ERUPTIVE MOLLUSCA CONTAGIOSA IN AN IMMUNOCOMPETENT INDIAN ADULT

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A 35- year -old Indian woman with eruptive onset of mollusca contagiosa with no underlying immunodeficiency who responded to etretinate therapy is reported.

Key words : Molluscum contagiosum, Immunocompetent

Introduction

Molluscum contagiosum is a commom childhood infection caused by a member of pox group of viruses. It is transmitted by direct contact or fomites in children and may be transmitted sexually in adults. Transmission is facilitated by mechanical trauma. Lesions are known to resolve spontaneoustly in 6-12 months. Atypical and recalcitrant lesions have been described in immunocompromised individuals, including those with HIV infection.

Case Report

A 35-year-old woman presented with multiple, asymptomatic rapidly progressive skin lesions on face, neck, chest and arms of one month duration. No other family members including husband and children had similar lesions. There was no history of any concomitant topical or systemic immunosuppressive therapy. Examination revealed multiple (600-700) transluscent papular lesions on face, neck, chest and both arms (Fig. I). Lesions varied in size from pin head size to 5 x5 mm. Larger lesions showed umbilication in the centre and a white molluscum body could be extruded. A few lesions on arms showed secondary bacterial infection and these subsided with a course of antibiotic. All systems were clinically normal. Routine investigations including hemogram, blood, sugar, LFT, serum lipid profile and x-ray chest revealed no abnormality. Test for HIV infection by ELISA was negative on three separate occasions. Histopathology from a papular lesion stained with hematoxylin and eosin showed enlarged proliferating keratinocytes containing eosinophilic cytoplasmic inclusions

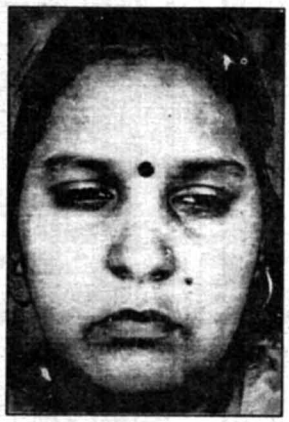

Fig.1. Multiple, transluscent Mollusca lesion on face

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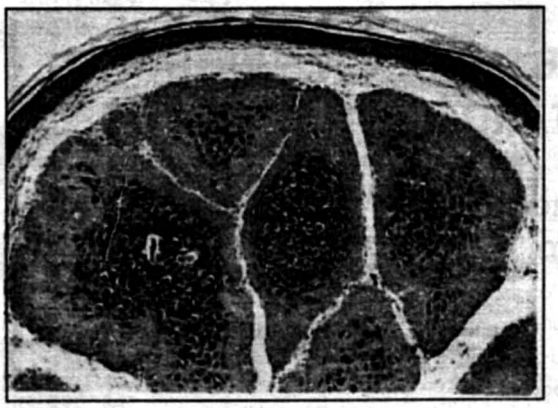

Fig.2. Enlarged proliferating keratinocytes containing eosinophilic cytoplasmic inclusions. (H & E) X 100

(Fig.2). Since the lesions were too profuse and eruptive to be treated by conventional treatment modalities, she was started on oral etretinate (50 mg. daily for two weeks). Following initiation of therapy, minimally appreciable improvement was noticed over first two weeks. However, at 4 weeks dramatic resolution of lesions was observed. A few persistent and large (>5 x5mm) lesions were ultimately cauterised chemically.

Discussion

Molluscum contagiosum in children is considered as an innocuous and spontaneously resolving disease which in most cases requires no active therapeutic intervention. Even in immunocompromised patient including those with HIV infection, lesions may be large in size, eruptive in onset and numerous. Moreover these may be resistant to conventional treatment modalities.[1] In patients on immunosuppressive therapy, topical or systemic (topical / systemic corticosteroid, methotrexate) lesions as numerous as 500 to 700 in number, predominently on face have been reported.[2,3] This has prompted the use of newer therapeutic approaches in immunocompromised patients such as topical antivirals (acyclovir, 5 FU and cidofovir) and systemic agents such as oral isotretinoin and cidofovir.[4,5] Our patient did not have evidence of an immunocompromised state nor was she on any immunosuppressive therapy. In view of multiplicity and extent of lesions systemic therapy with oral etretinate in low dose (0.6 mg/ kg) was initiated. The probable mode of action of etretinate in molluscum contagiosum is by perhaps increasing epidermal turnover resulting in extrusion of infected keratinocytes. The appearance of therapeutic response in our patient after four weeks of initiation of therapy supports the proposed mode of action.

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