essentially supportive. Prophylactic antibiotics are needed only when *M. pneumoniae* is suspected.

The role of steroids is controversial and better avoided when infectious etiology is suspected. Encouraging results are being published recently with intravenous immunoglobulin therapy. Affected children are to be followed up regularly for sequelae like keratitis sicca, synechae, symblepharon and skin pigmentation.

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Giant Molluscum Contagiosum

A 10-year-old healthy girl presented with erythematous, broad based exuberant growth over medial aspect of left upper eyelid of one-month duration. Tip was umbilicated, with adjacent yellowish crust (*Fig. 1.*). Multiple pearly umbilicated lesions on both eyelids were present. She developed irritation in the left eye with redness and watering. Examination revealed chronic blepharitis, follicular conjunctivitis and multiple papules over lid margins. Extirpation of the papule led to expression of the curd like central core, which on gram stain showed pinkish, homogenously, staining molluscum bodies. Bacterial cultures of the crust grew staphylococcus aureus. A diagnosis of molluscum contagiosum of the eyelid was made. Serology for HIV was negative. Patient was prescribed oral cloxacillin and all lesions were extirpated

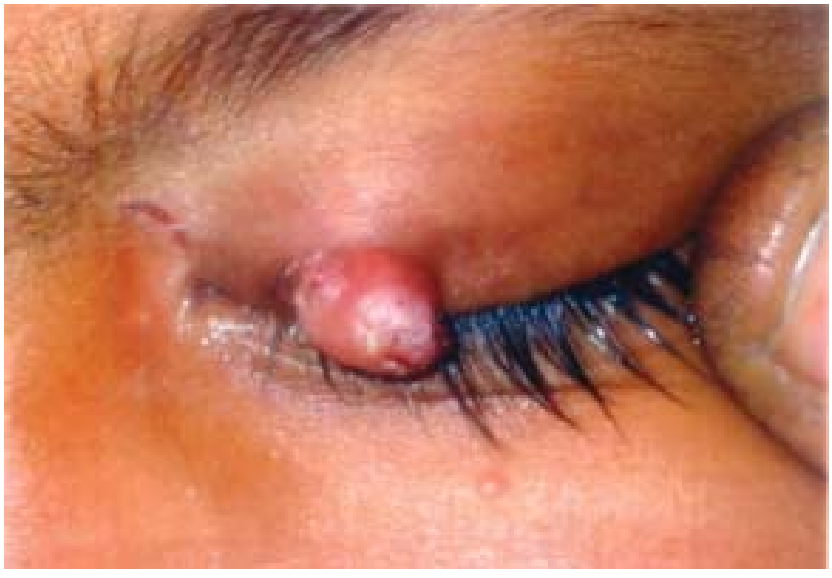

Fig. 1. Erythematous broad based umbilicated lesion over left upper eyelid. Note adjacent small pearly papules.

followed by 10% TCA cauterization.

Molluscum contagiosum is a common skin infection in children caused by DNA poxvirus. It spreads by both sexual and nonsexual route like direct contact with infected skin or fomites. After an average incubation period of two to three months, flesh colored, dome shaped, 3-5 mm sized papules with central umbilication appear on the face, trunk and exposed body parts. In patients with acquired immune disease syndrome, such lesions can occur on the eyelid, conjunctiva and can be large in size (10-15 mm) and number, resistant to therapy and more prone to secondary infection. Thus all patients with the aforesaid presentation should be screened for HIV. Increased number of lesions may also be seen in patients with atopic dermatitis, malig-nancies and, those on steroids and other immunosuppresive drugs. Differential diag-noses include folliculitis, warts, basal cell epi-thelioma, keratoacanthoma, cryptococcosis and nevi. Laboratory confirmation is by demonstrating the enlarged epithelial cell with intracytoplasmic molluscum bodies on cytologic or histologic studies. Newer diagnostic options include electron microscopy, *in-situ* DNA hybridization and fluorescent antibody test. Treatment modalities include cryotherapy with liquid nitrogen, extirpation followed by cauterization of the base with electro-dessication, or chemical agents such as silver nitrate, phenol and trichloroacetic acid. Resistant cases in immunocompromised patients may be treated with topical antiviral agent cidofovir(5%) or intralesional interferon alpha. Infected patients should avoid sharing of towels and common bathing areas like swimming pools.

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