

Consider Patient When Choosing Molluscum Tx

BY DAMIAN McNAMARA

Miami Bureau

MIAMI BEACH — Treatment of molluscum contagiosum can be guided by patient age, lesion location, cosmetic considerations, and the anxiety of the parent and patient, according to two presentations at the annual Masters of Pediatrics conference sponsored by the University of Miami.

"Most warts and molluscum [lesions] go away on their own," Dr. Lawrence Schachner said. "But most of the time, you cannot talk parents into just waiting for a year. They want something done."

Physicians can destroy lesions on the body by using cantharidin, or on the face by using trichloroacetic acid (TCA). Curettage, cryotherapy, and sensitization with squaric acid are other office-based options. Topical treatments and systemic cimetidine are among the home-based strategies, said Dr. Schachner, professor of pediatrics and dermatology and chairman of dermatology at the University of Miami.

"Molluscum treatment varies considerably with the doctor you go to," Dr. Bernice Krafchik, professor emerita at the University of Toronto, said during a separate presentation at the meeting. "Every doctor believes their treatment is the best."

Lesions are typically 1-5 mm, discrete, shiny, and pearly. "You will always see umbilication and a domed papule if you look, which makes it easy for the differential [diagnosis]," Dr. Schachner said. Incubation takes 2-8 weeks, and spontaneous resolution can take up to 2 years. Molluscum contagiosum accounts for approximately 280,000 physician visits annually (Pediatr. Dermatol. 2004;21:628-32).

Molluscum contagiosum can be spread by skin-to-skin contact, fomites, autoinoculation, or warm pool or bath water. "It also can be an STD in sexually active adolescents or adults," Dr. Schachner said.

"Do no harm," Dr. Krafchik asserted. "I treat mollus-

cum but I don't treat warts. The treatment of molluscum is relatively easy, and you see a lot of inflammation if you leave them alone."

For both Dr. Schachner and Dr. Krafchik, topical cantharidin (an extract from the blister beetle) is the treatment of choice for young children with widespread lesions. It should be initially applied using the blunt end of a cotton-tipped swab or a toothpick to a few lesions. "Do not use it on 25 lesions the first time . . . because some children are hyperreactors," he added. Cover the treated area with a bandage and soak it off in a bath 3-4 hours later.

Warn parents that bullae can form on treated lesions, Dr. Krafchik said. She instructs parents to leave the blisters alone; however, if the blisters are painful, parents can drain them with a sterile needle and apply an over-the-counter topical antibiotic. Cantharidin cleared the lesions in 90% of 300 children after an average of 2.1 visits in a retrospective study (J. Am. Acad. Dermatol. 2000;43:503-7).

"My conclusion is it is safe and effective," Dr. Schachner said. "But it's an office technique. I would never send a patient home with some cantharidin."

TCA for face or neck lesions is another office-based treatment option. Start at 25% strength and increase as tolerated, Dr. Schachner said.

He did not recommend the use of topical tretinoin or keratolytics for molluscum contagiosum, but imiquimod (Aldara) can be used to treat a limited number of lesions. The agent "works pretty well, but it's awfully irritating anywhere skin may rub on skin," Dr. Schachner said, adding that "it is not my first choice, but it is a choice. It's a little expensive."

"Remember, Aldara is very expensive," Dr. Krafchik said. "Parents get peeved when they come back to your office."

Curettage can be very effective and yields immediate results. "If you put a little nick in it and squeeze it, the



"Molluscum treatment varies considerably with the doctor," said Dr. Lawrence Schachner whose therapy of choice is cantharidin.

viral core will come out," Dr. Schachner said. Curettage is generally reserved for older children with a limited number of lesions.

Dr. Krafchik said that she no longer performs curettage on molluscum contagiosum lesions because "it always bleeds and kids hate the sight of blood." A meeting attendee said that one lesion is easy to remove. "You're right," Dr. Krafchik replied. "It is easy to remove one molluscum . . . and it's quite a different thing when there are many."

Cryotherapy is another consideration in older children, particularly if the lesions are large or located on the face or neck, Dr. Schachner said. A cotton-tipped application of liquid nitrogen for a 5- to 10-second freeze, repeated at 2- to 4-week intervals, can be effective, but pain, blistering, scarring, and dyspigmentation are potential adverse events.

"Regarding liquid nitrogen: I don't use [it] in children as a rule," Dr. Krafchik said. "It's very painful and you cannot use it long enough to get a good result. It's not fair to the kids." ■

Skin Issues Offer Clues to Underlying Gastrointestinal Disease

BY DOUG BRUNK

San Diego Bureau

LA JOLLA, CALIF. — Certain skin conditions may provide clues to the diagnosis of underlying gastrointestinal disease in children, ranging from epithelial defects, polyposis, or vascular syndromes to autoimmune and allergic disease.

"There are several areas of overlap between the skin and the GI tract," Dr. Magdalene A. Dohil said at a meeting sponsored by Rady Children's Hospital and the American Academy of Pediatrics. If you pick up on these cutaneous signs, you may find an underlying GI disease.

Diseases of the GI tract that commonly involve some form of cutaneous manifestation noted by Dr. Dohil include:

► **Epidermolysis bullosa.** This condition presents with different degrees of skin fragility and blister formation. The severity "really depends on the underlying molecular defect," said Dr. Dohil, who is a pediatric dermatologist at Rady Children's Hospital, San Diego.

"GI disease in epidermolysis bullosa is extremely common, particularly in the recessive dystrophic type," [in which] almost 80% of children are affected [by dysphagia]. The dysphagia that these children often suffer from can be so severe that they are unable to swallow their own saliva," she said. In fact, the lumen of the esoph-

agus might be obliterated to 2 mm in these patients, whereas a normal lumen is 15-20 mm wide. Other symptoms may include lingual adhesions and microstomia; esophageal disease including strictures, webs, herniation, atony, and pseudodiverticula leading to feeding problems and ultimately protein-energy malnutrition; anemia; and vitamin and mineral deficiency.

► **Blue-rubber bleb nevus syndrome (BRBNS).** This disease causes multifocal venous malformations in the skin and GI tract. Most cases are sporadic, and histology demonstrates intact epithelium but insufficient smooth muscle. Dr. Dohil described the case of a child who presented with venous malformations on the bottom of the foot, which resembled common warts at first glance. "But when you palpate these lesions, they are soft and compressible," she said.

Common complications of BRBNS include bleeding, chronic anemia, and the need for blood transfusion. Treatment often involves different degrees of surgical intervention including wedge resection, polypectomy, suture ligation, band ligation, and sometimes bowel resection.

"Medical treatment attempts haven't been very successful because these are not proliferative tumors, so we don't expect them to respond to corticosteroids or interferon," explained Dr. Dohil, also of the University of California, San Diego.

Capsule endoscopy "facilitates the diagnosis and follow-up of children who need endoscopic intervention and assessment."

► **Peutz-Jeghers syndrome.** The hallmark skin-related characteristics of this disease include mucocutaneous pigmentation due to melanin deposition. A GI work-up often reveals polyps that may reach into the antral part of the stomach or present throughout the duodenum. These polyps can cause significant morbidity including obstruction, intussusception, pain, hematochezia, and prolapse.

Children with Peutz-Jeghers also carry a high risk of developing invasive carcinoma. In fact, their cumulative risk of developing cancer is 93%, most commonly cancers of the breast, colon, and pancreas, noted Dr. Dohil.

► **Cowden's disease.** This condition, also known as multiple hamartoma-neoplasia syndrome, causes hamartomas that involve the skin, intestine, breast, and thyroid. It is autosomal dominant and has near complete penetrance by age 20 years. Only 40% of cases will have GI polyposis, but about 80% of cases will present with dermatologic tumors. Consider the diagnosis if you spot more than one trichilemmoma.

► **Henoch-Schönlein purpura.** The most common skin presentation is a petechial rash that may develop into multiple raised purpuric lesions. GI symptoms occur in 50%-85% of cases and include abdominal

pain, bleeding, vomiting, and bowel edema. The GI effects include mucosal redness, as well as duodenal petechiae and hematoma-like protrusions. Most of these changes can be detected with ultrasound.

► **Celiac disease.** Classic GI symptoms include abdominal distention, weight loss, failure to thrive, and diarrhea. Although serology has facilitated the diagnosis, small-bowel biopsy remains the preferred method. "In these cases you will see villous atrophy, crypt hyperplasia, and lymphocytic infiltrate," Dr. Dohil said. "Such a blunted GI tract doesn't bode well for the absorptive functions that it's intended for."

Dermatitis herpetiformis (Dühring's disease) is considered a cutaneous manifestation. This condition affects about 25% of celiac disease patients and is marked by a pruritic eruption of lesions that may be symmetrical, erythematous, papular, vesicular, or bullous.

These lesions "are fairly uncommon in children, and when they do occur they may not be very distinct," she said. Recently conditions such as xerosis, urticaria, vitiligo, and alopecia areata have been linked to celiac disease. Since they are fairly nonspecific, skin biopsies with direct immunofluorescence and antibody studies of gliadin, endomysium, and transglutaminase are often needed to confirm the diagnosis.

Dr. Dohil reported having no relevant disclosures to make. ■