**Patient Concerns Drive Wart Treatment**

**By Jane Salo dof MacNeil**

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.

Hearing 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.

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 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 cancer, Dr. Lynch estimated 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 genital warts are diagnosed in pregnant women, he recommended home care with imiquimod (Aldara) or podofilox (Condylox). Thoroughly, a patient 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.

“What’s 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 discernable lesions. Dr. Lynch said, warning that acetic acid soaks have turned out to be misleading and should not be used.

Conventional biopsy can also 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 re-referral, bolstering HIV prevention and treatment efforts, Dr. Cadoff said.

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**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 re-referral, bolstering HIV prevention and treatment efforts, Dr. Cadoff said.