Molluscum contagiosum is a common pox virus infection of the skin

- **Children** are most often affected, particularly if there is a background of eczema
- It gives a characteristic papular eczema
- Lesions are small, hard, firm and show central umbilication (a dimple)
- They often occur in clusters
- Common sites include the axilla, popliteal fossa and groin (photo)
- Typically, the papules are asymptomatic but if they develop a secondary infection or if eczema develops on the surrounding skin then they can be itchy or irritating
- Lesions and will often become inflamed before a resolution is noted

**When to refer:**
(Referral is rarely needed)

- Diagnostic uncertainty
- Extensive, painful, inflamed or persistent lesions (>18 months)
- Lesions warranting treatment where topical hydrogen peroxide or potassium hydroxide is ineffective, poorly tolerated or contraindicated
- Immunosuppressed patients with extensive lesions
- Widespread/anogenital molluscum
- Consider referral to ophthalmology if eye lesions as it can be associated with conjunctivitis

**Complications:**
- Children may develop eczema around the molluscum papules which can be treated with emollients and mild topical steroids if needed. (Potent topical steroids may encourage the spread of molluscum)
- Secondary infections/impetigo may be related to scratching
- Lesion near the eye may cause conjunctivitis
- Scarring

**Treatment:**

- No single treatment is convincingly effective.
- Topical 5% potassium hydroxide (Molludab) is available in the community to purchase over-the-counter (OTC) as an off-license treatment which can be offered/suggested prior to considering referral
- 1% hydrogen peroxide (available OTC as Crystacide cream) may be used for the face
- Anogenital molluscum contagiosum can be treated with podophyllotoxin paint once a week and in adults would warrant referral to a genitourinary medicine clinic.
- **Cryotherapy** with liquid nitrogen is rarely considered due to scarring risk but may be an option for older children with papules in cosmetically sensitive locations, however the risk of scarring normally outweighs the short-term benefit.

**General advice for patients:**

- In the majority of cases no treatment is needed as the rash will spontaneously resolve. Treatments may increase the risk of scarring and therefore reassurance is the mainstay of treatment
- Most individual lesions resolve within a few months but as it often spreads to different areas of the body through autoinoculation, it can take 12-18 months to completely clear
- Reduce the risk of passing on the infection by avoiding sharing towels and sponges
- Transmission is through close direct contact and contaminated objects. Patients remain infective until the skin is clear of papules
- No need to exclude from school, swimming or sports

Images courtesy of DermNet NZ and Wikipedia