Follow Cervical Intraepithelial Neoplasia Closely in HIV+ Women

**San Francisco** — Women who are HIV positive are at increased risk of cervical intraepithelial neoplasia and must be managed 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. HPV-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 1 (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 CIN 1 who can commit to follow-up are treated only with close observation.**

- **Cryotherapy is appropriate for a woman with CIN 1 if her CIN 4 count is less than 200 cells/L or if she has a higher CIN 4 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.**

- **A 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 carcinoma is confirmed by colposcopy.**

- **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.**

---

**Some Genital Warts Need Treatment, Some Don’t**

**BY JANE SALDOFF MacNEIL**

Conservatism Wins

**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 warts 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 meeting on HIV and cervical intraepithelial neoplasia (CIN) on May 20 in Sacramento.

Having said all that, 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, he said.

Vulvar warts must be characterized and the source of infections confirmed before they are treated. Vulvar HPV lesions are highly variable and the most common forms are:

- Filiform warts (condyloma acuminata) are taller than they are wide. They are about a quarter-inch in diameter 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 types of the virus.

High-risk types such as HPV 16 and HPV 18 occur in 3%-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 consider the following three therapeutic options:

- **Home-based medical therapy** in which the patient applies a 5% cream of imiquimod (Alldara) or podophyllin (Condylolox). 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 patients with all forms of treatment and one with very little benefit.

- **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 not eradicate latent virus in the host, he said at a meeting on HIV and cervical intraepithelial neoplasia (CIN) on May 20 in Sacramento.

He attributed 95% of adult infections to sexual transmission but said general warts in children are often transmitted 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 HPV, 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,” 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, recommended home care with imiquimod (Alldara) or podophyllin (Condylolox) to minimize psychological and physical trauma.

—Jane Saldooff MacNeil