SPECIALTY: GENERAL MEDICINE - DERMATOLOGY
CLINICAL PROBLEM: Management of Cutaneous Warts

These guidelines are based on Guidelines produced by
The British Association of Dermatologists (BAD)
They have been developed to assist the management of
cutaneous warts in primary care

Approximately 70% of warts will resolve spontaneously by 2 years.

Differential Diagnosis
Plantar warts must be distinguished from callosities which are ill-defined areas of wax, yellowish thickening, which on paring reveal no capillaries. Corns occur on pressure points and are usually smaller and painful with a central plug. (Plane warts must be distinguished from lichen planus which will normally show a violaceous discoloration and Wickham’s striae.)

Transmission of warts
Warts are spread by contact, either directly from person to person, or indirectly via fomites left on surfaces. Infection via the environment is more likely to occur if the skin is macerated and in contact with roughened surfaces, the conditions which are common in swimming pools and communal washing areas. Socks can be used to cover warts and are available from pharmacists.

Warts and malignancy
Warts in immunocompetent individuals almost never undergo malignant transformation. Warty lesions are especially common in immunosuppressed and transplant patients and dysplastic change is quite common.

These guidelines do not cover therapy for anogenital warts. Patients with such warts are best seen and investigated by genito-urinary physicians to exclude the possibility of other sexually transmitted disease. If female patients prefer, referral can be made to the gynaecology department where they will be seen in the colposcopy clinic.

Treatment
There is no single treatment that is 100% effective and different types of treatment may be combined. Research into efficacy of treatment must take into account the possibility of spontaneous regression. It is a valid management option to leave warts untreated if this is acceptable to patients.

Facial warts should not be treated with wart paints because of the risk of severe irritation and possible scarring. Plane warts Koebnerize readily and any destructive technique may exacerbate the problem.

The majority of warts can be treated in general practice and increasingly wart clinics are run by nursing staff.
Management of cutaneous warts

A summary of treatments is given below:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Suggested method of use</th>
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<tbody>
<tr>
<td>1 No treatment - majority of patients</td>
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<tr>
<td>2 Salicylic acid (SA) (A Keratolytic)</td>
<td>Daily application of 15-20% salicylic acid in suitable base (suggestion OTC oclusal) 2-5% SA cream may be used for plane face warts</td>
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<tr>
<td>3 Cryotherapy</td>
<td>15-20 s single or double freeze of warts, repeated in 3-4 weeks (care needed when considering treatment of children under 12 years)</td>
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**NB** Solitary viral warts - consider for curettage, which is provided under the GMS/PMS contractual arrangements.

**Indications for referral**

1) Immunosuppressed patients

**Where to refer** – to secondary care (interim) this will change in light of the introduction of an Integrated Dermatology Model from 2012/13.

**REFERENCES:** British Association of Dermatologists Guidelines for the Management of Cutaneous Warts
British Journal of Dermatology 2000 144 4-11
[Accessed May 2011]

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