

Case Report: Eyelid Molluscum Contagiosum Simulating Chronic Allergic Conjunctivitis

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Abstract

Molluscum contagiosum (MC) is caused by a poxvirus that produces benign, self limiting papular eruptions on the skin and mucous membranes caused by Poxvirus .The lesion have central depressions or umbilications that contain a waxy, curdlike core. They can be located anywhere on the body and usually occur in clusters. Signs of MC infection have been reported in about 4.5% of children under 10 years old. In developed countries, infections are sometimes acquired from swimming pools, saunas, and sports centers. In addition, it can also be seen in immunosuppressed patients (e.g. with AIDS or using drugs such as corticosteroids, TNF- α antibodies, and methotrexate.

Methods:- A 7 year old child presented to us with a history of itching in his left eye and lesions over left eyelid and left side of cheek from last 6 months. They had consulted two ophthalmologists before and a diagnosis of allergic conjunctivitis was made each time. He got relief from the symptoms after using topical medications followed by recurrence of complaints after stopping treatment.

Results:- On examination, left upper eyelid had two papular lesions having central umbilication with whitish curdy material and other lesion was secondarily infected. There was presence of follicular hypertrophy in epibulbar conjunctiva and upper palpebral conjunctiva. Similar single lesion was also observed on left side of cheek. After dermatology consultation, a diagnosis of molluscum contagiosum involving left upper eyelid and left cheek with secondary infected lesion was made. The lesions were excised with 26 G hypodermic needle followed by 10% KOH application in the base of lesions. Child completely recovered after 3 weeks follow up.

Conclusion:- Molluscum contagiosum involving eyelid may present and mimic as chronic allergic conjunctivitis. Any patient presenting to us as chornic ocular allergic symptoms should be carefully looked for any eyelid lesions, so that timely diagnosis and management of such cases may be done.

Keywords: molluscum, eyelid, conjunctivitis

1. INTRODUCTION

Molluscum contagiosum (MC) is caused by a poxvirus that produces benign, selflimiting papular eruptions on the skin and mucous membranes caused by Poxvirus and affects otherwise healthy children with peak incidence between 2-4 years¹The virus is transmitted by direct contact with an infected host or contaminated fomite. Lesions are typically small (between two and six millimetres) and often have central depressions or umbilications that contain a waxy, curdlike core. They can be

located anywhere on the body and usually occur in clusters. Most lesions resolve spontaneously over the course of several months.²Signs of MC infection have been reported in about 4.5% of children under 10 years old. In developed countries, infections are sometimes acquired from swimming pools, saunas, and sports centers. In addition, it can also be seen in immunosuppressed patients (e.g. with AIDS or using drugs such as corticosteroids, TNF- α antibodies, and methotrexate), and in patients with atopic dermatitis, sarcoidosis, and Wiskott-Aldrich syndrome.^{3,4,5,6}



IMAGE 1. Showing left eye having upper lid molluscum lesion (medially), epibulbar follicular response with conjunctival congestion and a molluscum lesion on left cheek.



IMAGE 2. slit lamp image showing umbilicated molluscum lesions with epibulbar follicular hypertrophy.



IMAGE 3. showing follicular hypertrophy in upper palpebral conjunctiva.

2. CASE REPORT

A 7 year old child presented to us with a history of itching in his left eye and lesions over left eyelid and left side of cheek from last 6 months. According to mother, they had consulted two ophthalmologists before and a diagnosis of allergic conjunctivitis was made each time, for which he was prescribed topical mast cell stabilizer, topical chlorpheniramine with naphazoline eye drops, syrup levocetirizine and cold compresses. He got relief from the symptoms after using

topical medications followed by recurrence of complaints after stopping treatment. On further enquiring, mother denied about any history of sexually transmitted disease, HIV and any congenital infections in the child. On careful examination, left upper eyelid of the child had two popular lesions, one was of size approximately 2-2.5 mm having central umbilication with whitish curdy material and other lesion was secondarily infected surrounded by discharge and matted eyelashes (image 1 and 2). There was presence of follicular hypertrophy in epibulbar conjunctiva (image 1) and upper palpebral conjunctiva (image 3). Similar single lesion was also observed on left side of cheek (image 1). The child had normal visual acuity on Snellen's testing, normal pupillary reactions, clear cornea and ocular movements were within normal limits. After dermatology consultation, a diagnosis of molluscum contagiosum involving left upper eyelid and left cheek with secondary infected lesion was made. The lesions were excised with 26 G hypodermic needle followed by 10% KOH application in the base of lesions. Child was advised syrup amoxiclav 15mg/kg orally 12 hourly, topical tobramycin 0.3% 6 times/day, topical phenylephrine with chlorpheniramine eye drops for symptomatic relief and chlormycetin ointment at bed time. Child completely recovered after 3 weeks follow up.

3. DISCUSSION

Ocular involvement of MC presents with round, small, hard papules on the eyelids. The virus proliferates in epithelial cells. After the lesions reach about 3-5 mm in diameter, a central depression forms due to the cellular damage mechanism and they typically develop the appearance of whitish lesions filled with caseous material and having a dimple or pit in the center.^{7,8} Although the diagnosis is made clinically when these characteristic MC lesions are evident on the lids, half of patients cannot be diagnosed at the first examination. Charteris et al.⁸ examined the clinical and immunopathologic features of 35 MC cases and found that only 60% of the patients were diagnosed at the time of initial presentation. Histopathologic sections showed increased numbers of T lymphocyte cells and macrophages in the epidermis and dermis around the molluscum lesion.

The molluscum contagiosum may have to be differentiated from conditions like trichoepithelioma, basal cell carcinoma, ectopic sebaceous gland, syringoma, hidrocystoma, keratoacanthoma (molluscum sebaceum) and warty dyskeratoma.⁹ However typical umbilication is a clue for diagnosis of molluscum contagiosum. In case of uncertain diagnosis histopathological examination helps. In molluscum contagiosum, epidermis is hyperplastic, hypertrophied. It extends into dermis and projects above skin surface.¹⁰

Surgical techniques include cryotherapy with liquid nitrogen, cauterization, needle aspiration, photodynamic therapy, and various laser therapies.¹¹ Silver nitrate, phenol, and trichloroacetic acid are used as chemical agents, while treatment options for immunocompromised patients with refractory

lesions include topical cidofovir (5%), intralesional or systemic interferon, imiquimod cream (5%), salicylic acid, glycolic acid, tretinoin, tazarotene, 5% sodium nitrate, podophyllotoxin, liquefied phenol, cantharidin, potassium hydroxide, 1% adenine cream, and oral cimetidine. Eyelid scarring, depigmentation, and eyelash loss may occur after these treatments. Karabulut et al.¹² reported dramatic improvement in dense eyelid lesions with only physical drainage in an immunocompetent pediatric patient with MC. Weller et al.¹³ compared esthetic appearance after chemical ablation with phenol versus emptying the lesion by squeezing and reported that although there was no significant difference, phenol treatment caused more scarring.

Our patient presented with a 5 -6 month history of itching, red eye and lid lesions. Although previously seen by several ophthalmologists, but the lid lesions were overlooked and his condition had been treated as chronic allergic conjunctivitis. Child responded promptly after surgical excision of lesions with 10% KOH application without recurrence on follow up.

4. CONCLUSION

Molluscum contagiosum involving eyelid may present and mimic as chronic allergic conjunctivitis. Any patient presenting to us as chronic ocular allergic symptoms should be carefully looked for any eyelid lesions, so that timely diagnosis and management of such cases may be done. Although MC is generally self-limiting, chronic anterior segment involvement is best managed by the surgical removal of the lesion.

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