician monitor compliance. He characterized this choice as inconvenient for patient and clinician, and the response rate is similar to home-based treatment.

► Office-based destructive treatment can be quite effective. Treatments requiring anesthesia (electrosurgery, excision, laser therapy) can have a 100% response rate. Treatments that can be done without anesthesia (cryotherapy, podophyllin, tri- or bichloracetic acid, and 5-fluorouracil) lead to complete clearance in two-thirds of patients.

His advice: "Either use home therapy, where the patient treats herself … or go to destructive therapy. Expect at least a 35% recurrence rate with either approach. Medical therapy in the office has all the disadvantages of home therapy without any improvement in results."

Patient-Delivered Tx for Partners Lowers Rates of Some STDs

BY KATE JOHNSON
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The provision of chlamydia or gonorrhea treatment directly to patients' sexual partners, without requiring the partners to visit a physician, significantly improved infection control in patients, researchers at the University of Washington in Seattle reported.

"We believe that the inadequacies of current approaches to partner notification and the persistence of unacceptably high levels of morbidity from sexually transmitted infections in the United States should motivate both clinicians and public health authorities to incorporate patient-delivered partner therapy and other approaches to expedited care of partners into clinical and public health policies," wrote Matthew R. Golden, M.D., the lead investigator (N. Engl. J. Med. 2005;352:676-85).

The study randomized 2,751 patients recently treated for chlamydia and/or gonorrhea infections to either expedited treatment or standard referral for their partners.

The 1,376 patients in the expedited treatment group were offered medication to give to as many as three partners. An additional 1,375 patients in the standard referral group were advised to tell their partners to seek care, available at no cost at the public health department's sexually transmitted diseases (STD) clinic.

The medication for partners in the expedited treatment group was distributed to patients at the STD clinic, by direct mail, or through participating pharmacies. It consisted of either a single 400-mg dose of cefixime and a 1-g sachet of azithromycin for partners of patients with gonorrhea or azithromycin only for partners of patients with chlamydia. Warnings and information about the medication, condoms, and STD prevention also were included in the packets.

A total of 1,860 patients completed the study and were interviewed and retested 10-18 weeks after their initial diagnosis and treatment.

More patients in the expedited treatment group reported that their partners were likely to have been treated, or to have tested negative for STDs—making persistent or recurrent infection with either gonorrhea or chlamydia significantly less common in this group (10%), compared with the standard referral group (13%), for a relative risk of 0.76.

Expedited treatment was more effective in reducing gonorrhea (73%) than chlamydia (15%)—a finding that might be partially explained by chlamydia treatment failure, the authors suggested.

The findings represent "a major advance for the control and prevention of STDs," reported Emily J. Erbelding, M.D., and Jonathan M. Zenilman, M.D., of Johns Hopkins University, Baltimore, in an accompanying editorial (N. Engl. J. Med. 2005;352:720-1).

"We can conclude that the use of expedited approaches designed to circumvent traditional evaluation by a clinician increases the chance of an exposed partner's receiving proper therapy and, most important, reduces the original patient's risk of reinfection," they wrote.

The study authors noted several weaknesses in their model of patient-delivered partner therapy, including legal barriers in many states, the uncertain availability of cefixime, and the potential adverse effects of treating partners without a clinical evaluation. ■