Introduction
Dermatoses of the nipple are rare and diagnosis of such lesions causes great dilemma. Typical clinical features include Paget’s disease, including eroded and scaling nipple areola, molluscum contagiosum (MC) (i.e., pearly, papular lesions with dimples in the center), cellular blue nevus, and a rare example of pedunculated nipple–areola.

However, MC being a common cutaneous infection rarely presents on nipple. These lesions are caused by a double-stranded DNA poxvirus. Skin lesions classically present as small, flesh-colored papules with central umbilication. Lesions are frequently seen on the face, trunk, and extremities of children, or on the genitals of young adults as a sexually transmitted infection. Till now only few such cases are reported, so here we report a case of MC.

Case Report
A 20-year-old woman presented to the Department of Surgery and her medical history revealed that she had swelling over right breast areola region measuring 1 × 0.5 cm which is attached to the nipple and blood-stained discharge present since 3 days. She had not taken any treatment. Family history revealed that no such lesions were present in her family. On palpation, it was soft in consistency, non-compressible, and non-tender. There was no history of surface discharge or alteration in their size. No such lesions were present elsewhere on the body. Routine blood investigations were performed, and the patient was also found to be HIV serology negative.

Cytopathology revealed intracytoplasmic inclusion in keratinocytes, appearing as ovoid and deeply basophilic bodies with a hyaline, homogeneous structure surrounded by a membrane (molluscum bodies). The background shows mixed inflammatory cell infiltrate and anucleate squames. On the basis of case history and clinical findings, working diagnosis of MC was made [Figures 1 and 2].

Investigations
Cytopathology revealed characteristic molluscum bodies. HIV serology was negative.

Treatment
It depends on clinical presentation of the disease.
In young immunocompetent children, aggressive treatment should not be attempted as it causes scarring. Instead, continuous application of surgical tape to each lesion after bathing can yield better results.

If the lesions are limited and child is cooperative, light cryotherapy, application of trichloroacetic acid, or removal by curettage are other treatment modalities. Application of eutectic mixture of local anesthetics cream for 1 h before any painful treatment can further relieve the distress. Topical 5% sodium nitrite with salicylic acid can also be used.

In adults with genital involvement, removal by curettage or cryotherapy is most effective, or surgical excision. Screening for other probable coexistent sexually transmitted disease (STD) should be compulsorily done.

In our case, we had used local application of topical 5% sodium nitrite with salicylic acid and swelling over nipple gradually reduced with time (i.e., 21 days) [Figures 3 and 4].

Discussion

MC is a common, self-limiting skin lesion associated with MC virus (MCV), a member of the poxviridae family. It spread by direct contact with infected individuals or fomites. It is primarily found in three distinct patient populations: children, sexually active adults, and immunocompromised individuals. Children frequently develop MC lesions on the trunk, arms, and face. Adults may develop lesions near the genitals as a sexually transmitted infection. Finally, in immunocompromised individuals MC can present with atypical morphology (such as giant lesions) or unusual distribution (such as disseminated).

The lesions of MC have a characteristic appearance. They are small (2–8 mm), pearly, dome-shaped, skin-colored papules with central umbilication. They can be solitary. However, they more commonly present in clusters, which have an average of 11–20 lesions. Immunocompromised patients or those with atopic dermatitis may develop multiple, diffusely distributed lesions of MC. Lesions are usually asymptomatic. However, some patients complain of tenderness or pruritus.

The areola and nipple are unusual locations to develop MC. Using the search terms MC and breast or nipple or areola, we have reported this case in which there was MC on nipple. Diagnosis was confirmed on the basis of histology and patient was not immuno compromised.

We had treated the patient with salicylic acid, and on fourth day the size of swelling over nipple got decreased. The clinical diagnosis of MC is usually straightforward and histological examination is often unnecessary.

Differential diagnosis comprises Paget's disease, papilloma, papular granuloma annulare, syringoma, basal cell carcinoma, benign adnexal tumor, condyloma accuminatum, cutaneous fungal infections (coccidioidomycosis, cryptococcus, or histoplasmosis), glandular (adenomatous) hyperplasia, keratoacanthoma, leiomyoma, and verruca vulgaris.

The definitive diagnosis of MC is made by visualizing molluscum bodies (Henderson–Patterson bodies), the pathognomonic feature of MCV. Molluscum bodies are large, ovoid, homogeneous, dense bodies found in the cytoplasm of infected keratinocytes. They often are sufficiently large to displace the nucleus to the cell periphery. Identification of molluscum bodies can be made using either cytology or histology. Clinicians can attempt to express keratinous material through the central pore of the molluscum
papule; this material can be applied to a slide and stained, using Giemsa, Gram, Papanicolaou, or Wright stain. This allows clinicians to make a diagnosis without needing to do a lesional biopsy. Alternatively, molluscum bodies can be identified on tissue obtained from a punch or shave biopsy of a clinical lesion.

Treatment of MC is somewhat controversial. The lesions are usually self-limiting. In such individuals, they generally clear spontaneously in 6–9 months. However, owing to the highly contagious nature of the disease, many practitioners opt to treat the lesions. Medical options include cantharidin, cidofovir, cimetidine, imiquimod, salicylic acid, or retinoic acid. Alternatively, lesions may be treated with cryotherapy, curettage, or surgical excision.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

References
1. Brown J, Janniger CK, Schwartz RA, Silverberg NB. Childhood molluscum contagiosum. Int J Dermatol 2006;45:93-9 (Review).
2. Bandino JP, Wohltmann WE, Hivnor CM. What is your diagnosis? Giant molluscum contagiosum. Cutis 2011;88:164,170-2.
3. Inui S, Asada H, Yoshikawa K. Successful treatment of molluscum contagiosum in the immunosuppressed adult with topical injection of streptococcal preparation OK-432. J Dermatol 1996;23:628-30 (Review).
4. Schmid-Wendtner MH, Rütten A, Blum A. [Flat rapidly growing tumor in a 20-year-old woman]. Hautarzt 2008;59:838840 [German].
5. Carvalho G. Molluscum contagiosum in a lesion adjacent to the nipple. Report of a case. Acta Cytol 1974;18:532-4.
6. Kumar N, Okiro P, Wasike R. Cytological diagnosis of molluscum contagiosum with an unusual clinical presentation at an unusual site. J Dermatol Case Rep 2010;4:63-5.
7. Parlakgumus A, Yildirim S, Bolat FA, Caliskan K, Ezer A, Colakoglu T, et al. Dermatoses of the nipple. Can J Surg 2009;52:160-1.
8. Hanson D, Diven DG. Molluscum contagiosum. Dermatol Online J 2003;9:2.
9. Guirguis-Blake J. Interventions for molluscum contagiosum. Am Fam Physician 2006;74:1504.