

How Do I Treat

How Do I Treat Condylomas?

Carsten Sand, Consultant

Department of Dermato-venereology
Bispebjerg Hospital, University of Copenhagen, Denmark. e-mail: KPO3@bbh.hosp.dk

It is easy to treat the more classical sexually transmitted diseases such as gonorrhoea, syphilis, chlamydia and trichomoniasis. Those infected with genital herpes and who suffers frequent recurrent episodes can be offered suppressive antiviral therapy, normalising their lives. As a consequence patients with one of the above diseases only confront the staff of the STD clinic for a limited number of visits. In contrast, patients presenting with human papillomavirus (HPV) induced genital warts or condyloma acuminatum cannot be promised a rapid, uneventful and easy cure for their disease.

Before discussing different treatment modalities of condylomas it should be emphasised that in the majority of patients it is a benign condition rarely associated with premalignant or malignant transformation. Therefore aggressive therapeutic approach is seldom indicated. A chronic course is seen in approximately 50% of our patients, with successful outcome often hampered by the multicentric presence of subclinical foci of infection and a high frequency of recurrence irrespective of treatment applied. The duration, localisation and morphology of wart lesions and the immune status of the patient also vary, influ-

encing the expected cure rate. The clinician should be aware that current treatments are not especially successful and recurrences are common irrespective of the chosen treatment modalities.

Those referred for treatment to our STD clinic either constitute patients with previously untreated genital warts or patients who have received treatment by general practitioners or by specialists. As a consequence the group of patients with condylomas seen in our clinic is highly heterogeneous.

First-line treatment

In cases of previously untreated genital warts I would select either podophyllotoxin or podophyllin. The use of the latter has been discouraged in recent treatment guidelines, but I am still not convinced that podophyllotoxin is significantly more effective than podophyllin, and self-application of podophyllotoxin may be difficult in women with vulvar lesions and in patients with peri-intraanal lesions (1, 2). A carcinogenic effect of podophyllin has not been substantiated.

Podophyllotoxin

Podophyllotoxin ethanolic solution 0.5% or cream 0.15% is applied twice daily for 3 days, repeated after four drug-free days, for 8-12 weeks.

Podophyllin

Podophyllin ethanolic solution 20% is used once weekly for 8-12 weeks. The



Condyloma Accuminatum

treated area should be washed with water after 2-8 hours to reduce the risk of local toxic reaction.

Second-line treatment

Those not responding to a course of podophyllotoxin or podophyllin are offered one of the following treatment options:

Cryotherapy

Liquid nitrogen is applied for 5-10 seconds. Treatment can be repeated twice monthly.

CO₂-laser

Laser vaporisation of visible warts. A single treatment is rarely sufficient, and residual wart lesions should be eradicated through repeated treatments.

Imiquimod

Imiquimod (Aldara) cream 5% is applied 3 times weekly for a maximum of four months.

Third-line treatment

If one or a combination of the above treatments does not result in sustained clearance of wart lesions I would suggest one of the following treatment options:

5-fluorouracil

5-fluorouracil cream 5% (Efudix) is used topically once daily before bedtime. Treatment duration depends on clinical response and induction of local toxic reaction, but 1-3 weeks is usually sufficient.

Interferon

Interferon a 2b (Introna) 1-5 mill. units is injected in warts lesions thrice weekly for 8-12 weeks.

Cidofovir

This topical remedy is produced at the local pharmacy from non-marketed cidofovir solution (Vistide infusion solution, Pharmacia), approved for intravenous treatment of severe CMV disease in HIV-infected individuals. Cidofovir displays a broad antiviral activity against a number of herpes virus and HPV. Cidofovir 1% is usually applied once daily before bedtime for 1-2 weeks.

The multiple treatment options suggest that no single treatment is effective in all patients. We have no tradition of using trichloroacetic acid 80-

90% solution, but it is effective in some patients and may therefore be included in the group of second-line options.

If all or a significant number of treatments seem to be unsuccessful, don't panic! The patients should be told that the long-term prognosis is fairly good and that spontaneous regression can occur at any time. We rarely see chronic wart patients over 40 years of age.

References

1. von Krogh, G, Lacey CJB, Gross G, Barraso R, Scheider A. European course on HPV associated pathology: guidelines for primary care physicians for the diagnosis and management of anogenital warts. *Sex Trans Dis* 2000; 76: 162-168.
2. Wilson J. Treatment of genital warts - what's the evidence? *Int J STD AIDS* 2002; 13: 216-222.