**Referral Support Service**

**Dermatology**

**D12**

**Molluscum Contagiosum**

**Definition**

* [Molluscum contagiosum](https://www.pcds.org.uk/clinical-guidance/molluscum-contagiosum) is a common self-limiting viral skin infection.

* Young children are most commonly affected but it can also affect older children and adults.
* Lesions mostly multiple and in clusters but can present as solitary lesion.
* Lesions appear as small, pearl like smooth shiny papules with an umbilicated centre.
* Diagnosis usually clinical and no investigation necessary.

**Differential Diagnosis**

* [Viral wart](https://www.pcds.org.uk/clinical-guidance/warts): Rough surface, no umbilication.
* [Milia](https://www.pcds.org.uk/clinical-guidance/milia): Small, pin head sized, white cysts mostly on the face.
* [Lichen Planus](https://www.pcds.org.uk/clinical-guidance/lichen-planus) (uncommon): Purplish papules, inflammatory and pruritic.

**Complications**

* **Secondary bacterial infection of skin and eyes**
* **Disseminated eczema (this is an id reaction to the virus)**
* **Scarring**

**Exclude Red Flag Symptoms**

* If very widespread, numerous and persistent consider immunosuppression and HIV test if appropriate.

**Management**

* Most cases are self-limiting with resolution within 18 months in immunocompetent individuals, so no treatment is required. However, it can last up to 4 years.
* Patients need to be managed in **primary care and referral to secondary care** is **not routinely commissioned for treatment.** (see under “Indication for referral) for advice and guidance).
* Advice about **self – care and prevention** of spread and auto-inoculation:
* Avoid sharing towels, clothing and baths.
* Avoid scratching or squeezing.
* Use condoms if in genital area to avoid spread through skin to skin contact.
* Exclusion from school, gym and swimming is **NOT necessary**.
* Any surrounding eczema should be managed with standard eczema therapy.
* If skin is infected prescribe topical antibiotic like **Fusidic acid**.
* **Molludab®** (potassium hydroxide) is **NOT commissioned** and should not be prescribed. The evidence for this is limited to small uncontrolled trials.

**Patient funded treatment options-** these are all poorly evidenced and expensive, and the condition is self-limiting in any case. However, the patients can try these if they wish with the knowledge that this is the case.

* **Molludab** can be bought over the counter if desired but costs around £20. It should be used every day, twice a day until the lesions become inflamed, andshould then be stopped. Stop at 14 days in any case if no inflammation occurs
* **Cryotherapy** for 5-10 seconds per lesion can be helpful for cosmetically sensitive lesions, though children may not tolerate it
* **Imiquimod 5%** 3x per week for up to 16 weeks

**Indications for referral**

1. **Urgent referral to Ophthalmology** if eyelid margin or ocular lesions associated with red eye.
2. **Referral to the dermatology department** should only be made if patients have either of the following:

* Molluscum Contagiosum in known immunosuppressed patients.
* Congenital immunosuppression is suspected (these cases are extremely rare and patients often have hundreds of lesions)
* Diagnostic uncertainty of a solitary lesion.

3**. Advice & Guidance (A&G)** attaching clinical photographs if appropriate to seek specialised opinion, where Molluscum Contagiosum is causing significant problems in the management of atopic eczema, or other widespread conditions. (Prior approval from individual funding request (IFR) panel is **not necessary for A&G referral**).

4. **Referral for secondary care** for all other requests will not be accepted outside of the exceptional instances outlined in (2), even if IFR is agreed.

5. **Genito-Urinary clinic** referral for adults with Molluscum in the ano-genital region to rule out sexually transmitted infection. Molluscum is not a sexually transmitted infection, but could be transmitted through skin to skin contact.

**Information to include in referral letter**

* Site and number of lesion
* How long lesion(s) has been present
* Photograph is desirable if solitary lesion
* Relevant past medical/surgical history
* Current regular medication
* BMI/Smoking status

**Investigations prior to referral**

* For widespread Molluscum Contagiosum: FBC, CRP, Consider HIV/ BBV screening.

**Patient information leaflets/ PDAs**

Patient information leaflet available on

* [patient.co.uk website](https://patient.info/childrens-health/viral-skin-infections-leaflet/molluscum-contagiosum)
* [British Association of Dermatologists](https://www.bad.org.uk/)

**References**

* [PCDS website](https://www.pcds.org.uk/clinical-guidance/molluscum-contagiosum) for information and pictures
* [Dermnetz](https://dermnetnz.org/topics/molluscum-contagiosum) for images
* [Molluscum contagiosum | Health topics A to Z | CKS | NICE](https://cks.nice.org.uk/topics/molluscum-contagiosum/) (Mar 2022)
* [Health protection in children and young people settings, including education - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities) (updated Oct 2023, practical guidance for infection control)
* [Minor Skin Surgery for Skin Lesions Commissioning Policy](https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=6717), Scarborough and Ryedale, Vale of York Clinical Commissioning Group, May 2018