

ANOGENITAL WARTS V2.0

Comments from the Expert Advisory Group

1. Anogenital warts are caused by human papilloma virus (HPV), usually types 6 and 11 which are not associated with dysplasia or malignancy.
2. Infection with HPV is common in non-HPV vaccinated sexually active people, most infections do not lead to visible anogenital warts and clear spontaneously.
3. Most HPV infection is acquired through sexual contact. Perinatal infection can occur and is rarely harmful to children.
4. The current HPV vaccination programme for adolescent girls and boys is with a nonavalent vaccine which protects against HPV 6, 11, 16, 18, 31, 33, 45, 52, and 58.
5. The HPV vaccine is recommended for gay, bisexual and other men who have sex with men (gbMSM) ≤ 45 years, people living with HIV ≤ 26 years, HIV infected gbMSM aged ≤ 45 years, haematopoietic stem cell or solid organ transplant recipients aged ≤ 45 years. Patients with Fanconi anaemia aged over 12 months should be offered HPV vaccine as soon as the diagnosis is made.
6. Individuals diagnosed with anogenital warts should be offered testing for other STIs including HIV, hepatitis B, syphilis, chlamydia and gonorrhoea.
7. [Hepatitis C \(HCV\) testing](#) should be considered part of routine sexual health screening in the following circumstances: gbMSM; People living with HIV; Commercial sex workers; People who inject drugs (PWID). Partners of the above should also be considered for HCV testing.
8. Discuss smoking cessation, as there is an association between smoking, increased incidence of anogenital HPV infection and development of anogenital warts.
9. Anogenital warts are a [notifiable disease](#).

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Treatment

ANOGENITAL WARTS TREATMENT TABLE

Small volume warts may resolve without treatment. All treatments are associated with non-response, relapse and local skin irritation.

Topical treatment

- Clear instructions on application method are available in the patient information leaflet insert for each product (also available on www.hpra.ie)
- Topical treatments are not for internal use.
- Topical treatments should be avoided in pregnancy.

Drug	Dose	Duration	Notes
Podophyllotoxin cream (Warticon®)	Apply every 12 hours for three consecutive days followed by a four day break	Repeat if necessary for up to 4 weeks	In general, soft, non-keratinised warts respond better to podophyllotoxin while cryotherapy is more useful for keratinised warts.
Imiquimod 5% (Aldara®) cream	Apply at night three times a week (e.g. Monday, Wednesday, Friday) and wash off 6-10 hours later.	Repeat if necessary for up to 16 weeks	Imiquimod (Aldara®) is no longer marketed in Ireland. Price & availability may vary. Aldara® may weaken condoms/ vaginal diaphragms and should be washed off the treated area before use of condoms and sexual contact.
Green tea leaf extract (Catephen®) ointment	Apply every eight hours, up to 0.5cm for all warts	Until complete clearance of warts (Maximum duration of 16 weeks)	Catephen® may weaken condoms/ vaginal diaphragms and should be washed off the treated area before use of condoms and sexual contact.

Physical ablation

Cryotherapy to warts	Weekly	For up to four weeks	Cryotherapy is safe in pregnancy but treatment of warts may not be necessary in pregnancy, particularly if low volume.
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Patient Information

- [Genital Warts patient information leaflet](#)
- [HSE Health A-Z Genital warts](#)