2001 National Guideline on the Management of Molluscum Contagiosum.

Clinical Effectiveness Group (Association for Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases).

Aetiology.

- Molluscum contagiosum is caused by a poxvirus.
- The virus is probably passed on by direct skin-to-skin contact, and may affect any part of the body.
- Sexual contact may lead to the appearance of lesions in the genital area.
- There is anecdotal evidence associating facial lesions with HIV-related immunodeficiency (1,2).

Clinical features.

Symptoms and Signs.

- After an incubation period of three to twelve weeks, discrete pearly, papular, smooth or umbilicated lesions appear (3).
- In immunocompetent individuals the size of the lesions seldom exceeds five millimetres, and if untreated there is usually spontaneous regression after several months.

Complications.

- In the immunocompromised, eg those with HIV infection, lesions may become large and exuberant, and secondary infection may be problematic.

Diagnosis.

- This is usually based on characteristic clinical appearance.
- The core of lesions can be sent for examination by electron microscopy, under which typical poxvirus- like particles will be seen.

Management.

General Advice.

- As the natural history is of spontaneous regression of lesions, treatment is offered for cosmetic reasons only.

Further Investigation

- As other STI's may co-exist, a full screen for these should be undertaken (4).
- In patients presenting with facial lesions, consideration should be given to HIV testing (1).

Treatment.

The aim is tissue destruction, with viral demise accompanying this.

Recommended regimens.

- Cryotherapy - apply the tip until a halo of ice surrounds the lesion. Repeat applications may be necessary (level of evidence 4, grade of recommendation C).
- Expression of the pearly core, either manually or using forceps (level of evidence 4, grade of recommendation C).
- Piercing with an orange stick, with or without the application of tincture of
- iodine, or phenol (level of evidence 4, grade of recommendation C).
- Curettage or diathermy may be carried out under local anaesthesia (level of evidence 4, grade of recommendation C).
- Podophyllotoxin cream (0.5%) can be self-applied in men (level of evidence 1b, grade of recommendation A).(5)
- Imiquimod cream (1%) can be self-applied in men (level of evidence 1b, grade of recommendation A).(6). NB. Currently unlicensed in UK for this indication.

In patients with HIV infection, the introduction of highly active antiretroviral therapy may lead to the resolution of lesions (level of evidence III, grade of recommendation B). (7,8)

Pregnancy and Breastfeeding.

- Cryotherapy and other, purely mechanical methods of destruction are safe.
- Podophyllotoxin should not be used.

Sexual partners.

- There is no evidence to indicate a need for contact tracing, unless another STI is diagnosed.

Follow-up.

- No specific follow-up is indicated.
- Patients may wish to return for further treatment of lesions.

Auditable outcome measures

- Number of patient attendances to achieve resolution

Acknowledgements.
None.

Author and Centre.
Gordon Scott, Edinburgh Royal Infirmary

Membership of the CEG
Clinical Effectiveness Group: Chairman, Keith Radcliffe (MSSVD); Imme Ahmed (AGUM); Jan Welch (MSSVD); Mark FitzGerald (AGUM); Janet Wilson (Royal College of Physicians GU Medicine Committee).

Conflict of Interest.
None.

Evidence Base.
Medline search strategy
Years covered 1966-1997
Key terms - molluscum contagiosum, molluscum contagiosum/dt, and molluscum contagiosum/th.
One controlled trial on the use of podophyllotoxin, and one controlled trial on the use of imiquimod were found.
Nothing was found in the Cochrane databases.

References
1. Schwartz JJ, Myskowski PL. Molluscum contagiosum in patients with human immunodeficiency virus infection. J Am Acad Dermatol 1992;27:583-8.

2. Goldstein B, Berman B, Sukenik E. Correlation of skin disorders with CD4 lymphocyte counts in patients with HIV/AIDS. J Am Acad Dermatol 1997;36:262-4.

3. Gottlieb SL, Myskowski PL. Molluscum contagiosum. Int J Dermatol 1994;33:453-61.

4. Radcliffe KW, Daniels D, Evans BA. Molluscum contagiosum: a neglected sentinel infection. Int J STD AIDS 1991;2:416-8.

5. Syed TA, Lundin S, Ahmad M. Topical 0.3% and 0.5% podophyllotoxin cream for self-treatment of Molluscum contagiosum in males. Dermatology 1994;189:65-8.

6. Syed TA, Goswami J, Ahmadpour OA, Ahmad SA. Treatment of molluscum contagiosum in males with an analog of imiquimod 1% in cream: a placebo-controlled, double-blind study. J Dermatol 1998;25:309-13.

7. Hicks CB, Myers SA, Giner J. Resolution of intractable molluscum contagiosum in a human immunodeficiency virus infected patient after institution of anti-retroviral therapy with ritonavir. Clin Inf Dis 1997;24:1023-5.

8. Calista D, Boschini A, Landi G. Resolution of disseminated molluscum contagiosum with Highly Active Anti-Retroviral Therapy (HAART) in patients with AIDS. Eur J Dermatol 1999;9:211-3.