MOLLUSCUM CONTAGIOSUM

Molluscum is a benign viral skin infection that is caused by a DNA pox virus.
It commonly occurs in one of three settings:

- Acquired through direct close physical contact or fomites, or through contact with contaminated objects e.g. towels, bedding. The incubation period can vary between 7 days and 6 months. Can affect adults, but 90% of cases presenting to GPs are in those under 15 years. Typically, the face, neck, trunk and/or limbs are affected
- Acquired as an STI through sexual contact, usually in young adults. Lesions typically affect the genitals, pubis, lower abdomen, upper thighs and/or buttocks
- Severe Molluscum infection in immunocompromised states can be significantly more aggressive and widespread, presenting with 100 or more lesions in one individual and progressing as confluent, coalescing plaques. Notably seen in late-stage HIV disease.

Diagnosis:

Characteristic discrete smooth-surfaced papules, often with an umbillicated centre. Usually 2-5mm in diameter (can be much bigger if immunocompromised), and vary from pearly white, to yellow to pink in colour.
No need for laboratory confirmation.
It can be associated with eczema, may be itchy, and can be secondarily infected.

Management:

- Offer STI testing if appropriate.
- Most lesions spontaneously regress/crust over in 3-9 months, although secondary bacterial infection can occur if lesions are scratched.
- Immunocompetent clients can be reassured that lesions usually resolve and treatment is not necessary.Treatment may be requested for cosmetic reasons .
- In adults with facial lesions , extensive or very large lesions, consider HIV testing.
- In clients with immunodeficiency due to HIV infection, anti retroviral therapy may assist in resolution of lesions.

General Advice:

- Patients must be warned of risks of autoinoculation and, for example, advised against shaving or waxing their genital regions, to prevent further spread of lesions. Similarly, patients should be advised against squeezing molluscum spots, both due to risk of super-infection and also as the central plug is full of infectious virus which is easily spread to uninfected skin.

- Towels, bed-linen, clothes etc. should not be shared when active lesions are present, to reduce risk of onward transmission.

- Lesions should be covered with waterproof bandages or clothes, if possible, prior to using swimming pools.

- With genital molluscum, condoms may reduce transmission, but this is not absolute.

Treatment:

- Immunocompetent clients should be reassured and await spontaneous regression.
- If treatment is requested, discuss the risks of treatment versus awaiting spontaneous regression
    - Cryotherapy with liquid nitrogen can be offered as a single treatment. The aim is tissue (viral) destruction. This is suitable for pregnant women. Apply for 5 – 10 seconds. There are no reported trials on its efficacy in treatment of molluscum. Clients should not be offered return weekly cryotherapy courses for molluscum.
    - Podophyllotoxin cream (0.5%) for men and non-pregnant women). There is one randomised controlled trial demonstrating the efficacy of Podophyllotoxin in treating genital molluscum,.. Apply as per genital HPV treatment – bd for 3 days, then 4 days without, repeat weekly up to 4 weeks. This is an unlicensed use.
    - Imiquimod cream 5% for men and non-pregnant women. There is limited evidence of efficacy of Imiquimod in treating molluscum in both HIV positive and negative patients. Apply cream three times per week for up to 16 weeks. This an unlicensed use.
- Treatment of molluscum elsewhere in the body includes agents such as 5% potassium hydroxide and salicylic acid. These should not be used on genital lesions

Follow-up and Partner Notification:

No need for partner notification.
No specific follow-up.

References:

BASHH Guidelines. UK national guideline for the management of Genital Molluscum in adults, 2014. (accessed online 10/09/2018)