

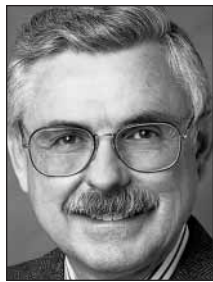
# Some Genital Warts Need Treatment, Some Don't

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.

"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.



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, he said, 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). 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 treatments can be quite effective. Electrosurgery, excision, laser therapy (all requiring anesthesia) can have a 100% response rate, while cryotherapy, podophyllin, tri- or bichloroacetic acid, and 5-fluorouracil (without anesthesia) will lead to complete clearance in two-thirds of patients.

"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.

His recommendation: Use home therapy or go to destructive therapy and expect at least a 35% recurrence rate with either approach. A caveat: Dr. Lynch said vulvar warts should be treated in pregnant women, but warned that podophyllin and its derivatives should not be used. ■

## Warts Do Not Always Carry Tales of Transgression

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 physicians 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."

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 dis-

cernable 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.

—Jane Salodof MacNeil

## Follow Cervical Intraepithelial Neoplasia Closely in HIV+ Women

BY ROBERT FINN  
San Francisco Bureau

SAN FRANCISCO — Women who are HIV positive are at increased risk of cervical intraepithelial neoplasia and must be followed closely, according to Meg Newman, M.D.

Furthermore, treatment of squamous intraepithelial lesions (SIL) or cervical intraepithelial neoplasia (CIN) is less effective, and there's a very high risk of recurrence, in women with the virus. HIV-positive women should be warned of this possibility, so they'll be prepared for any necessary retreatment, she said at a meeting on HIV management sponsored by the University of California, San Francisco.

Despite the risk of SIL/CIN recurrence in HIV-positive women, it is possible to avoid invasive cervical carcinoma, said Dr. Newman of the University of California, San Francisco, and San Francisco General Hospital. She said

her hospital has developed the following treatment guidelines for SIL/CIN in patients with HIV infection:

► While treatment of CIN I (mild dysplasia) has a high failure rate in HIV-positive women, it appears to have a relatively low rate of progression. At San Francisco General Hospital, women with CD4 counts more than 200 cells/ L who can commit to follow-up are treated only with close observation.

► Cryotherapy is appropriate for a woman with CIN I if her CD4 count is less than 200 cells/ L or if she has a higher CD4 count but is likely to be lost to follow-up.

► Appropriate treatment for HIV-infected women with CIN II (moderate to marked dysplasia) or CIN III (severe dysplasia) requires an ablative or excisional procedure.

► Cryotherapy is appropriate for CIN II or III if there is a satisfactory colposcopy; there has been no previous cervical treatment; and the lesion is completely visible, less than 2 cm in diameter, and affects only one or two quadrants.

► Laser ablation is better when the lesion is greater than 2 cm in diameter or involves three or four quadrants.

► The loop electrosurgical excision procedure (LEEP) is helpful when cryotherapy is inappropriate due to lesion size, or if the lesion is located high in the endocervix.

► LEEP can't be done when the cervical architecture is disrupted secondary to a prior LEEP or to a cone biopsy.

► A cold-knife cone biopsy requires an operating room. This procedure is best used for a high-grade lesion when malignancy is detected on Pap smear and microinvasive disease or a glandular lesion is present.

► After excisional or ablative treatment of CIN II or III, topical 5-fluorouracil appears to be useful as an adjunctive treatment.

Finally, Dr. Newman noted that cigarette smoking is one behavior that may play an important role in the acquisition and recurrence of SIL/CIN, and women should be counseled to quit. ■