Paediatric Clinical Practice Guideline

Ano-genital warts (AGWs)

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See also: ***Child sexual abuse*** *guideline available on BSUH microguide > Paediatrics and Neonatology > Paediatrics > Safeguarding*

Proposed Modes of transmission:

- Autoinoculation: transmission from another body region on patient e.g. hands infect own genitals
- Sexually transmitted: consensual sex vs SEXUAL ABUSE
- Vertical / perinatal: mother's genital lesions infect baby, usually from passage down birth canal
- Horizontal: another person's lesions infect the patient e.g. warts on mother's or father's hands

Always consider sexual abuse as a form of transmission especially in older children.
Currently there is only evidence for perinatal and sexual transmission

The risk of Child Sexual abuse / assault (CSA) in a child with genital warts is estimated to be 31% - 58% *(RCPCH: The Physical Signs of Child Sexual Abuse 2015*). For children aged 4 – 8 yrs with AGWs the positive predictive value for sexual abuse is 50% and those >8 yrs, 70% (*Sinclair 2006*). It is not possible to "swab" (viral typing) warts. The diagnosis is clinical - unless you have histology.

- All GP referrals should be triaged to the AGW clinic with Dr Sharmila Jeyasingh, Dr Frankie Howsam or Dr Katy Fidler - to confirm AGW and avoid misdiagnosis. These children will be seen via L7, please email all 3 consultants to arrange.

- All patients must have an initial social service check prior to review in clinic to ensure child is not known to social care. If GP has referred, they are responsible for this. IF YOU ARE CONCERNED ABOUT A CHILD'S SAFETY, REFER IMMEDIATELY TO SOCIAL CARE.

- CED / RACH patients who are being assessed in the department please use **AGW proforma**. This is accessible on BSUH Microguide > Paediatrics and Neonatology > Paediatrics > A > ano-genital warts proforma

- **All cases 2 yrs – 13yrs with confirmed AGW need referral to social care and a strategy meeting (to include children's Sexual Abuse Referral Centre [SARC]) to decide if health assessment at the SARC is required. Outside of these ages please consider on a case by case basis, bearing in mind possibility of child sexual exploitation in older children.**

- Please give **genital warts leaflet** to families (BSUH Microguide > Paediatrics and Neonatology > Paediatrics > A > ano-genital warts leaflet).

- If genital warts are an incidental finding e.g. in theatre, please confirm clinical diagnosis (histology may be appropriate in these cases), arrange a paediatric assessment first as above. All cases 2yrs – 13yrs require referral to social care and a strategy meeting as above. It is the responsibility of the treating team to inform the family.

- If there are no acute medical / safeguarding concerns the child can go home and the outcome of the strategy meeting will be communicated to the family by CSC.

References can be found at the end of the AGW proforma

Management flowchart for anogenital warts 2yrs -13yrs.

Take full history including detailed **social and behavioural** history.

Enquire about oral or genital lesions in mother, index case and family members.

Information to be gathered at CED / RACH:

1. Check if Child Sexual Abuse (CSA) disclosure or professional concerns. Use AGW proforma on intranet.

- Sexualised / challenging behaviour
- Ano-genital discharge (unexplained)
- Other genital symptoms / PR bleeding

2. Initial check with social care relevant to geographical area.

3. Health visitor / school nurse referral + letter to GP (Symphony or Medway)

4. All cases to be discussed with Consultant (either CoW or CED)

Examination: Ensure the child has no injuries, especially in supra-pubic / genital / inner thigh region: **Consent and take clinical photography.**

Investigation: All children to have viral (& NAAT) and bacterial swabs of lesions unless clear AGW infection.

If unusual genital / anal discharge*, take **pink** NAAT swab for Chlamydia and gonorrhoea in girls, or urine in younger girls and boys.

*Features of unusual discharge: Profuse, Chronic, Strong/offensive smell, Green / Blood stained (anything other than scanty, white).

Ensure results of tests are going to be followed up by RACH team

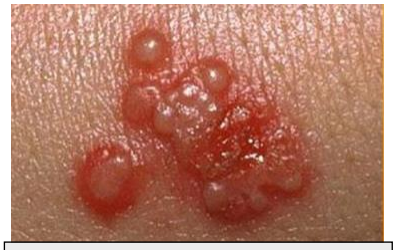
Suspected AGW

All GP cases will be referred to AGW clinic and *if confirmed AGW* needs social care referral followed by strategy meeting with SARC present.

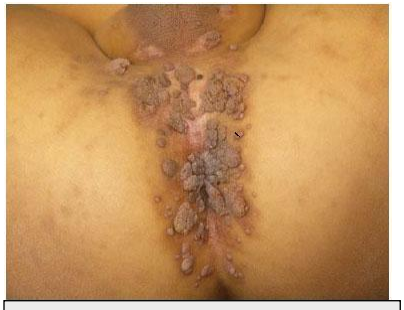
CED / ward cases – if confirmed AGW, social care referral followed by strategy meeting with SARC present.

MDT decision about where best for child to be seen.

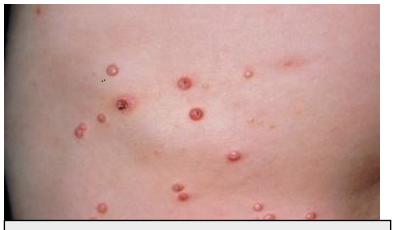
Consider treatment with Imiquimod



Herpes virus



Anogenital warts



Molluscum contagiosum

Dosing instructions for Imiquimod:

Prescribe 4 sachets only (1 month supply)

Open 1 sachet per week and use on Mon / Wed / Fri then discard

If any safeguarding or safety concerns at any stage, or an allegation/disclosure of sexual abuse, refer to the appropriate social care.

For further advice please contact the SARC Paediatrician (10:00 – 16:00 daily) Tel. 01273 242288