# Warts Do Not Always Indicate Recent Infection

*Only 20% of new human papillomavirus infections actually produce lesions during 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.

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 practitioners not to assume 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."

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HPV is widespread in the general population, but it is difficult to diagnose, and its prevalence has been hard to establish, according to Dr. Lynch. It grows only in epithelial cells, and researchers have been unable to grow the virus in culture.

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, said Dr. Lynch. Though simple inexpensive test kits have become available, 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. ■

# Patient Concerns Drive Wart Treatment

BY JANE SALODOF MacNEIL
*Contributing Writer*

HOUSTON — Whether to treat genital warts would 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 so widespread that it's "nearly universal." Moreover, 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.

**The patient's wishes, concerns about cancer risks, and legal vulnerability make treatment of genital warts difficult to ignore.**

"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," concluded Dr. Lynch, a dermatologist in Sacramento.

Having said all that, he included himself among the majority of clinicians who treat genital warts. The patient's wishes, concerns about cancer risks, and legal vulnerability make genital warts difficult to ignore, he said.

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. These are usually smooth but can feel rough if they occur 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, especially in flat warts, which are the most likely to show dysplasia. More than 90% of vulvar HPV infections are caused by low-risk forms of the virus.

High-risk types such as HPV 16 and HPV 18 occur in 5%-8% of vulvar HPV infections. Although these can lead to malignancy, he characterized the transition as very slow, with ample time for curative therapy.

Once vulvar HPV infection is established, other anogenital areas should be examined to rule out possible HPV infection there, as well. The next step to take, is to choose among the following 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. Dr. Lynch estimated about a third of patients will have complete clearance after 2 months of such treatment.

► Office-based medical therapy allows the clinician to monitor compliance. Dr. Lynch 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) will lead to complete clearance in two-thirds of patients, Dr. Lynch estimated at the meeting.

"Unfortunately, there are no criteria to choose one [treatment] over the other. It is disturbing how little we have, except for anecdotal data," Dr. Lynch said of the three options.

His recommendation: "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."

One caveat: Dr. Lynch said vulvar warts should be treated in pregnant women, but he warned that podophyllin and its derivatives should not be used. ■

# *Seropositive Rate Doubles With Rapid HIV-1 Antibody Test*

WASHINGTON — The first 1,000 uses of the OraQuick Advance Rapid HIV-1 Antibody Test in New Jersey identified nearly double the number of HIV-positive patients, compared with the traditional blood tests, Evan Cadoff, M.D., wrote in a poster presented at the annual meeting of the American College of Preventive Medicine.

However, the data represent rates of seropositivity, not necessarily rates of new HIV infections, wrote Dr. Cadoff of the University of Medicine and Dentistry of New Jersey.

**After the first 1,000 results, the seropositive rate rose 4.72%, compared with 2.36% recorded with traditional testing during the previous year.**

The test requires an oral fluid sample, and delivers results in 20-40 minutes.

Rapid testing in New Jersey began in November 2003 at publicly funded counseling and testing sites throughout the state. After the first 1,000 results, the seropositive rate increased to 4.72%, or double the 2.36% seropositive rate recorded with traditional testing during the previous year.

Overall, 63% of the people who tested positive had not previously been diagnosed with HIV. However, whether the numbers represent improved detection rates in previously targeted at-risk populations or new groups of patients who previously went untested remains uncertain, according to the poster.

The rapid availability of test results reduces the time between a patient's initial diagnosis and referral, bolstering HIV prevention and treatment efforts, Dr. Cadoff said.

**—Heidi Splete**