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Recurrent follicular conjunctivitis: A complication of Molluscum Contagiosum

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ABSTRACT: To report a case of Molluscum Contagiosum presented with recurrent follicular conjunctivitis, successfully treated with surgical excision. A 23year old male presented with chief complains of grittiness, discomfort on closing the eye along with mild redness in the same eye. He had previously been seen by different ophthalmologist and had been treated with topical antibiotics, steroids and anti-viral eye drops but no relief in the symptoms. On Slit lamp examination single dome shaped with centre umbilicated core in right lower eyelid was noticed. Suspecting Molluscum Contagiosum and no improvement with the course of topical medication given, we decided for excision. The lesion was surgically excised andwas sent for histopathological examination. MC resolves spontaneously within months in healthy, immunocompetent individuals, it requires surgical treatment in refractory cases. After surgical excision the patient symptoms has completely resolved and no signs of follicular conjunctivitis are present. He remains under follow-up and no recurrence has been seen for 6 months.

KEYWORDS:molluscum contagiosum, follicular conjunctivitis, histopathological examination

I. INTRODUCTION

Molluscum contagiosum (MC) is caused by a poxvirus that produces benign, self-limiting papular eruptions on the skin and mucous membranes. [1]It is particularly common in hot, developing countries and in communities with poor personal hygiene. Thecondition is most seen in children but during the past 30 years has become more common in immunocompromised adults and in patients with atopic dermatitis, sarcoidosis etc.[2]

Lesions are typically small (between two and six millimetres) and often have central depressions or umbilications that contain a waxy, curd like core. They can be located anywhere on the body and usually occur in clusters.[1]Diagnosis is usually based on clinical findings, and histopathological examination and laboratory tests are often not necessary.[1]

Ophthalmic MC lesions are often located on the eyelids. Chronic conjunctivitis or keratoconjunctivitis can be associated with eyelid lesions. [3]

II. CASE REPORT

A 23-year-old male presented to the outpatient department of Jayarogya hospital, Gwalior with chief complains of single raised painless lesion on the lower lid of right eye for past 3 months and history of grittiness, discomfort whileclosing the eye along with mild redness in the same eye. He had previously been seen bydifferent ophthalmologist and had been treated with topical antibiotics, steroids and anti-viral eye drops with relief in the symptoms. But recurrence was seen on stopping the medication.

Examination -

On Slit lamp examination (Right Eye)

- single lesion one-two millimetre dome shaped with centre umbilicated core in between the medial two-third and lateral one-third of the right lower eyelid. (Figure 1)
- The conjunctiva was hyperaemic and there was follicular reaction in the lower fornix
- cornea was not involved. (Figure 2)

Suspecting Molluscum Contagiosum and no improvement with the course of topical medication given we decided for excision. The lesion was surgically excised after clamping and haemostasis ensured, preserving the integrity of the cyst wall the lesion was sent for histopathological examination.

Histopathology reportsuggested stratified keratinized squamous epithelium with underlined dermis within epidermis and large central crater

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filled with molluscum bodies. The basal layers show intracytoplasmic eosinophilic inclusions that compress the nucleus to the periphery. (Figure 3)

The patient symptoms have completely resolved, and no signs of follicular conjunctivitis are present. (Figure 4) He remains under follow up and no recurrence have been seen for 6 months.

III. DISCUSSION

MC occurs worldwide but is more common in areas with tropical and humid climates.The virus istransmitted by close physical contact, autoinoculation, and occasionally, contaminated fomites (e.g., clothing, bath sponges, and towels), especially if the skin is wet. In adults, the disease may be spread by sexual contact and is typically found in a bathing-trunk distribution.[2]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 centre.[3]Although the diagnosis is made clinically when these characteristic MC lesions are evident on the lids.

The differential diagnosis of lid lesions can include basal cell carcinoma, papilloma, chalazion, sebaceous cyst, keratoacanthoma, blepharitis, wart, eczema, obstructed nasolacrimal duct, and ectropion.[2]Viral proteins shed from the lid lesions into the tear film can lead to a hypersensitivity reaction with secondary chronic follicular reaction, punctate keratopathy in the conjunctiva, and in some cases subepithelial opacities and pannus.[4]

IV.CONCLUSION

While MC lesions usually resolve spontaneously within a few months' treatments such as excision, incision and curettage, cryotherapy, cauterization, topical chemical agents, and oral cimetidine can be used in refractory cases. It should be kept in mind that progressive corneal neovascularization and scarring may develop, especially in patients with chronic conjunctivitis and corneal involvement. There is no known antiviral treatment specific for MC. While topical ganciclovir is approved for use in acute herpetic keratitis, its efficacy has also been demonstrated against cytomegalovirus and some strains of adenovirus.

V.FIGURES

Figure 1: showing single lower lid lesion and Conjunctival Hyperaemia

Figure 2: showing follicular reaction in lower fornix

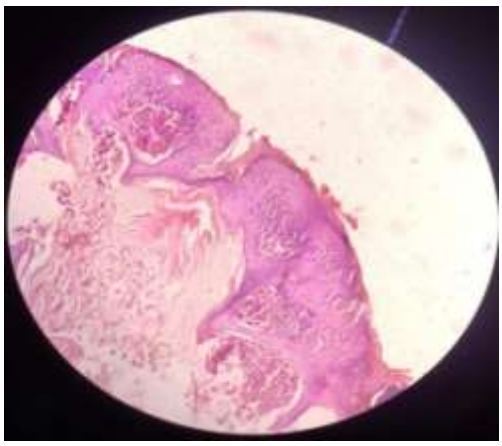

Figure 3: Histopathological image

Figure 4: showing post-Surgical excision

DECLARATIONS

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