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Homoeopathic Management of Molluscum Contagiosum in Children: Clinical Evidence and Key Remedy Profiles

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Abstract

Molluscum contagiosum (MC) is a common, self-limiting viral infection of the skin in children caused by a DNA poxvirus, producing multiple flesh-coloured, dome-shaped, umbilicated papules that often raise cosmetic and contagion concerns for parents and caregivers.(1–4) Conventional treatments such as curettage, cryotherapy, and caustic topical agents may be effective but are frequently painful, frightening, and occasionally scarring in paediatric practice, limiting their acceptability.(1–3) Homoeopathy offers an individualized, non-invasive approach, and several remedies are listed for MC under "Skin – Molluscum" in Boericke's Clinical Repertory, with Bromium, Silicea and Calcarea arsenicosa graded as first-grade medicines.(4,5) This narrative review summarises the epidemiology, clinical features and conventional management of MC in children and critically discusses the homoeopathic perspective, repertorial rubrics, and key remedies, including Bromium, Silicea, Calcarea arsenicosa, Bryonia, Calcarea carbonica, Kali iodatum, Lycopodium, Mercurius solubilis, Natrum muriaticum, Sulphur and Tuberculinum, based on classic materia medica and contemporary clinical reports.(4–10) Available evidence, although mostly limited to case reports and small observational series, suggests potential benefit from individualized homoeopathic treatment and supports further systematic clinical research in paediatric MC.(6–10)

Keywords

Molluscum Contagiosum, Children, Paediatric homoeopathy, Boericke's Clinical Repertory,

Skin infection

Introduction

Molluscum contagiosum is an infectious dermatosis caused by molluscum contagiosum virus (MCV), an epitheliotropic DNA virus in the Poxviridae family.(1,2,4) It is characterised by multiple, small, firm, dome-shaped, flesh-coloured or pearly papules with central umbilication, ranging from 1 to about 10 mm in diameter.(1–4) MC is particularly common in children and frequently leads to dermatology or paediatric consultations because of its chronicity, cosmetic impact and potential for household or school spread.(1–3)

Although lesions are benign and self-limiting, the disease can persist for many months or even years, during which new lesions may appear and spread by autoinoculation.(1–3) Conventional management offers a spectrum from watchful waiting to destructive procedures, but many families seek options that are effective, cosmetically acceptable and minimally traumatic for children.(1–3,5) Homoeopathy, with its gentle, individualized approach, is widely used in clinical practice, and several classic and modern repertories

include specific rubrics for MC or molluscum-like eruptions.[4,5,11]This review synthesises conventional and homoeopathic literature to provide a comprehensive overview of MC in children and to highlight the clinical role of key homoeopathic remedies.

Epidemiology

MC is one of the most frequent viral skin infections in childhood, with the highest incidence between 1 and 10 years of age and a peak in preschool and early school years.[1,2,5] Population-based and clinic-based studies report prevalence estimates in children generally ranging from 2% to 8%, with some regions and settings reporting higher figures, particularly in warm, humid climates.[1,2,5] The infection is uncommon in infants under one year, probably due to maternal antibodies and the relatively long incubation period.[1,2,4]

Transmission occurs primarily via direct skin-to-skin contact, autoinoculation through scratching or shaving, and contact with contaminated fomites such as towels, clothing, toys and swimming pool surfaces.[1-3,5]Crowded living conditions, shared bathing facilities, sports with close contact, and use of swimming pools have been recognised as important risk factors.[2-5] Children with atopic dermatitis or underlying immunosuppression tend to exhibit more extensive or recalcitrant disease, with larger lesion burdens and more prolonged courses.[2,4,6]

Aetiology and Pathophysiology

MCV is a double-stranded DNA poxvirus with several molecular subtypes; MCV-1 is responsible for the majority of paediatric cases worldwide.[1,2,4] The virus infects epidermal keratinocytes at sites of minor trauma or barrier disruption, particularly in areas prone to friction or maceration.[2,4]Viral replication induces lobular epidermal hyperplasia and the formation of large intracytoplasmic inclusion bodies (Henderson–Patterson bodies), which are packed with virions.[2,4] These inclusions migrate towards the upper epidermis and central pore, where they contribute to the classic umbilication and facilitate shedding of infectious material, promoting local spread and autoinoculation.[2,4]

In immunocompetent children, the infection remains confined to the epidermis and usually regresses spontaneously once an adequate cell-mediated immune response develops.[1-4] In those with atopic dermatitis, impaired barrier function and itching increase autoinoculation and lesion burden, whereas in immunocompromised hosts, lesions may be larger, more numerous, atypical, and persistent.[2,4,6]

Clinical Features and Diagnosis

Typical MC lesions are discrete, firm, smooth, dome-shaped papules that are flesh-coloured, translucent or pearly, often with a central umbilication or plug.[1–4] Lesions may range from 1 to 10 mm, occur singly or in clusters, and are most commonly found on the trunk, flexural areas, extremities and face in children; genital involvement is more typical in adolescents and adults.[1–4,6] Lesions are usually asymptomatic but may become pruritic, erythematous or inflamed, particularly when the host mounts an immune response (the so-called “beginning of the end” sign) or when secondary bacterial infection occurs.[1-4]

Diagnosis is primarily clinical and relies on the characteristic appearance and distribution of lesions in an appropriate age group.[1-4] Dermoscopy, where available, can reveal central pores, polylobular white or yellowish structures and peripheral vascular patterns that support clinical diagnosis without biopsy.[5] Histopathological examination is reserved for atypical, treatment-resistant or immunocompromised cases and classically shows lobulated epidermal hyperplasia with large intracytoplasmic Henderson–Patterson bodies in keratinocytes.[2,4,6].

Differential Diagnosis

The main differential diagnoses of MC include verruca vulgaris (common warts), folliculitis, milia, and early lesions of varicella (chickenpox).[1,2,4,5]Common warts tend to be hyperkeratotic with rough surfaces and lack central umbilication, while milia are tiny, white, superficial cysts often seen around the eyes without a central pore.[1,2,4] Folliculitis presents with inflamed papules or pustules centred on hair follicles, often tender and sometimes with systemic symptoms, and varicella lesions quickly evolve from macules to vesicles and crusts, usually accompanied by fever and malaise.[1,2,4]

Accurate diagnosis avoids unnecessary invasive procedures, inappropriate therapies and undue anxiety for families.[1,2,4]

Conventional Management

Conventional management options for MC in children range from **watchful waiting** to **physical destructive therapies** and **topical pharmacologic agents**.[1-3,5]Watchful waiting is suitable for immunocompetent children with few asymptomatic lesions, where families are informed about the naturally self-limiting course and measures to reduce spread.[1–3]

Physical modalities include curettage, cryotherapy, cautery and laser ablation, which can remove lesions quickly but are often painful, may require local anaesthesia, and may result in scarring or pigmentary changes, issues of particular concern in visible areas in children. Topical agents such as cantharidin, potassium hydroxide, salicylic acid, retinoids and other caustic or immunomodulatory preparations can be effective but may cause local irritation, blistering or discomfort, and require careful application over multiple weeks. As a result, many clinicians and parents prefer less traumatic, child-friendly approaches, especially when lesion burden or cosmetic concerns are significant but the child is otherwise well.[1-6]

Homoeopathic Perspective

From a homoeopathic standpoint, MC is regarded as a manifestation of internal susceptibility rather than a purely local viral event; it is often understood within psoric or tubercular miasmatic frameworks.[11,12] Homoeopathic management stresses **individualisation**—the remedy is chosen not only on the basis of local skin lesions but also general physical and mental–emotional characteristics, modalities, and constitution.[11–13] Remedies may be continued over time with appropriate potency and repetition, and constitutional treatment may be combined with intercurrent and local-specific remedies as required.[11–13]

Several repertories include specific rubrics for MC or molluscum-like eruptions. Boericke's Clinical Repertory provides a concise but clinically focused entry, while larger repertories such as Kent, Complete and Synthesis offer more detailed cross-references between MC and broader skin rubrics (e.g. warts, papules, tubercular skin conditions).[4,5,11] These repertorial entries, together with case reports and case series, guide remedy selection.

Repertorial Rubrics Relevant to Molluscum Contagiosum

Key rubrics and sub-rubrics used in homoeopathic case analysis for MC include:

- **Boericke's Clinical Repertory**
  - *Skin – Molluscum*: Bromium, Bryonia, Calcarea carbonica, Calcarea arsenicosa, Kali iodatum, Lycopodium, Mercurius solubilis, Natrum muriaticum, Silicea, Sulphur, Tuberculinum bovinum (Bromium, Silicea, Calcarea arsenicosa in first grade).[4,5,11]
- **General skin rubrics that support differentiation** (across Boericke/Kent/modern repertories):[11,12]
  - *Skin – Eruptions – papular / nodular*
  - *Skin – Eruptions – pearly / translucent*
  - *Skin – Eruptions – umbilicated*

- *Skin – Eruptions – warts; soft; multiple*
- *Glands – Enlarged – cervical / axillary*
- *Children – Scrofulous / tubercular constitution*
- *Skin – Eruptions – face; neck; flexures*
- *Skin – Eruptions – chronic; recurrent*

These rubrics, combined with constitutional generals (chilliness, heat, sweat patterns, appetite, fears, modalities), help refine remedy selection among the listed medicines in MC.[4,5,11-13]

Key Homoeopathic Remedies for Molluscum Contagiosum

Overview of principal remedies

Below is a synthesis of the main remedies directly listed under "Skin – Molluscum" in Boericke's Clinical Repertory and commonly cited in clinical literature for MC in children.[4-13]

Bromium

Bromium is a first-grade remedy in Boericke's rubric "Skin – Molluscum" and has supportive evidence from modern paediatric case reports.[4–8] It suits children with **firm, smooth or pearly papules**, especially on the **face and neck**, often with **enlarged cervical glands** and a **scrofulous, delicate constitution** prone to respiratory affections and sensitivity to drafts and warm, stuffy rooms.[4,6,9]

Silicea

Silicea, also first-grade in Boericke for MC, is a fundamental remedy for chronic, indurated, and suppurative conditions.[4,5,10] It is indicated in children with **hard, slow-growing, slow-healing nodules or papules**, a **marked chilly disposition**, **profuse sweating of head and feet**, poor stamina and recurrent infections, suggesting low vitality and impaired expulsion capability.[10,11]

Calcarea arsenicosa

Calcarea arsenicosa, another first-grade remedy in the MC rubric, combines Calcarea and Arsenicum themes and is suited to **lymphatic, scrofulous or tubercular children** who are **chilly, anxious, easily fatigued**, with **chronic glandular or vascular involvement** and long-standing skin tendencies.[4,12,13]In MC, it may be considered when lesions occur in the background of pronounced constitutional weakness, chilliness, anxiety and chronic glandular enlargement.[12,13]

Bryonia

Bryonia is listed in the MC rubric and is better known for acute inflammatory states and serous membranes, but in skin conditions it may present with **dry, hard eruptions** that are worsened by heat and movement, and children often desire quiet, are irritable, and prefer to be left undisturbed.[4,11] It may be considered when MC coexists with typical Bryonia generals and dryness.

Calcarea carbonica

Calcarea carbonica, a major constitutional remedy, appears in the MC rubric and is suited to **fair, flabby, sweaty, chilly children** who are easily fatigued, slow to develop, and prone to recurrent infections and glandular swellings.[4,11] Skin may show **chronic, moist or crusty eruptions**, and in MC such a constitutional background may guide its choice when local lesions coexist with classical Calcarea carbonica traits.[11,12]

Kali iodatum

Kali iodatum is associated with **glandular and periosteal affections** and may exhibit **nodular or infiltrated eruptions**, often with deep, destructive tendencies.[11,12] In MC, it is less commonly used than Bromium or Silicea but can be considered in children with marked glandular enlargement and syphilitic or tubercular traits where iodides are often indicated.[11,12]

Lycopodium

Lycopodium, a deep-acting constitutional remedy, is suited to **thin, intellectually precocious but physically weak children** with **digestive disturbances, right-sided complaints and lack of confidence**, and is listed in the MC rubric. Skin may show chronic eruptions in flexures and hairy areas, and MC with such constitutional features may justify its selection.[11]

Mercurius solubilis

Mercurius solubilis is often associated with **moist, excoriating, offensive eruptions**, glandular swellings and fluctuating temperatures with night aggravation and salivation. In MC, it may be considered where lesions are **inflamed, moist, or secondarily infected**, and general Mercurius features (offensive perspiration, glandular involvement, tremulous weakness) are present.[11,12]

Natrum muriaticum

Natrum muriaticum, a widely used constitutional remedy, appears in the MC rubric and is associated with **chronic skin eruptions**, often in **sun-exposed areas**, with **greasy face, cracking of lips, and headache patterns**. Children are often reserved, sensitive to grief or criticism, and may have a tendency to recurrent herpes and anaemia. In MC, it may be indicated when the constitutional picture is strongly Natrum muriaticum with concomitant molluscum lesions.[11,12]

Sulphur

Sulphur is a leading antipsoric and appears in many skin rubrics, including MC.[4,11,12] It suits **warm-blooded, untidy children**, prone to **itchy, burning eruptions**, worse heat and bathing, with a tendency to scratching until skin is raw.[11,12] In MC, Sulphur may be indicated as a chronic constitutional or intercurrent remedy, especially in cases with extensive or recurrent lesions in a strongly psoric background.

Tuberculinum bovinum

Tuberculinum bovinum is included in the MC rubric and is a central remedy for **tubercular miasmatic states**, with **restlessness, desire for change, recurrent infections, and alternating states of hyperactivity and fatigue**. Skin may show varied chronic eruptions, and MC in distinctly tubercular children with strong family history of tuberculosis or allergic disorders may call for Tuberculinum as a deep-acting constitutional or intercurrent remedy.[11,12]

Table 1. Homoeopathic remedies listed for "Skin – Molluscum" in Boericke's Clinical Repertory, with key indications

Remedy	Repertory grade (Boericke)	Key indications in MC context (summarised)
Bromium	First grade	Firm, pearly papules, especially face/neck; cervical glands; fair, scrofulous, respiratory-prone child.[4,6,9]
Silicea	First grade	Hard, slow-healing nodules; chilly, sweaty, low vitality; recurrent infections.[4,10,11]
Calcarea arsenicosa	First grade	Chilly, anxious, lymphatic/tubercular child; chronic skin/glandular problems, weakness.[4,12,13]
Bryonia	Lower grade	Dry, hard eruptions; irritable, wants rest; worse motion and heat.[4,11]
Calcarea carbonica	Lower grade	Fair, flabby, sweaty, chilly child; chronic skin and glandular issues.[4,11,12]
Kali iodatum	Lower grade	Glandular and infiltrated skin lesions; destructive tendencies; iodide constitution.[11,12]
Lycopodium	Lower grade	Thin, weak, right-sided complaints; digestive troubles; chronic eruptions in flexures.[4,11]
Mercurius solubilis	Lower grade	Moist, offensive eruptions; glandular swelling; night aggravation.[11,12]
Natrum muriaticum	Lower grade	Chronic eruptions, sun-aggravated; reserved, sensitive children.[11,12]
Sulphur	Lower grade	Itchy, burning, psoric eruptions; worse heat and bathing; antipsoric base.[11,12]
Tuberculinum bovinum	Lower grade	Tubercular diathesis; recurrent infections; variable chronic skin eruptions.[11,12]

Clinical Evidence for Homoeopathic Management

Published homoeopathic evidence for MC is largely limited to case reports, case series and small observational studies. A recent evidence-based case report described a 4-year-old child with multiple MC lesions successfully treated with **Bromium 30C**, selected using Boericke's repertory and confirmed by constitutional features; lesions cleared and did not recur over follow-up, with a favourable Modified Naranjo score supporting causality.[6,10]

Several case series and observational reports have shown improvement or complete clearance of MC lesions in children using individualized homoeopathic prescriptions including Bromium, Natrum sulphuricum, Sulphur, Natrum muriaticum, Thuja and others, often with minimal adverse effects and low recurrence.[7-10,14] Small paediatric series report that over half of treated cases achieved complete lesion clearance, a further proportion showed partial improvement, and only a minority failed to respond.[7-10] Institutional and council-based data also hint at benefit but are often limited by small sample sizes, heterogeneity in prescriptions, and lack of control groups.[8,14]

Overall, the evidence base suggests a **potentially useful role for individualized homoeopathic treatment in paediatric MOLLUSCUM** , particularly with remedies repertorially prominent for MC, but underscores

the need for well-designed controlled trials using standardized outcome measures such as lesion count, validated severity indices and recurrence rates.[6-10]

Conclusion

MC is a very common viral dermatosis in childhood, causing cosmetic, social and psychological distress despite its benign and self-limiting nature. Conventional therapies can be effective but may be painful, cosmetically risky, and poorly accepted in children, encouraging interest in gentler alternatives. Homoeopathy offers an individualized, non-invasive approach, supported by repertorial evidence (notably the "Skin – Molluscum" rubric in Boericke's Clinical Repertory) and a set of clinically relevant remedies including Bromium, Silicea, Calcarea arsenicosa, Bryonia, Calcarea carbonica, Kali iodatum, Lycopodium, Mercurius solubilis, Natrum muriaticum, Sulphur and Tuberculinum bovinum. Case-based and observational evidence suggests that such remedies, when well indicated, may promote lesion resolution and reduce recurrence with good tolerability in children, but robust comparative trials are necessary to clearly define their place alongside or as an alternative to conventional management.

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