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Case Report Open Access

Periocular Molluscum Contagiosum Causing Chronic Unilateral Conjunctivitis and Mimicking Basal Cell Carcinoma

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Abstract

Molluscum contagiosum is a benign viral skin infection that rarely can cause chronic follicular conjunctivitis when lesions are located near the eyelid margin. It may also mimic other periocular lesions, including basal cell carcinoma.

We present a case of an otherwise healthy 50-year-old man with 18 months of unilateral periocular eczema, irritation, tearing, conjunctival redness, and chronic conjunctivitis. He was referred with clinically suspected periocular basal cell carcinoma. Histopathological examination revealed molluscum contagiosum and after removal of the lesion, the symptoms of chronic conjunctivitis resolved within two months.

Careful inspection of the entire eyelid and eyelid margin is important in chronic unilateral conjunctivitis, even when a single suspicious periocular lesion is identified, as additional subtle molluscum lesions may be present and may contribute to persistent symptoms if left untreated. Removal of the causative lesions can resolve symptoms and prevent unnecessary treatment.

Introduction

Molluscum contagiosum (MC) is a benign and usually self-limiting poxvirus skin infection. It is most common in children, but can occur at any age. Periocular MC is uncommon, particularly in immunocompetent adults, and is therefore mainly described in case reports and retrospective case series[1-4]. When located on or close to the eyelid margin, MC can cause chronic unilateral conjunctivitis and superficial punctate keratitis, presumably due to shedding of viral particles into the tear film[1, 5-7]. Because the causative eyelid lesion can be small, diagnosis is often delayed, and patients may initially be treated for more common causes of conjunctivitis[1, 3, 7, 8]. MC can also mimic other eyelid lesions[1, 9]. We describe a case of chronic unilateral conjunctivitis in an immunocompetent adult referred with suspected periocular basal cell carcinoma (BCC).

Case Presentation

A 50-year-old man was referred to the Department of Ophthalmology, Vejle Hospital, University Hospital of Southern Denmark, with suspected periocular BCC close to the lash line of the right upper eyelid. For 18 months, he had had unilateral eczema below the right eye, with mild conjunctival redness, irritation, itching and tearing. Previous treatments with warm compresses, antibiotic ointment, antiallergic eye drops, and topical corticosteroid had been unsuccessful. Because of increased intraocular pressure as a result of steroid response, the treatment was later changed to topical tacrolimus – with no effect.

On examination, blepharitis was present. In the central part of the right upper eyelid, close to the lash line, there was a well-defined, firm, and shiny lesion measuring 4 × 2 mm, with central umbilication, crusting, and telangiectasia but no ulceration or madarosis (Figure 1A). It was freely movable over the tarsal plate. The firmness, shiny surface, umbilication, crusting, and telangiectasia raised clinical suspicion of BCC, as these features may resemble the characteristic pearly appearance, central depression, and surface telangiectasias associated with BCC. A smaller, similar lesion was seen temporally (Figure 1B). The skin beneath the right lower eyelid appeared erythematous (Figure 1C).

Best-corrected visual acuity (BCVA), measured using a Snellen chart, was 1.0 (equivalent to 20/20) in both eyes, and intraocular pressure was 16 mmHg bilaterally. Slit-lamp examination revealed mild bulbar conjunctival hyperemia (Figure 1C), while the inferior palpebral conjunctiva showed marked hyperemia and follicular conjunctivitis. The cornea, remainder of the anterior segment, and fundus examination were unremarkable in both eyes.

As the clinical findings were considered more suggestive of MC than of malignancy, both lesions were excised in toto. Histopathological examination confirmed MC in both lesions. The findings included lobules of acanthotic epidermis extending into the dermis, and central umbilication with a crater-like depression (Figure 2A). At higher magnification, enlarged keratinocytes containing characteristic intracytoplasmic inclusion bodies, known as molluscum bodies or Henderson–Patterson bodies, were observed (Figure 2B).

Two months later, the patient was symptom-free, with no irritation or tearing.

Discussion

This case highlights that periocular MC may mimic BCC, particularly when presenting as a small, well-demarcated eyelid-margin lesion. Although central umbilication is characteristic of MC[1], BCC may also present with a pearly appearance, a central depression, and telangiectasia, making clinical distinction difficult. Given the patient's

Figure 1. Clinical presentation
A. Central lesion of the right upper eyelid adjacent to the lash line, showing a shiny surface, central umbilication, crusting, and telangiectasia. Mild blepharitis is also present.
B. Smaller, similar lesion located temporally on the right upper eyelid.
C. Mild bulbar conjunctival and eyelid margin hyperemia, with erythema of the right lower eyelid.
All images are published with the patient's written informed consent.

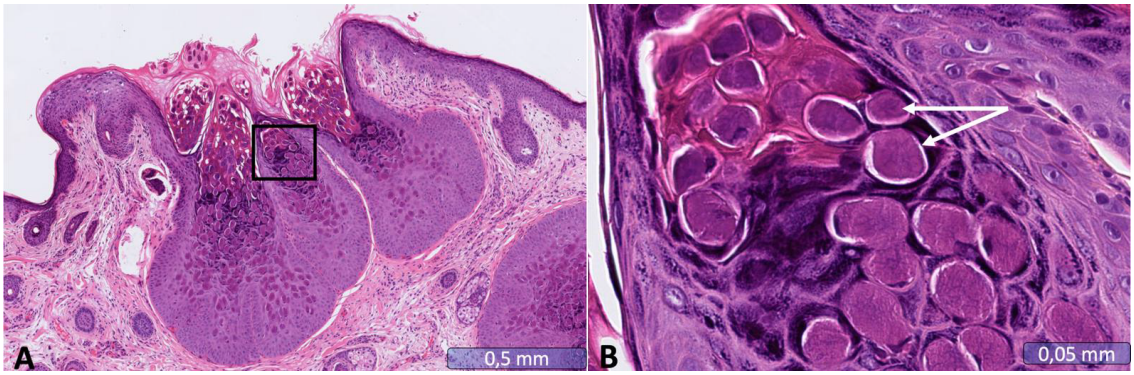

Figure 2. Histopathological examination of the excised lesion.
A. Low-power photomicrograph of an H&E-stained histological section of the molluscum contagiosum lesion excised from the right upper eyelid, showing lobules of acanthotic epidermis extending into the dermis. The lesion demonstrates characteristic central umbilication with a crater-like depression. Scale bar: 0.5 mm. H&E, hematoxylin and eosin.
B. High-power photomicrograph corresponding to the boxed area in panel A, showing enlarged keratinocytes containing characteristic intracytoplasmic inclusion bodies, known as molluscum bodies or Henderson–Patterson bodies (arrows). Toward the surface, the inclusion bodies enlarge and occupy nearly the entire cell. Scale bar: 0.05 mm.

age, the persistence of the lesion, and its periocular location close to the lash line, clinical suspicion of BCC was appropriate. However, the chronic unilateral follicular conjunctivitis, lack of response to topical treatment, and presence of another similar lesion supported MC as an important differential diagnosis.

In previous retrospective case series of periocular MC, ocular surface involvement, including conjunctivitis, was reported in 54–66% of cases. The reported mean duration of symptoms before diagnosis ranged from approximately three to six months, and patients often required multiple clinical visits before MC was recognized[3, 4, 6]. In comparison, our patient had experienced symptoms for 18 months and had undergone several unsuccessful treatment attempts. Once the eyelid-margin lesion was identified and BCC was suspected, the patient was referred for further evaluation. This prolonged diagnostic delay is a notable feature of the present case and illustrates how a small or subtle eyelid-margin lesion may remain unrecognized as the underlying cause of chronic unilateral follicular conjunctivitis.

A recent systematic review found that ocular and periocular MC may be misdiagnosed as several other conditions, including chalazion, bacterial conjunctivitis, and BCC[1]. Cutaneous cryptococcosis is another rare differential diagnosis, as it may present with molluscum-like umbilicated lesions. Although it occurs predominantly in immunocompromised patients, it may also occur in immunocompetent individuals[10]. In a retrospective series of 32 histopathologically confirmed cases of MC, 12 cases (38%) had initially been clinically diagnosed as other benign lesions. Two cases (6%) had initially been suspected to represent carcinomas[3].

Unlike suspected BCC, where incisional biopsy may be used before definitive treatment, periocular MC causing conjunctivitis should ideally be treated completely, as residual infected tissue may allow continued viral shedding and persistent symptoms[1,7,11]. The few available retrospective case series of periocular MC have reported recurrence rates of approximately 3–6% in immunocompetent patients following surgical excision, with or without cautery[3, 4]. However, MC in immunocompetent patients often follows a benign course and may clear without treatment over several months[1, 6]. Beyond treatment considerations, this case reinforces previous recommendations to inspect the entire eyelid, including the eyelid margin, as subtle additional MC lesions may be overlooked[4, 11]. In a historical review of 428 reported cases of eyelid MC, only 11 were described as solitary lesions, further supporting careful examination for additional lesions[12].

Conclusion

MC should be considered in patients with suspected periocular BCC when an eyelid-margin lesion is associated with chronic unilateral follicular conjunctivitis. Careful eyelid margin examination is essential, as complete removal of all visible lesions may be both diagnostic and therapeutic.

Learning Points

- Periocular molluscum contagiosum can mimic basal cell carcinoma.
- Chronic unilateral follicular conjunctivitis should prompt careful examination of the eyelid and eyelid margin.
- Other subtle lesions may be present, and complete removal of all visible lesions may lead to resolution of symptoms.

List of abbreviations

BCC (basal cell carcinoma), MC (molluscum contagiosum), H&E (hematoxylin and eosin)

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Conflicts of Interest

The authors declare no conflict of interest.

Authors' Contributions

SK and NB performed the clinical assessment; SK drafted the manuscript and managed the clinical case description. NB and FM reviewed the manuscript critically and contributed to the interpretation of the case and its clinical relevance. All authors approved the final manuscript.

Ethics statement

The study was approved by the National Scientific Ethical Committees on Health Research Ethics, Denmark (reference no 2307458). Written informed consent for publication of the case details and clinical images was obtained from the patient.

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