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Effectiveness of Homeopathic Medicine in Molluscum Contagiosum: A Case Report

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ABSTRACT

Molluscum Contagiosum (MC) is a common viral skin infection caused by the Molluscum Contagiosum Virus (MCV), primarily affecting children, sexually active adults, and immunocompromised individuals. While MC is self-limiting, it may persist for months or even years, leading to secondary infections and cosmetic concerns. Conventional treatments, including cryotherapy and curettage, are often associated with pain and recurrence. Homeopathy, as an alternative approach, aims to stimulate the body's immune response for long-term resolution. This case study presents a 20-month-old female child diagnosed with MC, treated with individualized homeopathic remedies, primarily Sulphur, based on symptom totality. Over three months of treatment, there was a gradual improvement, with complete resolution of lesions and only residual pigmentation remaining. This case highlights the potential of homeopathy in managing MC effectively and painlessly, suggesting the need for further research to validate its role in dermatological conditions.

Keywords- Homoeopathy, Molluscum Contagiosum, Sulphur.

I. INTRODUCTION

The Molluscum Contagiosum Virus (MCV), a member of the Poxviridae family, is the cause of the common viral skin infection known as Molluscum Contagiosum (MC). Children, sexually active adults, and immunocompromised people are the main groups affected. It manifests as tiny, flesh-colored, dome-shaped papules with a central umbilication. (1) The infection spreads through direct skin contact, contaminated objects, or autoinoculation. (2)

Even though Molluscum Contagiosum usually goes away on its own, it can linger for months or even ye ars, leading to secondary bacterial infections and cosmeti c issues.(3) Various treatment options, including cryotherapy, curettage, and homeopathic remedies, have been explored for faster resolution.(4) Understanding the pathophysiology, clinical manifestations, and management of MC is crucial for effective treatment and prevention strategies.

II. EPIDEMIOLOGY

Molluscum Contagiosum (MC) is a globally prevalent skin infection, affecting individuals of all ages, with higher incidence in children, sexually active adults, and immunocompromised individuals. (1) It accounts for approximately 1% of all dermatological diagnoses in the general population, with increased cases in warm and humid climates. (5)

Children between the ages of one and ten are frequently found to have MC, which is spread by direct skin contact, shared objects (such as toys or towels), and swimming pools.(6) MC mostly affects the vaginal area

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and is frequently regarded as a sexually transmitted infection (STI) in sexually active individuals.[7] Due to impaired cell mediated immunity, immunocompromised people – especially those with HIV/AIDS are more likely to develop large and long – lasting lesions.[8]

III. PATHOPHYSIOLOGY

Molluscum Contagiosum (MC) is caused by the Molluscum Contagiosum Virus (MCV), a double-stranded DNA virus from the *Poxviridae* family, specifically the Molluscipoxvirus genus. The virus primarily infects keratinocytes in the epidermis, leading to the formation of characteristic dome-shaped papules with central umbilication. [1]

Viral Replication and Lesion Formation

Through micro abrasions, MCV enters the skin and attaches itself to basal cells of the epidermis, starting intracellular reproduction in the cytoplasm. [9] MCV is able to avoid host immune detection because it is episomal, in contrast to herpesviruses, which integrate into the host genome. Abnormally multiplying infected keratinocytes create intracytoplasmic inclusion bodies (Henderson-Patterson bodies), which contain viral particles and aid in the formation of lesions.[10]

Immune Evasion Mechanisms

MCV uses a variety of immune evasion techniques, such as blocking apoptosis, tumor necrosis factor (TNF) pathways, and interferon (IFN)-mediated responses.[11] The viral proteins MC159 and MC160 delay immune recognition and reduce inflammation by blocking nuclear factor kappa B (NFκB) activation.[12] The virus can survive for 6 to 12 months in immunocompetent people and for much longer in immunocompromised patients because of this mechanism.[13]

Host Immune Response

Although MC lesions employ immune evasion t actics, they ultimately cause a delayed hypersensitivity r eaction, which resolves on its own as the immune system builds a T-cell mediated response.[5] Cell mediated immunity is essential for viral clearance, as evidenced by the presence of CD4+ and CD8+ cells in regressing lesions [14] due to reduced T- cell function, immunocompromised people, including those with HIV/AIDS, frequently develop unusual, persistent and extensive lesions. [8]

IV. CLINICAL FEATURES

Molluscum Contagiosum (MC) is characterized by small, dome-shaped, flesh-colored papules with a central umbilication, typically ranging from 2 to 5 mm in diameter.[1] In children, lesions typically affect the face, trunk, axillae, and limbs, while in sexually active adults, they are more likely to affect the genital, perineal, and lower abdominal regions. Lesions can arise alone or in clusters.[2]

Primary Skin Lesions

- **Papular Lesions**: Papular lesions are solid, smooth, and painless papules that have the potential to become itchy or inflammatory over time. [15]
- **Central Umbilication**: A characteristic that arises from the buildup of keratinized debris and virus particles inside the lesion is central umbilication. [16]
- **Koebner Phenomenon**: The Koebner Phenomenon states that MC lesions can develop at skin trauma sites, such as places that are frequently scratched or irritated. [17]

V. CLINICAL VARIANTS

- **Giant Molluscum**: Lesions larger than 10 mm in people with HIV/AIDS or other immunocompromised conditions. [8]
- **Eczematous Molluscum**: Hypersensitivity responds to viral antigens resulting in surrounding dermatitis. [5]
- **Inflamed Molluscum**: Lesions that exhibit erythema, swelling, and discomfort are known as inflammatory molluscum, and they frequently indicate an upcoming immune-mediated clearance. [3]

VI. COMPLICATIONS

- **Secondary Bacterial Infection**: Staphylococcus aureus or Streptococcus pyogenes superinfection or excoriation might result in secondary bacterial infection. [4]
- **Conjunctivitis**: Autoinoculation from periocular MC lesions may result in chronic conjunctivitis. [7]
- **Widespread and Atypical Lesions**: These might cause disfigurement or recurring eruptions in immunocompromised patients, especially those with advanced HIV/AIDS. [13]

VII. INVESTIGATIONS

The diagnosis of Molluscum Contagiosum (MC) is primarily clinical, based on its characteristic dome-shaped, umbilicated papules. However, in atypical, persistent, or immunocompromised cases, further investigations may be necessary to confirm the diagnosis and rule out other conditions. [1]

1. Clinical Diagnosis

- Diagnosis is mainly based on visual inspection of the characteristic skin lesions. [2]
- Dermoscopic Examination: Shows a central white/yellow amorphous structure with surrounding blood vessels in a crown or radial pattern. [3]

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2. Laboratory Investigations

- Light Microscopy (Tzanck Smear)
  - Molluscum bodies, also known as Henderson-Patterson bodies, are massive eosinophilic cytoplasmic inclusions within keratinocytes that can be seen when the lesion is scraped and stained with Giemsa or Wright stain. [17]
- Histopathology (Skin Biopsy)
  - Biopsy of the Skin in Histopathology is recommended for patients with HIV, particularly those with unusual or persistent lesions. [8]
  - Displays extensive intracytoplasmic inclusion bodies and hyperplastic epidermis[5]
- Polymerase Chain Reaction (PCR)
  - Molluscum Contagiosum Virus (MCV) DNA detection, especially when it's necessary to distinguish it from other poxvirus infections. [3]

Table 1: Differential diagnosis

1.	Viral Infections	• Verruca Vulgaris (Common Warts) • Varicella (Chickenpox) and Herpes Simplex Virus (HSV) Infections
2.	Bacterial Infections	• Furunculosis (Boils) and Folliculitis
3.	Benign Skin Tumors	• Basal Cell Carcinoma (BCC) • Sebaceous Hyperplasia
4.	Fungal and Parasitic Infections	• Cryptococcosis and Histoplasmosis (Fungal Infections in Immunocompromised Patients) • Scabies (Sarcoptes scabiei Infestation)
5.	Other Dermatological Conditions	• Milial Cysts (Milia) • Keratoacanthoma

VIII. PATIENT INFORMATION

A 20 months old female child came to the outpatient department (O.P.D.) of Dr. M.P.K. Homoeopathic Medical College, Hospital and Research Center, Jaipur, on 12-04-2024 for the following complaint, which was present since 18-19 months. Her symptoms were white, pearl like, firm, round, papular eruptions on face and neck. Patient has not taken any medicine for the same till now.

There was no significant past history. Her mother was having hypotension, hypothyroidism and leucorrhoea and her elder brother was having similar type of whitish popular eruptions on his face.

The child was cheerful and jolly in nature. Thermally hot patient, he was vegetarian and has aversion to milk, her appetite was good, she drinks small quantity of water at short intervals, her bowel moments were regular and satisfactory. Urine was normal.

IX. CLINICAL FINDINGS

On inspection the patient was having round, white, firm, pearl like papular eruptions on face and neck. On general examination, the patient was conscious and well-built, with no pallor, cyanosis, jaundice or clubbing.

X. DIAGNOSTIC ASSESSMENT

The case was diagnosed as Molluscum Contagiosum clinically on the basis of signs and symptoms.

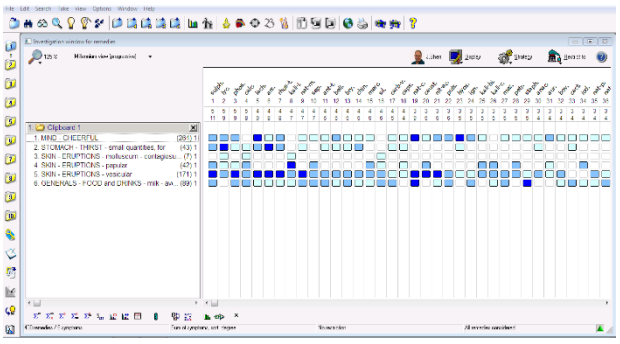
XI. ANALYSIS AND EVALUATION OF SYMPTOMS

Table 2: Analysis and Evaluation of Symptoms

MENTAL GENERALS	PHYSICAL GNERALS	PARTICULARS
• Cheerful $^{2+}$	• Hot patient 2+ • Aversion-milk2+	• White pearl like eruption on face and neck.$^{3+}$ • Firm, rounded, papular eruption on face and neck.$^{3+}$

XII. REPERTORISATION

The totality of symptoms for this case included cheerful, aversion to milk, drinks small quantity of water at short intervals, white pearl like, firm, rounded, papular eruption on face and neck.



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XIII. THERAPEUTIC INTERVENTION

Individualized, single homoeopathic medicine *SULPHUR 200/1 dose* in the morning on an empty stomach prescribed along with *RUBRUM 30/TDS* for 7 days on 12/04/2024.

XIV. FOLLOW UP AND OUTCOME

Table 3: Follow Ups

DATE	FOLLOW - UP	PRESCRIPTION
19/04/2024	Some new eruption appear	*SULPHUR 10M / 1 DOSE / EMES* *RUBRUM 30 / TDS FOR 7 DAYS*
26/04/2024	No changes	*PL 30 / 1DOSE / HS* *NIHILIUM 30 / TDS FOR 7 DAYS*
03/05/2024	No changes	*PL 200 / 1DOSE / STAT* *SAC LAC 30 / TDS FOR 7 DAYS*
10/05/2024	2 - 3 eruptions gone	*SAC LAC 200 / 1DOSE / HS* *RUBRUM 30 / TDS FOR 7 DAYS*
17/05/2024	Eruptions – red Slight increased	*SULPHUR 10M / 1 DOSE / EMES* *PHYTUM / 30 / TDS FOR 15 DAYS*
31/05/2024	No changes	*PL 1M / 1DOSE / HS* *NIHILIUM 30 / TDS FOR 15 DAYS*
21/06/2024	Better, almost all eruption clear, only pigmentation remains	*RUBRUM 30 / 1DOSE / HS* *NIHILIUM 30 / TDS FOR 15 DAYS*
12/07/2024	No any eruptions	*RUBRUM 200 / 1DOSE / STAT* *PL 30 / TDS FOR 15 DAYS*

XV. DISCUSSION

Molluscum Contagiosum is a prevalent dermatological condition with a well-documented viral etiology. While it is generally self-limiting, the duration of the disease varies, and lesions may persist for extended periods, particularly in immunocompromised individuals. Conventional treatment modalities, such as cryotherapy, laser therapy, and curettage, are associated with discomfort, potential scarring, and recurrence. As a result, alternative therapies, including homeopathy, have been explored for their efficacy in managing MC in a less invasive manner.

In this case study, Sulphur was selected as the primary remedy based on symptom totality, including constitutional factors such as the patient's cheerful disposition, heat sensitivity, and aversion to milk. The selection was made using a repertorial approach, ensuring individualized prescription in line with homeopathic principles. The treatment demonstrated a gradual but steady improvement, with lesions initially persisting but later reducing in size and number. Notably, new eruptions appeared after the initial prescription, which is often considered a sign of immune response activation in homeopathic practice. With subsequent administration of Sulphur 10M, followed by placebo and adjunctive remedies, the lesions resolved completely by the end of treatment.

Given that conventional treatments often lead to pain, discomfort, and occasional recurrences, homeopathy provides an alternative that is gentle, non-invasive, and potentially effective in promoting complete resolution of MC lesions without side effects.

Despite the promising outcome, it is essential to acknowledge certain limitations. This is a single case study, and broader clinical trials are necessary to establish homeopathy's role in treating MC on a larger scale. Future research should focus on controlled studies with comparative groups to assess efficacy, recurrence rates, and long-term outcomes of homeopathic management versus conventional approaches.

In conclusion, this case highlights the effectiveness of Sulphur in treating MC, reinforcing the value of individualized homeopathic prescriptions in dermatological conditions. While homeopathy appears to offer a safe and effective alternative, further research is warranted to validate these findings and explore its broader applicability in viral dermatology.

Declaration of Patient Consent: The patient's parents were informed about the publication of her data in journal and written consent was taken from the patient's parents.

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Conflicts of Interest: None declared.

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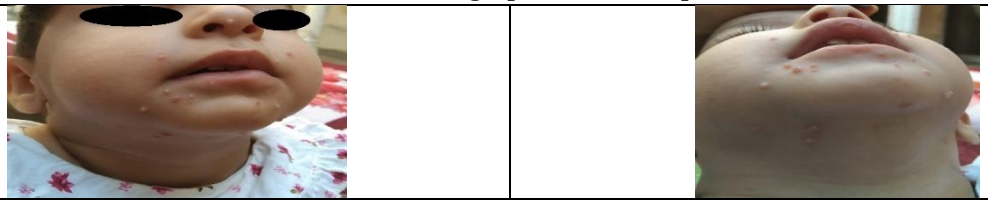
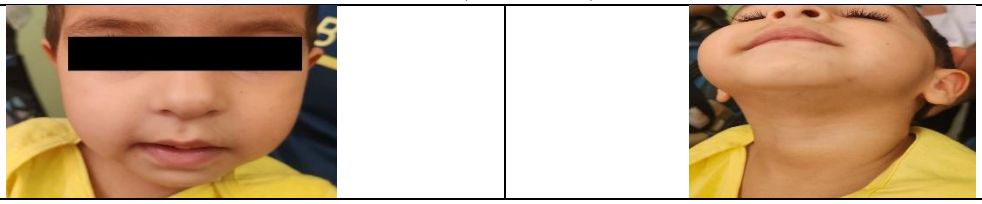
Table 4: Photographs of Follow ups



PRE (12/04/2024)



POST (12/07/2024)

ABBREVIATIONS

MCV – Molluscum Contagiosum Virus, MC – Molluscum Contagiosum, STI - Sexually Transmitted Infection, HIV – Human Immunodeficiency Virus, AIDS – Acquired Immunodeficiency Virus, PCR - Polymerase Chain Reaction.