نحوه اپروچ به خانم ۴۰ ساله با ضایعات ناحیه تناسلی مراجعه کننده به درمانگاه پزشکی خانواده

استاد راهنما: خانم دکتر مهین بندریان، عضو هیات علمی گروه زنان

ارائه دهنده: دکتر حسین غلام‌زاده، کارورز پزشکی خانواده

Chief complaints

بیمار خانم ۴۰ ساله با شکایت ضایعات ناحیه تناسلی

Present illness

بیمار خانم ۴۰ ساله با شکایت از ضایعات ناحیه تناسلی از ۲ ماه پیش مراجعه کرده اند، کورایزا - ، ترشح واژینال - ، درد و سوزش واژن - ، دیزوری و علائم ادراری - ، زخم ناحیه تناسلی - ، تب - ، فارنژیت - , ضایعات مشابه در اطرافیان - ، سابقه تماس جنسی unsafe

PMH: (-)

SH: (-)

AH: (-)

DH: (-)

HH: (-)

FH: (-)

Physical Examination

بیمار خانم میانسال هوشیار و اورینته – toxic - ill

ملتحمه pale نیست

اسکلرا icteric نیست - کاشکتیک نیست

V/S:

BP:125/80 RR:17 T:36.8 PR:87 SPO2:96 %

سمع قلب S1 و S2 بدون سوفل

سمع ریه نرمال و قرینه بدون کاهش صدا

شکم بدون دیستنشن، ارگانومگالی، اسکار جراحی، نرم بدون تندرس ریباند و گاردینگ

معاینه اندام‌ها: نرمال ، نبض‌ها پر و قرینه

ضایعات وارت مانند به صورت منفرد و گروهی در ناحیه vulva، بدون درد و ترشح و اریتم

عدم وجود ضایعات مشابه در ناحیه انورکتال

DDX

GENITAL WARTS

Table 1. Differential Diagnosis of External Genital Warts

Condition	*Distinguishing features*	*Diagnosis*	*Treatment*
Condyloma lata	Warty white to gray plaque in moist mucous membranes; may secrete fluid	Examination for spirochetes; serology, including Venereal Disease Research Laboratory and rapid plasma reagin testing	Intramuscular penicillin (first-line therapy)[9]
Epidermoid cysts	Smooth compressible papule or nodule, often with a central punctum	Examination for a dilated central punctum	Surgical removal of cyst wall if symptomatic; otherwise, no treatment necessary[10]
Fordyce spots	Smooth, 1- to 2-mm, flesh-colored papules on the scrotum or labia	Examination	No treatment necessary[11]
Granuloma annulare	Smooth, often annular plaques	Biopsy required for genital lesions	Intralesional steroids[12]
Lichen planus	Smooth, purple, polygonal papules and plaques	History of pruritus; examination may reveal lacy white Wickham striae	Topical or intralesional steroids[13]
Molluscum contagiosum	Pearly, flesh-colored to brown papules with central umbilication	Examination is usually diagnostic; a short pulse of sprayed liquid nitrogen may reveal central umbilication	Cryotherapy, curettage, or imiquimod (Aldara)[14]
Pearly penile papules	1-mm white papules arranged circumferentially around the corona or sulcus of the glans penis	Examination	No treatment necessary
Seborrheic keratosis	Well-demarcated, rough, brown verrucous papules	Comedo-like openings and milia-like cysts on dermoscopy	No treatment necessary; cryotherapy and/or curettage for cosmetic treatment
Squamous cell carcinoma	May appear warty, leukoplakic, or sclerotic	Shave or punch biopsy required	Excision[13]
Vulvar intraepithelial neoplasia	Heterogeneous appearance, but may appear as a red, white, or pigmented irregular plaque on the vulva	Shave or punch biopsy required	Excision; laser ablation; topical therapy with imiquimod, fluorouracil, or other agents[15]

Information from references 8 through 15.

Introduction

Condyloma acuminata (genital warts) is a sexually transmitted infection that causes small, skin-colored or pink growths on the labia, or around or inside the anus. Although warts affect both genders, more women than men are diagnosed with warts.

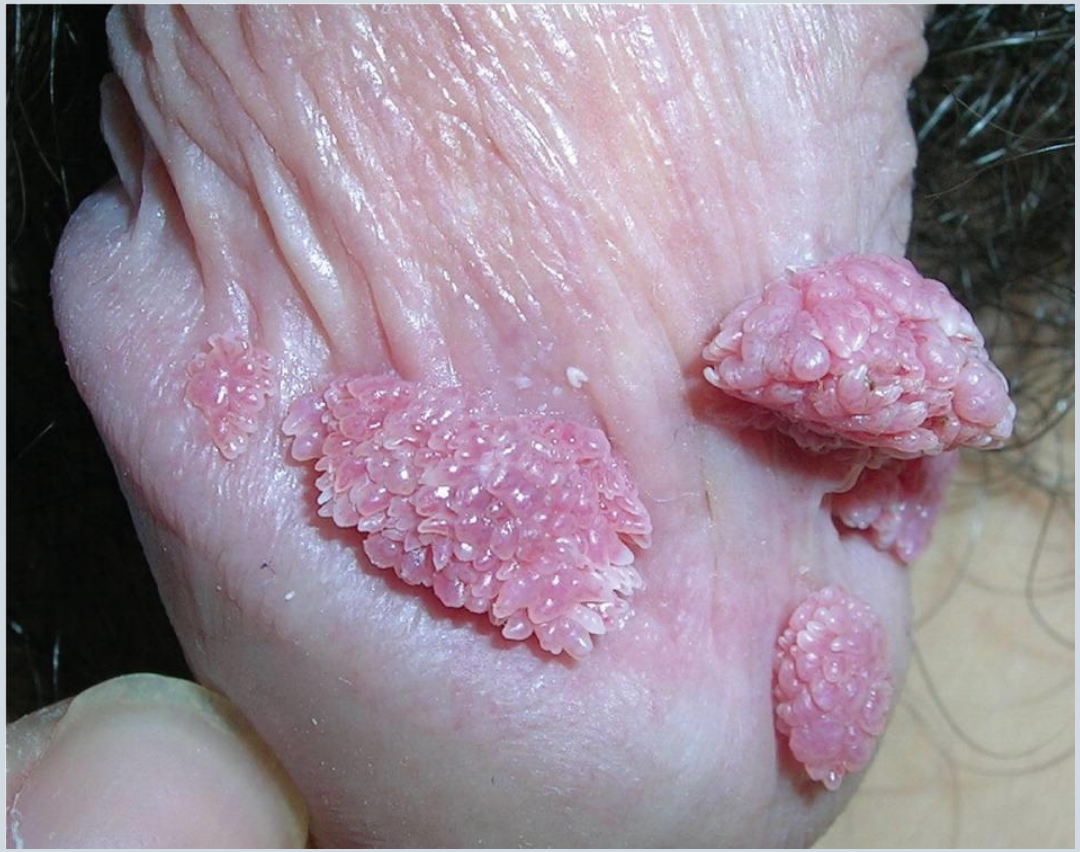
EPIDEMIOLOGY

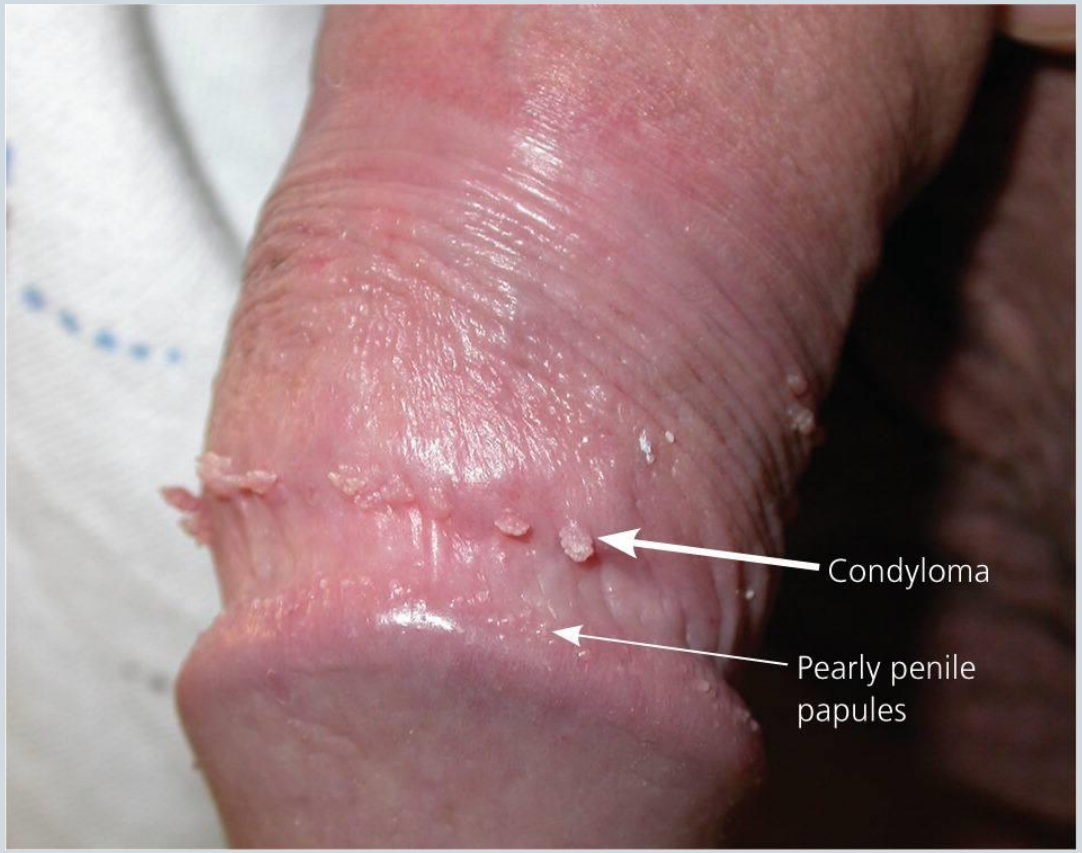
Human papillomavirus (HPV) infection is the most common sexually transmitted disease in the world . At least 75 percent of sexually active adults in the United States have been infected with at least one genital HPV type at some time . The estimated prevalence rate of HPV anogenital infection in the United States adult population is 10 to 20 percent among unvaccinated individuals .HPV infection rates are trending downward in countries where HPV vaccination has been implemented

GENITAL WARTS SYMPTOMS :

External anogenital warts are typically found on the vulva, penis, groin, perineum, perianal skin, and/or suprapubic skin. The warts can be single or multiple, flat, dome-shaped, cauliflower-shaped, filiform, fungating, pedunculated, cerebriform, plaque-like, smooth (especially on the penile shaft), verrucous, or lobulated. The color varies; warts may be white, skin-colored, erythematous (pink or red), violaceous, brown, or hyperpigmented. Anogenital warts are usually soft to palpation and can range from 1 mm to more than several centimeters in diameter. The warts are typically asymptomatic but may be pruritic.

External anogenital warts can be accompanied by involvement of the cervix or urethra . CA may also develop in the anal canal, typically manifesting as small flat-topped to globoid-shaped papules, usually distal to the dentate line. Extensive CA can cause marked disfigurement of the anogenital area and may interfere with defecation. Urethral warts may result in urethral bleeding (including bleeding during coitus) and, in rare cases, urinary obstruction. Most women with warts do not have any symptoms at all. Less commonly, there may be itching, burning, or tenderness in the genital area.




Condyloma
Pearly penile papules

CAUSES OF GENITAL WARTS

Genital warts are caused by the human papillomavirus (HPV). There are over 100 different types of HPV, which can cause different types of problems. HPV types 6 and 11 are the major causes of warts, and types 16 and 18 are the major causes of cervical cancer. The wart-producing strains of HPV do not typically cause cancer.

Transmission

HPV is spread by direct skin-to-skin contact, including sexual intercourse, oral sex, anal sex, or any other contact involving the genital area (eg, hand-to-genital contact). It is not possible to become infected with HPV by touching a toilet seat. Most people with the virus do not have visible warts, but can still transmit the virus. Treating the warts may not decrease the chance of spreading the virus. Therefore, all people who are sexually active should be regarded as potential sources of HPV, not just those with visible warts. Warts may appear weeks to a year or more after being exposed to the virus; it is not usually possible to know when or how you became infected.

RISK FACTORS

Sexual activity is the primary risk factor for anogenital human papillomavirus (HPV) infection. Immunosuppression is associated with the development of larger and more treatment-resistant CA, higher rates of recurrence, and malignant transformation of anogenital warts, Conditions like being infected with HIV, receiving immunosuppressive therapy or suffering from Diabetes. Smoking has been associated with increased risk for CA. Risk for CA may increase as the number of cigarettes smoked per day and number of pack-years increase. Male circumcision may reduce risk for HPV infection. The impact of male circumcision on risk for sexually transmitted infections is reviewed separately.

CLINICAL COURSE

After initial appearance, anogenital warts may increase in number and size or regress spontaneously. It is estimated that approximately one-third of anogenital warts regress without treatment within four months. Human papillomavirus (HPV) infection may persist despite resolution of visible warts and may result in wart recurrence. Recurrence rates are not well defined. Mechanical irritation, wounding, immunosuppression, inflammation, and other extracellular influences affect viral copy number in the latently infected cells and may predispose to reappearance

GENITAL WARTS TREATMENT

There are many ways to treat genital warts: some involve using a medicine and some involve a procedure. Even with treatment, it is possible that the warts will come back within a few weeks or months. This is because treating the warts does not necessarily get rid of all of the virus (HPV) causing the warts. Some cells in the normal-appearing genital skin and vagina may remain infected with HPV. There is currently no treatment that will permanently get rid of HPV in all infected cells, but most people will clear the virus and the warts with their own immune systems within two years.

AVAILABLE VACCINES

Three different vaccines, which vary in the number of HPV types they contain and target, have been clinically developed, although not all are available in all locations:

- Quadrivalent HPV vaccine (Gardasil) targets HPV types 6, 11, 16, and 18.
- 9-valent vaccine (Gardasil 9) targets the same HPV types as the quadrivalent vaccine (6, 11, 16, and 18) as well as types 31, 33, 45, 52, and 58.
- Bivalent vaccine (Cervarix) targets HPV types 16 and 18.

Females

Vaccination with 9-valent, quadrivalent, or bivalent HPV vaccine provides a direct benefit to female recipients by safely protecting against cancers that can result from persistent HPV infection. This preventive effect is most notable and best studied with cervical cancer, which is one of the most common female cancers worldwide. HPV types 16 and 18, which are targeted by all three HPV vaccines, cause approximately 70 percent of all cervical cancers worldwide, and HPV types 31, 33, 45, 52, and 58, which are additionally targeted by the 9-valent vaccine, cause an additional 20 percent. HPV types 16 and 18 also cause nearly 90 percent of anal cancers and a substantial proportion of vaginal, vulvar, and oropharyngeal cancers. Vaccination with the quadrivalent or 9-valent HPV vaccine also protects against anogenital warts (90 percent of which are caused by HPV types 6 and 11); although they are benign lesions, they are associated with physical and psychological morbidity and have a high rate of treatment failure. The adverse effects of HPV vaccination are generally limited to mild local reactions.

Males

HPV vaccination provides a direct benefit to male recipients by safely protecting against cancers that can result from persistent HPV infection. HPV types 16 and 18 cause nearly 90 percent of anal cancers and substantial proportion of oropharyngeal and penile cancers. Vaccination with 9-valent or quadrivalent vaccine also protects against anogenital warts (90 percent of which are caused by HPV types 6 and 11). The overall burden of HPV-associated cancers and precancers among males is less than the burden of cervical cancer in females. Nevertheless, despite a smaller direct absolute benefit of HPV vaccination in males compared with females, the overall benefit of vaccinating males outweighs its potential risks because of additional population benefits from herd immunity and the documented safety of HPV vaccines.

Indications and age range

Female: HPV vaccine is recommended at 11 to 12 years. It can be administered starting at 9 years of age, and catch-up vaccination is recommended for females aged 13 to 26 years who have not been previously vaccinated or who have not completed the vaccine series. Male: HPV vaccine is recommended at 11 to 12 years. It can be administered as starting at 9 years of age, and catch-up vaccination is recommended for males aged 13 to 21 years who have not been previously vaccinated or who have not completed the vaccine series.

The main reason that routine catch-up HPV vaccination is not recommended for individuals older than 26 years is the increased likelihood of prior exposure to HPV vaccine types with age, which reduces the potential individual benefit and thus the cost-effectiveness of HPV vaccination. However, for some individuals in this age group, such as those with no prior sexual experience or certain lifelong sexual monogamy, the risk of prior HPV exposure may be very low. We offer HPV vaccination to such individuals, as it may be beneficial if they are deemed to have a future risk of HPV exposure;

Optimal timing

Within the recommended age range, the optimal time for HPV immunization is prior to an individual's sexual debut. Clinical trial data of vaccine efficacy in males and females suggest that immunization with HPV vaccine is most effective among individuals who have not been infected with HPV (e.g., patients who are "HPV-naïve"). None of the available HPV vaccines treat or accelerate the clearance of preexisting vaccine-type HPV infections or related disease

Pregnant or breastfeeding females

HPV vaccination during pregnancy is not recommended because of limited information about safety; however, data from inadvertent use in this setting are increasingly available and reassuring. Thus, if a woman is found to be pregnant after initiating the vaccination series, she can be reassured that available evidence does not indicate any increase in risk of adverse pregnancy outcome with vaccination. Nevertheless, the remainder of the series should be delayed until the woman is no longer pregnant.

Preexisting HPV-associated disease

A history of genital warts, a positive HPV test result, or abnormal cervical, vaginal, vulvar, or anal cytology all indicate a prior HPV infection but not necessarily with the HPV types included in the vaccines. Vaccination is still recommended in individuals within the recommended age range who have evidence of prior HPV infection, as it can still provide protection against infection with HPV vaccine types not already acquired. However, these patients should be advised that vaccination will have no therapeutic effect on preexisting HPV infection or HPV-associated disease, and the potential benefit of HPV vaccination is not as great as if they were vaccinated before their sexual debu

Immunocompromised hosts

Immunocompromised patients, particularly transplant recipients and HIV-infected patients with CD4 cell counts <200 cells/microL, are at especially high risk for HPV-related disease. HPV vaccination with a three-dose schedule (at 0, 1 to 2, and 6 months) is recommended for all immunocompromised patients through 26 years of age if they have not already been vaccinated. Immunocompromising conditions that warrant this three-dose schedule include B-lymphocyte antibody deficiencies, complete or partial T-lymphocyte defects, HIV infection, malignant neoplasm, transplantation, autoimmune disease, and immunosuppressive therapy.

Malignancy

Cervical intraepithelial neoplasia (CIN) is a premalignant condition of the uterine cervix.The ectocervix (surface of the cervix that is visualized on vaginal speculum examination) is covered in squamous epithelium, and the endocervix, including the cervical canal, is covered with glandular epithelium. CIN refers to squamous abnormalities. Glandular cervical neoplasia includes adenocarcinoma in situ and adenocarcinoma. Screening tests for cervical cancer include cervical cytology and testing for oncogenic subtypes of human papillomavirus .Follow-up of abnormalities in screening tests with colposcopy and cervical biopsy may result in a diagnosis of CIN, glandular neoplasia, or cervical cancer.

Initial screening

In the United States, we recommend that cervical cancer screening be initiated no earlier than age 21 in immunocompetent, asymptomatic women. In such women, we suggest initiating screening at age 21, regardless of the age of initiation of sexual activity

Starting at age 21, women should be screened even if they report sexual abstinence. Women may have a variety of reasons for not disclosing prior sexual activity, including social, religious, or cultural norms as well as reluctance to acknowledge prior sexual abuse or rape. In particular, women who have been sexually abused or raped are often reluctant to acknowledge this history, and abuse may underlie the decision to not engage in subsequent sexual activity.

Women <30 years

We suggest screening women age <30 years with Papanicolaou (Pap) test alone at intervals of every three years. We suggest that women age <30 years not be screened with HPV testing (primary or co-testing). In such women, who are more likely to have transient HPV infections, the poor specificity and correspondingly poor positive predictive value limit the usefulness of HPV testing as a screening modality. Randomized trials have demonstrated that primary HPV testing in women <30 years of age results in substantial detection of transient HPV infections and unnecessary colposcopies

Women ≥ 30 years

We suggest women age ≥30 years and older be screened with either:

- Pap test every three years
- Co-testing (Pap test and HPV testing) every five years if both initial tests are negative HPV infection in women ≥30 years is more likely to be persistent and, therefore, has a greater likelihood of clinical significance. However, any strategy that includes HPV screening increases the number of positive results from screening and the number of colposcopies performed.

Discontinuing screening

The age to discontinue screening in older women depends on whether or not they have received adequate prior screening. Adequate prior screening — In general, we suggest not screening women aged 65 years and older provided they meet the following criteria:

- No increased risk (i.e., history of abnormal screening, current smoker or history of smoking, unknown screening history, previous HPV-related disease, new partners, immunocompromised, in utero diethylstilbestrol exposure).
- Adequate prior screening: two negative consecutive co-tests or three negative Pap tests within the past 10 years, with the most recent test within the previous five years .
- No history of high-grade dysplasia or worse.

For women 65 years and older who have undergone adequate prior screening, the harms of screening may outweigh the benefits. Older women are less likely to realize the benefits of screening because of competing causes of death. The incidence of cervical intraepithelial neoplasia (CIN) and carcinoma in situ peaks in the mid-reproductive years and begins to decline in the fourth decade of life . Cervical cancer is no more aggressive in older women, and high-grade lesions are rare among older women who have been previously screened.

Women with other risk factors

Even in older women who have been adequately screened, it may be reasonable to continue to screen those with good life expectancy who have risk factors for cervical cancer. Risk factors include a history of an abnormal Pap test, current smoker or history of smoking, previous HPV-related disease, or new partners. Potential screening benefits need to be balanced against the potential harms of cervical cancer screening in older women. We continue to offer screening to women with good life expectancy who have risk factors for cervical cancer until about age 80, but the upper age limit may vary with the risk factor (e.g., women with good life expectancy and a history of CIN 2 or greater should be screened for at least 20 years following diagnosis)

Cervical cancer screening recommendations from United States professional organizations*

Organization	Age to initiate	Age to discontinue	Recommended screening test and frequency		Post-hysterectomy for benign disease	HPV vaccination
			Age 21 to 29	Age ≥30		
ACS/ASCCP/ASCP (2012)	21[¶]	65[Δ]	Pap test every three years (preferred)	Co-testing (pap test and HPV testing) every five years (preferred) Pap test every three years	Not indicated[◇]	Same recommendations as unvaccinated women
ASCCP/SGO (2015 interim guidelines)	21	N/A	Can consider primary HPV testing every three years for women age ≥25	Can consider primary HPV testing every three years	N/A	N/A
USPSTF (2012)	21	65[§]	Pap test every three years	Pap test every three years Alternative: Co-testing (pap test and HPV testing) every five years[¥]	Not indicated[‡]	Same recommendations as unvaccinated women
ACOG (2016)	21	65[†]	Pap test every three years Can consider primary HPV testing every three years for women age ≥25	Co-testing (pap test and HPV testing) every five years (preferred) Pap test every three years Can consider primary HPV testing every three years for women age ≥25	Not indicated**	Same recommendations as unvaccinated women
ACP (2015)	21	65[§]	Pap test every three years	Pap test every three years Alternative: Co-testing (pap test and HPV testing) every five years[¥]	Not indicated[‡]	N/A

سطوح پیشگیری

۱. Primordial Prevention
۲. Primary prevention
۳. Secondary prevention
۴. Tertiary prevention
۵. Quaternary prevention

Primordial Prevention

۱. آموزش و فرهنگ سازی به منظور کاهش بروز روابط پرخطر

Primary prevention

۱. شروع واکسینایون HPVطبق گایدلاین

Secondary prevention

انجام غربالگری طبق گایدلاین برای تشخیص زود هنگام آلودگی پیش از بروز بدخیمی

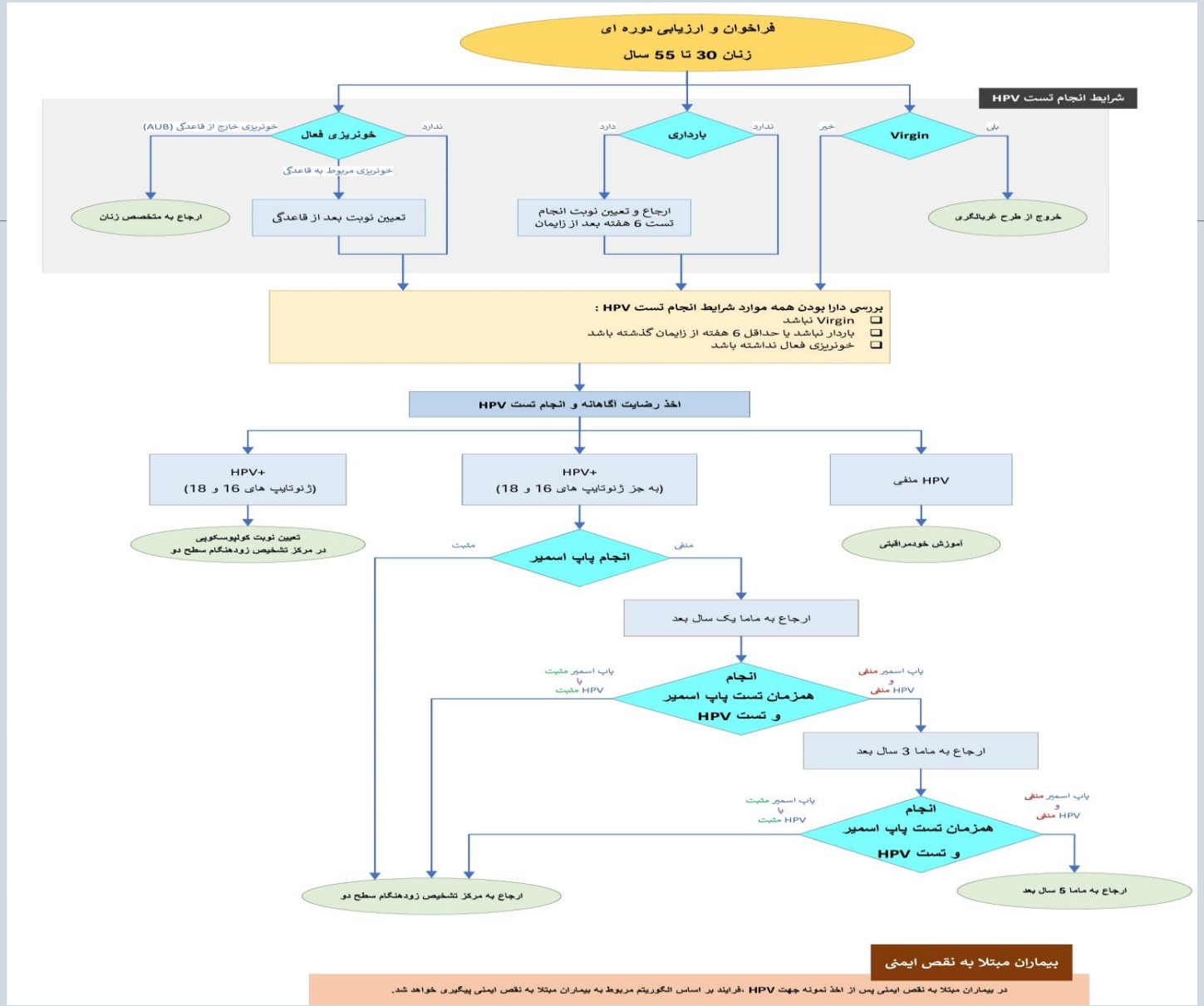
Tertiary prevention

آموزش علایم و تظاهرات بالینی جهت افزایش آگاهی مردم و مراجعه جهت دریافت درمانهای موجود مانند کرایوتراپی

توسعه درمانهای موجود در سطح کشور برای دسترسی آسان مردم

Quaternary prevention

عدم انجام اقدامات تشخیصی درمانی غیر ضروری


فراخوان و ارزیابی دوره ای
زنان 30 تا 55 سال
شرایط انجام تست HPV
Virgin
بلی
خیر
خروج از طرح غربالگری
بارداری
دارد
ندارد
ارجاع و تعیین نوبت انجام تست 6 هفته بعد از زایمان
خونریزی فعال
خونریزی خارج از قاعدگی (AUB)
خونریزی مربوط به قاعدگی
ندارد
تعیین نوبت بعد از قاعدگی
ارجاع به متخصص زنان
بررسی دارا بودن همه موارد شرایط انجام تست HPV :
Virgin نباشد
باردار نباشد یا حداقل 6 هفته از زایمان گذشته باشد
خونریزی فعال نداشته باشد
اخذ رضایت آگاهانه و انجام تست HPV
HPV منفی
HPV+
(به جز ژنوتایپ های 16 و 18)
HPV+
(ژنوتایپ های 16 و 18)
آموزش خودمراقبتی
انجام پاپ اسمیر
منفی
مثبت
تعیین نوبت کولپوسکوپی
در مرکز تشخیص زودهنگام سطح دو
ارجاع به ماما یک سال بعد
انجام
همزمان تست پاپ اسمیر
و تست HPV
پاپ اسمیر منفی
و
HPV منفی
پاپ اسمیر مثبت
یا
HPV مثبت
ارجاع به ماما 3 سال بعد
انجام
همزمان تست پاپ اسمیر
و تست HPV
پاپ اسمیر منفی
و
HPV منفی
پاپ اسمیر مثبت
یا
HPV مثبت
ارجاع به ماما 5 سال بعد
ارجاع به مرکز تشخیص زودهنگام سطح دو
بیماران مبتلا به نقص ایمنی
در بیماران مبتلا به نقص ایمنی پس از اخذ نمونه جهت HPV ،فرایند بر اساس الگوریتم مربوط به بیماران مبتلا به نقص ایمنی پیگیری خواهد شد.