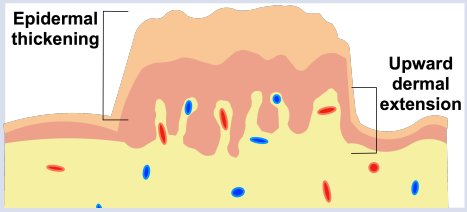
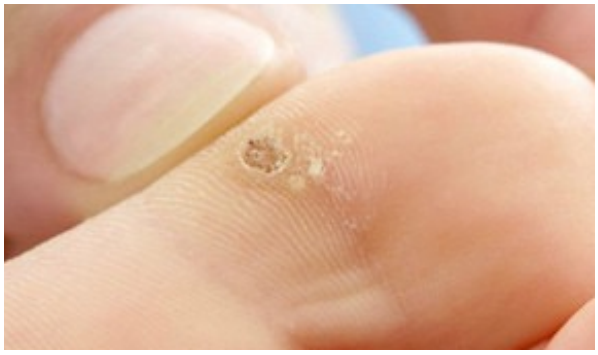
Approach to Warts (Verruca)

- Caused by a Human Papilloma Virus (HPV) infection in epidermal cells, leading to thickening of the epidermis and propagation of underlying dermal layer (with capillaries)
- Common in both healthy children and immunosuppressed patients
- Anogenital warts should raise suspicion of sexual abuse, although other transmission modes are possible



DIAGNOSIS

- ❑ Diagnosed by clinical appearance of thrombosed capillaries under a hyperkeratotic cap
- ❑ Differential Diagnosis → callus, closed comedone, lichen planus, corn, molluscum contagiosum



MANAGEMENT

Common/Plantar Warts (*Verruca vulgaris*)

At home:

- ➢ First line treatment
- ➢ Apply 17% salicylic acid and cover with duct tape
- ➢ Repeat daily for 12wks

In office cryotherapy:

- ➢ Cryotherapy is a good option in children, but may require topical anesthetic to be able to tolerate treatment
- ➢ Treat, wait for thaw, and repeat
- ➢ Follow up in 4wks

Flat Warts

- ➢ Topical tretinoin 0.1% cream (off-label) applied daily; follow up in 4wks

Anogenital Warts (*Condyloma acuminatum*)

At home:

- ➢ Imiquimod cream (off-label for children); use with varied frequency depending on the strength
- ➢ Sinecatechins (ex Veregen) ointment (off-label); apply a thin layer TID for up to 16wks; do not use in the vagina/anus

Note:

Alternative treatments may include laser ablation or intralesional bleomycin

Course & Complications

- Up to 65% of patients achieve spontaneous remission within 2 years, thus watching and waiting a reasonable treatment
- Blister-forming agents may result in new wart formation at periphery
- Patients with more pigmented skin may get dyspigmentation from treatment options
- Consider referral to a dermatologist for complicated warts or warts refractory to treatment

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