An Alternative Method for the Treatment of Flat Warts with Cantharidin: Letter to the Editor

Yassı Siğillerin Kantaridin ile Tedavisi için Alternatif Bir Yöntem

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Geliş Tarihi/*Received:* 05.11.2008
Kabul Tarihi/*Accepted:* 12.11.2008

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Key Words:
Cantharidin; warts

Anahtar Kelimeler:
Kantaridin; siğiller

Cantharidin, a vesicant produced by beetles in the order Coleoptera, has a long history both in folk and traditional medicine. In dermatology, topical cantharidin has long been used as a vesicant for the treatment of benign epithelial growths.[1] As the blistering is within the epidermis, scarring generally does not develop due to this treatment, even in more exuberant reactions.[2] There is no pain from application of cantharidin, though blister formation can be painful.[3] The development of annular warts following therapy has been reported.[3,4]

Our recent article on cantharidin was the first to report it as an effective and safe therapy for facial recalcitrant flat warts in children and adults if applied without occlusion for 4-6 hours every 3 weeks until clear by avoiding contact near the eyes and eyelids to prevent scleral erosion.[4] In addition, our study demonstrated that occurrence of annular warts might be prevented by applying cantharidin to the wart and a 1 mm rim of surrounding normal-appearing skin. We discovered that the lack of pain during the procedure was preferred by children and even adults, therefore cantharidin might be considered as a valuable therapy for flat warts.

We had additional experience with 20 adult patients (12 male and 8 female with an average age of 28 ± 5), seen in our dermatology department, who had recalcitrant flat warts situated on the arms and trunk. We treated warts with a proprietary formulation containing cantharidin 0.7% solution in an adherent film forming vehicle containing acetone according to the methodology we previously described.[4] The application was performed with the blunt wooden end of a cotton-tipped applicator to each lesion and a 1 mm rim of surrounding normal-appearing skin and with treatment of a maximum of 5 lesions per session. Patients were observed until the liquid film dried and lesions were not covered with occlusive tapes. After the blister formation, we proceeded with curettage within 2 days and the use of a topical antibacterial agent was recommended. This method was preferred if alternative treatments failed or if partial response was achieved after one session with cantharidin

therapy without curettage. In our experience, no scarring or annular warts were seen after therapy which was very well tolerated by the patients. Generally one session was enough for the treatment of lesions. This method was not performed in pediatric population because of the emotional trauma and the pain which may develop during the procedure. We suggest that curettage following cantharidin treatment is an alternative safe and effective method of cantharidin use which should be considered for the treatment of recalcitrant flat warts as well as hyperkeratotic common warts.

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