

Madigan Army Medical Center

Referral Guidelines

Molluscum

Diagnosis/Definition

- This common, generally self-limited, condition is most often found in young children on the trunk and upper arms and face. Occasionally, they are found on mucous membranes. They usually present as multiple white to skin-colored smooth papules classically with central umbilication (but not always). They lack scale or roughness (unless they have been scratched) unlike most warts. An eczematous or inflammatory reaction surrounding the lesions may occur as the molluscum are resolving.
- They may also be found in the genital area of sexually active adults.
- Extensive and recalcitrant molluscum may occur in patients who are severely immunocompromised, including transplant patients, those undergoing chemotherapy, and patients with HIV/AIDS. Large numbers may be seen in patients with atopic dermatitis.
- The causative organism is a poxvirus (Molluscivirus), and transmission is by direct contact.

Initial Diagnosis and Management

- General – Education of the patient on this condition should emphasize the self-limited nature of molluscum. In most cases with young children, these lesions will resolve without treatment within 6 months. It is important that the child not scratch the molluscum, as the contagious portion is a small kernel inside the papule that can spread the virus to other areas of the skin. Also, open lesions may become secondarily infected.
- Treatment options include:
 - 1st line
 - Doing nothing. Similar to wart treatment, some of the treatments below may cause more irritation or pain that is intolerable to young children.
 - Manual extrusion with fine forceps or gloved fingers – This can be time-consuming and physically painful to the patient, though once the kernel is expressed, the individual lesion will resolve.

Ongoing Management and Objectives

- Good resolution of lesions and minimizing scarring are the primary objectives.
- 2nd line treatments (if the above options fail):
 - Cryotherapy – A light freezing to individual lesions every 3-4 weeks.
 - Cantharidin – An in-office treatment that can result in a painful blister about 6-8 hours after application. It should be used with caution in young children, and bandaids should be applied to avoid the child touching the affected area and then rubbing their eyes.
 - Imiquimod 1-5% cream – An extremely expensive topical medication that can be used in stubborn cases, applied 3 times weekly (e.g., M-W-F, or M-T-W) for up to 16 weeks.
 - Retin A gel 0.025% may be applied to individual lesions bid (beware sun exposure – may result in increased sunburn)
 - Condylox (podophylox) gel may be applied bid for 3 days each week for 4-16 weeks.
 - Liquid Nitrogen may be applied for 3-5 seconds

- If the eczematous reaction occurs, this is a generally a good sign, and parents can be reassured. However, a moisturizer in these dry areas is usually necessary to minimize pruritus.
- Again, scratching should be avoided; however, if the child insists, allow them to scratch while soaking in the bathtub and ensure that their hands are well-washed to avoid transmission. It is not necessary to completely avoid contact with siblings; however, towels should not be shared.
- Bactroban ointment should be applied to open lesions to avoid secondary infection.

Indications for Specialty Care Referral

- Refer patients with moderate or severe molluscum that have not cleared with 6 months of conventional, conservative treatment (prescription meds), or if the patient is immunocompromised and have extensive molluscum.

Criteria for Return to Primary Care

Molluscum is resolved or improved on regimen of therapy.

Pictures of [Molluscum](#) from NZ DermNet - New Zealand Dermatological Society

Last Review for this Guideline: **October 2009**
Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
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