Guidance for the Management of Ano-genital Warts in Pre-Pubertal Children

1.0 Introduction

- Sexual abuse must be considered in any child presenting with ano-genital warts (AGW).
- Ano-genital warts are not commonly found in pre-pubertal children.
- In adults they should always be considered a sexually transmitted infection.
- Children will present to clinicians in a variety of health settings with AGW, a proportion, but not all of these children, will have been sexually abused.
- A specialist assessment by a paediatrician with expertise in child sexual abuse work is necessary for all pre-pubertal children.

2.0 Guideline scope

This guideline can be used for pre-pubertal children presenting with AGW across the North East region together with guidance from the Paediatric Forensic Team, local safeguarding procedures & Royal College of Paediatricians and Child Health (2015).

Guideline may be useful to Paediatricians, General Practitioners and all front line health professionals. Users should be mindful that this is a guideline and not a protocol.

Young teenagers may disclose consensual sexual activity as a route of infection. This should be explored using the usual tools for assessing safety of sexually active in young teens including sexual exploitation questionaires, available through your local Trust. Medical assessment may then be more appropriately undertaken by sexual health services.

Guideline does not replace your statutory responsibilities around safeguarding children as laid out in multi-agency Local Safeguarding Children Partnership procedures.

3.0 Background

- Ano-genital Warts (AGW), also known as condyloma acuminata, are caused by the human papilloma virus (HPV). They are the most common clinical presentation of genital HPV infection, the majority being latent and sub clinical.
- In adults, AGW infection can be transient or latent for many years.
- In children, neither the true incubation nor latency period is known.
- AGW are documented to regress or resolve spontaneously in children and adults.
- Many people infected with genital wart virus will never develop visible warts but can still transmit the virus.
- In adults, AGW are acquired through sexual transmission and most adults have been exposed to and carry sub clinical HPV.

In children 4 mechanisms of transmission have been proposed:

- **Sexual contact**
  - This can be by direct genital to genital contact or more rarely via sex toys.

- **Vertical transmission**
  - from an infected mother- the likelihood of this mode of transmission is thought to be higher the younger the child at presentation.
  - This can be a mode of transfer even in children who are born via Caesarean section.

- **Autoinoculation**
  - from the virus coming into contact with a child's hand and then being transmitted by the child themselves to the ano-genital area.

- **Hetero-inoculation**
  - contact between the ano-genital region and infected care giver through normal care e.g. at nappy changing).

Currently evidence only exists for vertical transmission and sexual transmission.

Sexual abuse must be considered in all cases, but the route of transmission is often unclear and may never be confirmed beyond doubt.

Sexual abuse is more likely to be confirmed in older children who are able to give a description of their abuse rather than in pre-verbal children.

In children under 24 months old, prenatally acquired infection is more likely, based on age alone; however clinicians must still consider all other safeguarding factors.

In children over 24 months, the likelihood that transmission has been perinatal is less. The possibility that warts have been sexually transmitted increases.

The evidence does not help to establish the age at which the possibility of vertical transmission can be excluded.

There is no good evidence that typing of HPV is of value in the diagnosis of sexual transmission.

4.0 What to do when presented with a child with AGW?

4.1 Referring clinician (e.g. GP, general paediatrician) should take a full safeguarding paediatric history:

Key points to include:

- Age at which AGW first appeared
- Associated symptoms, e.g. pain, itching, bleeding, discharge etc.
- Parental history of warts, including AGW/ abnormal smears etc.
- Detailed family and social history including of vulnerabilities, e.g. parental mental health concerns, domestic abuse, learning difficulties
- Any changes in the child's behaviour.
- Risk of sexual abuse should be sensitively explored with the child, separately if appropriate, and the presenting adult.
- Consider the child's behaviour, parent-child interaction and general wellbeing.
- Consider additional information available e.g. through the health visitor in children under age 5 years and in school age children from the school nurse (if involved), GP records, Great North Care Record or Emergency Department information etc.

4.2 Immediate Safeguarding Concerns

If there are any **immediate safeguarding concerns** for the child or the wider family, the **referring clinician must refer to Children's Social Care immediately** so these risks can be appropriately explored, e.g. in a situation where there is a disclosure from a child or concern from parent or professional of sexual abuse.

If concerns of sexual abuse are high, a strategy meeting may be convened by children's social care and referral for sexual abuse medical assessment may be arranged. The child is likely to be booked into a local non-recent (previously known as historic) CSA clinic, and appointment progressed with social worker input. Occasionally this will be done urgently through the Paediatric Forensic Network (see Regional Referral Pathway for Child Sexual Abuse (CSA) Forensic Medical

Assessment) where there are significant concerns about recent (within the last 7 days) and/or ongoing sexual abuse or the child has significant medical symptoms.

4.3 No Immediate Safeguarding Concerns

If there are no immediate safeguarding concerns, a referral should be made to the local paediatrician with expertise in the assessment of genital problems in children.

A holistic assessment will be performed by a clinician who can confirm the diagnosis and assess for physical signs of sexual abuse and undertake a Sexually Transmitted Infection screen.

The examining paediatrician will subsequently send clinic letter to: GP, Health Visitor (for children < 5 years old) or School Nurse for children >5 years& any other relevant professional if involved.

In the majority of cases, the paediatrician with expertise in the assessment of genital problems in children will make a referral to children's social care for further exploration of safeguarding risk, when the child is seen for assessment.

In young babies, a referral may not be appropriate but liaison with the health visitor should occur and documentation clearly recorded.

SEE APPENDIX 1

5.0 Management

5.1 Maternal Screening

If vertical transmission is thought to be likely, the child's mother needs to ensure she is up to date with cervical screening. The HPV subtypes that classically cause visible AGW in adults are not oncogenic but other HPV subtypes may also be present.

5.2 Treatment

Various treatment options exist:

Active Monitoring

- Spontaneous resolution of warts does often occur.
- If asymptomatic consider observation without active treatment for 6 months.
- Warts may recur after regression, without additional abuse.

Treatment Modalities

- If active treatment is necessary, medical treatment with topical therapy can be commenced. Topical cream, Imiquimod, is used as first line treatment.
- If there are many lesions and they are significantly symptomatic i.e. child has pain, bleeding and/or irritation, surgery may be indicated.
- Consider early HPV vaccination in cases of persistent warts in children aged 9 and above

6.0 References

- The Physical signs of Child Sexual Abuse, RCPCH May 2015
- UK National Guideline on the Management of Sexually Transmitted Infections and Related conditions in Children and Young People- 2010
- St Mary's Sexual Assault Referral Centre, Ano-genital Warts in prepubertal Children: referral and management guidelines
- NICE Clinical Guideline 89, When to suspect child maltreatment July 2009
- Northumbria Healthcare Ano-genital warts in pre-pubertal children guideline Dec 2015.
- Genital warts in children: what do they mean? Y Jayasinghe, S M Garland

APPENDIX 1

Guidance for the Management of Ano-genital Warts (AGW) in Children

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- Detailed family and social history including of vulnerabilities, e.g. parental mental health concerns, domestic abuse, learning difficulties
- Any changes in the child's behaviour.
- Risk of sexual abuse should be sensitively explored with the child, separately if appropriate, and the presenting adult.
- Consider the child's behaviour, parent-child interaction and general wellbeing.
- Consider additional information available e.g. through the health visitor in children under age 5 years and in school age children from the school nurse (if involved), GP records, Great North Care Record or Emergency Department information etc.
- ***Referrer to do background check with children's social care (this is not a referral).***

Immediate concerns about sexual or other forms of abuse or neglect identified?

YES

Referrer to make immediate referral to Children's Social Care following usual safeguarding procedures.

NO

- **Referrer does NOT need** to make a referral to Children's Social Care.
- **Referrer to made referral to local paediatrician** with expertise in the assessment of children's genital problems/ sexual abuse.
- Dr Hiley James Cook Hospital 01642 854868

Advice

Can be sought from local paediatrician with genital/sexual abuse expertise or via Paediatric Forensic Network 0191 282 4753