Warts and All

If you thought teenage acne was tough, HIV has an unsightly surprise in store for you

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Warts might not be the most serious of the HIV skin reactions—think shingles, KS lesions, drug rashes—but unless you wear a pointy hat and travel by broom, the last thing you want to find on your body is a wart or a molluscum cluster. Unfortunately, if you're HIV positive, chances are you will someday battle these ugly little suckers that work wonders at undermining morale, self-esteem and sex appeal.

If treated promptly and regularly, they can often be relegated to the realm of minor nuisance, but if denial is your preferred method of treatment, these epidermal invaders can literally take over your body. Barton Benes, a New York City–based artist whose "Lethal Weapon" exhibition featured squirt guns and Molotov cocktails full of his HIV-infected blood, wishes he hadn't ignored that tiny growth on his toe: After four doctors and a major operation on his eventually massive plantar warts, Benes is just now walking again.

Both warts and molluscum are caused by viruses that hijack the skin cells' replication machinery, causing the cells to grow out of control to sizes ranging from head-of-a-pin to golf ball. You know a wart when you see one, but molluscum is typically a smooth papule with a solid white core that generally appears in clusters. Sometimes a problem for immune-competent people, they can wreak havoc on the immunocompromised, affecting the feet, hands, lips, mouth, face, genitals and rectum.

The old wives' tale of catching warts from a toad is pure fiction; it's people you need to worry about, not Kermit the Frog. Human papilloma virus (HPV)—warts to you—and *molluscum contagiosum* (MC) are, as MC's Latin name implies, easily spread by physical contact. No exchange of bodily fluids is required here: Sharing towels can spread these viruses. And just say no to the steam room—the little buggers love a damp climate. The growths may be too small to see upon visual inspection, so avoiding skin-to-skin contact is the best way to ward them off. If your sexual partner also has HPV or MC, the virus will be passed back and forth, and both of you need to be treated. (Keep in mind that although condoms aren't completely effective against the transmission of HPV and MC, they may provide some level of protection against transmission of HPV to the cervix and anal area, reducing the risk of HPV-associated cancer.)

Men with facial molluscum or warts often stop shaving—not an attempt to conceal the evidence

under facial hair, but doctors' orders to avoid the virus that's unleashed and spread around the face each time a papule is nicked. After four years of molluscum madness, New York City AIDS activist Stephen Gendin is a self-described "world expert" on the matter. For two years, Gendin has sported a stylish two-day stubble, forgoing an old-fashioned shave in favor of the beard-trimmer attachment on his electric shaver.

Grooming aside, there are treatments available. The therapy for both warts and molluscum is determined by location, size, depth, number of lesions and the patient's personal treatment preference and tolerance for pain. For starters, treatments run hot and cold: Cryotherapy—you might indeed shed tears—freezes off the growths with applications of liquid nitrogen, and hyfercation (also called electrodesiccation or cauterization) burns off growths with an electric needle. If you want to feel the burn but aren't into needles, there are topical applications designed to fry the growths, including trichloroacetic acid, podophyllin and podofilox 0.5 percent (Condylox). High-techies may opt for a carbon dioxide laser zap, while curettage is a back-to-basics manual scraping-off of the growths with tiny, specialized instruments. Spot chemotherapy requires the injection of bleomycin or interferon into the wart or molluscum, but interferon may not be effective in patients with fewer than 200 CD4 cells.

Side effects of the above therapies differ drastically. Cryotherapy used on the cervix can cause a watery discharge for a few weeks after the procedure. Podophyllin can cause scarring, fever, nausea and vomiting, confusion, even coma or renal failure. And laser therapy often leads to local pain, vaginal discharge, and itching or swelling.

The news on the systemic drug front is less encouraging. Though several options to combat warts and molluscum exist, introduced orally or by injection, none are very successful. Dr. Sanford Schnoll, a San Francisco dermatologist specializing in HIV-related skin disorders, has tried Tagamet, an ulcer medication that is sometimes used in children with HIV to help stimulate their immune systems, but reports minimal results. Schnoll also uses Accutane, a Vitamin A synthetic analogue initially developed to treat acne cysts, though his experience has been that, on its own, Accutane is not very effective. In addition, it's loaded with side effects: Possible elevation in liver functions, elevated triglyceride levels and severe dryness (particularly for PWAs) of the lips, eyes, nose and anus.

For the time being, don't obsess about which treatments are the "best"—focus instead on what course of action is best *for you*. When treating a wart or molluscum, the goal is to be aggressive enough to eradicate contaminated cells, while destroying as little of the surrounding tissue (your face, for example) as possible.

Success varies from person to person and from growth to growth. For example, while Dr. David Colbert, a New York City dermatologist and internist who primarily treats HIV-related cases, reported success in injecting foot warts with bleomycin, the same treatment did nothing for Barton Benes' gargantuan plantar warts.

For large numbers of facial molluscum papules or warts, Colbert favors electrodesiccation followed

by curettage, with a periodic chemical peel. Sounds almost like a facial—not! Similarly, Schnoll believes that beard-zone molluscum should not be treated by freezing because of the risk of scarring. His solution involves injections of lidocaine (anesthesia), after which he scoops out the core—the instrument looks like a tiny melon scoop—then lightly burns the base so that remaining viral particles can't regenerate.

Manhattan-based cosmetic surgeon Jeffrey Brande, MD, receives many referrals for severe HIV-related wart cases because the laser procedure he uses for cosmetic surgery can also be used in treating warts. Brande believes in an "all-out attack" against warts, often deploying a combination of interferon injections, laser treatments and surgery. It was Brande who finally solved the problem of Benes' wart, after two podiatrists "made a mess" of his foot and a dermatologist unsuccessfully tried curettage and bleomycin injections. Under Brande's care, Benes received interferon injections three times each week for several months, followed by laser surgery. After a six-week healing period, the injections will begin again—along with side effects such as high fevers and chest pains.

Interferon helped restore a smile to the face of another PWA. While taking Doxil to treat KS lesions, Chicago-based PWA Alan Stewart (not his real name) developed a mouthful of warts. In his year long ordeal trying to rid himself of them, Stewart tried chemo injections, freezing and laser. "It was extremely painful, and I couldn't brush my teeth," he says. "It would take 10 days to two weeks to heal. What finally worked were intralesional interferon injections."

According to Stephen Gendin, it's all about your pain threshold. "Many people try all the treatment methods and discover which works best versus how much pain they're willing to put up with," Gendin says. "For me, scraping was the most effective, but also the second most painful. Liquid freezing is less painful but less effective. Sometimes I'm already in a bad mood or not physically strong, and I can't bear going through the scraping, so I'll have the freezing method."

Though tougher mortals may be able to undergo some of these procedures without numbing, most doctors use a local anesthestic beforehand. "One of the big mistakes in treating molluscum [and warts] is inadequate anesthesia," Dr. Schnoll says. EMLA cream (lidocaine 2.5 percent and prilocaine 2.5 percent), a topical anesthetic originally developed for children receiving shots, can partially numb the wart or molluscum if applied to the area an hour before treatment. "If the treatment hurts the patient, the doctor is reluctant to be aggressive and go deep enough to do the job. Therefore it grows back," says Schnoll.

And grow back they do: Give the bastards an inch, and they'll take a foot. . . or a hand, a scrotum, a vulva—anyplace inconvenient. Most of the time, warts and molluscum papules reappear after treatment, and must be zapped again. The bigger they are the more difficult they are to treat, and the bigger scar they leave. Several patients on the "AIDS cocktail" report that the size and frequency of molluscum papules and warts decreased as their immune systems improved. But if the HIV virus has already killed off all the wart- or molluscum-specific CD4 cells (clonal deletion), then a CD4 surge might not be enough to end the battle.

In the past four years, Stephen Gendin has visited his dermatologist over a hundred times, averaging an appointment every two to three weeks. “It’s frustrating because many of my molluscum papules are small, and for the few days following the treatment, the scabs look worse than the molluscum,” he said. “Sometimes after an appointment I look like the world’s worst shaver, with 30 scabs on my face. For three or four days afterward I don’t go out in public, but I have little scarring.”

In addition to a primary care doctor, it’s important that anyone suffering from HIV-related skin problems regularly visit a dermatologist. Most general practitioners have minimal training in dermatology, and a skin disorder might easily be overlooked or misdiagnosed. Often GPs are so focused on fending off the more life-threatening opportunistic infections that they disregard warts and molluscum, which can be a serious—and occasionally fatal—mistake.

Seemingly simple warts in the mouth, anus or genital region may sometimes be secondary symptoms of syphilis or histoplasmosis. Several doctors described cases of patients being treated for warts when it turned out they had syphilis (which a PWA with warts or molluscum should always be tested for), and vice versa. Moreover, “I had a case where a patient came to me after his GP mistakenly diagnosed him with molluscum, saying it would go away,” Colbert says. “Subsequently, it turned out the patient had histoplasmosis, a deep fungal infection that eventually spread through his body and killed him.”

Benes agrees. “Take care of all warts right away,” he says. “I never imagined they would spread like they did. Forget going to a podiatrist or GP. I should have immediately gone to a dermatologist who deals with HIV.”

If you’re looking for the silver lining in this cloud of epidermal S&M, it’s that (depending on how large and deep the growth) the skin usually heals within several days to a week, and with minimal scarring in Caucasians; darker skin pigmentation tends to scar more often, with noticeable skin discoloration.

It’s a fight, but there is hope on the horizon: Gilead Sciences in San Francisco is currently experimenting with a topical form of cidofovir (Vistide), an anti-CMV drug, to see if it affects warts and molluscum. Cidofovir is the first HPV therapy that attacks the virus itself, protecting uninfected cells and early results are very promising. Warts have been completely eliminated in some PWAs, and greatly reduced in many others. Another possibility is imiquimod (Aladar), which induces local production of interferon.

Meanwhile, Alan Stewart is all smiles again. His oral warts are now finally under control, although his lips—both inside and out—remain extremely cracked and dry as a result of the ravaging his mouth underwent, requiring frequent applications of Vaseline. Still, the wart nightmare is behind him: Stewart is ready for his close-up, Mr. DeMille. Or maybe even a kiss.
