Consider Waiting, Not Treating Anogenital Warts

BY KATE JOHNSON
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HOUSTON — Although most clinicians treat all anogenital human papillomavirus infections, nontreatment is something to consider in certain cases, Dr. Peter J. Lynch said at a conference on vulvovaginal diseases jointly sponsored by Baylor College of Medicine and the Methodist Hospital.

"Treatment is painful, and it's costly," said Dr. Lynch, professor and chairman of the dermatology department at the University of California, Davis.

"Spontaneous regression is likely in a young woman. In such a patient, I would biopsy one or two of the warts. If there is no dysplasia and if she is in a monogamous relationship and her partner is willing, I would be open to waiting several months to see if regression might occur without treatment," he said in an interview.

Most, but not all, human papillomavirus (HPV) infections resolve spontaneously, he explained. Those in older individuals and those caused by high-risk types resolve more slowly and occasionally persist indefinitely.

The argument for treatment is that it can reduce the degree of contagion; however, asymptomatic shedding still occurs. "In latency, the HPV DNA remains at the site of the lesion and may reactivate at any time," Dr. Lynch said.

In the case of a woman in a monogamous heterosexual relationship (she may have been infected many years previously or even at birth), the risk this presents to her partner is minimal. "Biologically, the infection behaves quite differently in men than in women," he said. "The male equivalent of vulvar intraepithelial neoplasia is extremely unlikely to progress to invasive disease. As such, infection with high-risk HPV is of trivial importance to the man but is of appreciable importance to a female sexual partner if spread to her cervix or vulva should occur."

Although treating female infection also may reduce the risk of subsequent malignant progression in patients with high-risk HPV types, absence of dysplasia on biopsy signals a low cancer risk in the first place, said Dr. Lynch. And not all lesions need biopsy. For example, filiform warts, common warts, and small nodular warts are unlikely to show high-risk HPV or dysplasia. However, flat-topped, pigmented, or large nodular warts could be dysplastic and therefore need to be biopsied, he said.

"If you took a poll, probably 98% of gynecologists and 85% of dermatologists would treat all HPV. But there is an option out there, and we shouldn't just blindly say every infection has to be treated." ■

Pigmented Vulvar Lesions Often Require Biopsy

HOUSTON — Biopsy should be considered more frequently for pigmented lesions that appear on the vulva, compared with elsewhere on the body, because in this location they are particularly tricky to identify by appearance alone, Dr. Libby Edwards said at a conference on vulvovaginal diseases jointly sponsored by Baylor College of Medicine and the Methodist Hospital.

"It is not that pigmented lesions are likely to be more dangerous on the vulva—they are not. It's just that their appearance is less specific," she said in an interview.

"Whereas the importance of pigmented lesions on other areas can usually be gauged relatively well by their appearance, on the vulva very abnormal-looking lesions may be unimportant and vice versa," said Dr. Edwards, a dermatologist in private practice in Charlotte, N.C.

For example, vulvar melanosis—patchy, irregular hyperpigmentation—is a benign condition that can appear indistinguishable from vulvar melanoma.

"You have to biopsy this, it is the only way you can rule out melanoma or pigmented vulvar intraepithelial neoplasia," she said.

Additionally, vulvar melanosis can occur as postinflammatory change associated with lichen sclerosus. "You need to treat any underlying disease, but otherwise there is no treatment for vulvar melanosis.

—Kate Johnson