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Sclerotherapy With Polidocanol for Digital Myxoid Cysts: A Series of 15 Cases☆

Tratamiento de los quistes mixoides digitales con escleroterapia con polidocanol: serie de 15 casos

To the Editor,

Digital myxoid cysts are the most common benign tumors of the fingers and toes. They present as single, generally translucent, nodules that typically affect the dorsal or lateral aspect of the distal interphalangeal joints or the proximal nail fold.[1] They tend to be asymptomatic, although they can cause pain.[2] The mechanism underlying their development is unclear. In most cases, degenerative changes involving the fibrous capsule of the joint are present. Multiple treatments exist, but none has proven ideal.

Polidocanol solution is a liquid sclerosing detergent that has been used to treat varicose veins, venous malformations, and other vascular anomalies.[1] The aim of this study was to describe our experience with the use of polidocanol sclerotherapy in the treatment of digital myxoid cysts at 2 university hospitals in Spain.

We performed a descriptive study of 15 digital myxoid cysts treated with polidocanol at Hospital Universitario Germans Trias i Pujol and Hospital Universitario Virgen de las Nieves. The procedure consisted of making an incision in the cyst and draining the fluid after application of cryoanesthesia. Polidocanol (Etoxisclerol 20/mL) was injected through the drainage incision using an insulin needle. The area was then covered with a compression bandage for 1 week. The first follow-up visit to assess response to treatment was held after 6 weeks. Patients with persistent cysts were advised to receive a second injection and return in 6 weeks.

Thirteen patients with 15 myxoid cysts were treated with polidocanol sclerotherapy (Table 1). Most of the patients (11/13 [85%]) were women. Their median age was 49.5 years (range, 41-79 years) and the median time since onset was 12 months (range, 4-24 months). Pain (9/13) and nail dystrophy (4/13) were the most common symptoms. One-third of the patients (5/13) had undergone previous treatment with corticosteroid injections and surgery. All 15 myxoid cysts were located on the fingers and the most common location was the distal interphalangeal joint of the third right finger.

At the 6-week follow-up visit, 8 of the 15 cysts had resolved completely, 6 had improved, and 1 persisted. The 6 cysts that showed improvement were treated with a second injection and 5 of them resolved. After 12 weeks thus, 13 of the 15 cysts (86%) had resolved (Fig. 1). Half of the patients (7/13) described pain as the most common adverse effect, but this disappeared in a few days. Just 3 of the 15 myxoid cysts recurred over a follow-up period of 6 months.

Various treatments exist for symptomatic digital myxoid cysts, including drainage, injection therapy with corticosteroids or sclerosing agents, cryotherapy, carbon dioxide or Nd:YAG laser therapy, and surgical excision. No treatment guidelines are available and none of the treatments used to date has proven to be totally effective.[1] Recurrence and adverse effects are common.

Little has been published on the use of polidocanol sclerotherapy in the treatment of digital myxoid cysts. Sclerosing agents include detergents (polidocanol, sodium sulfate, and sodium diatrizoate), chemical agents (iodine, alcohol), and osmotics (salicylates, hypertonic saline). Polidocanol is the most widely used agent for myxoid cysts.[2] Sclerosing agents attack the cell membrane, damaging the endothelial lining and triggering occlusion of the blood vessels that feed the cyst.[2]

The authors of a systematic review proposed sclerotherapy as second-line treatment after surgery, as they found it was the nonsurgical technique with the highest cure rates.[2,4]

The response rate in our series is similar to that described in 2 previous series of 63 and 6 cases, which reported a cure rate of 80% after 1 or 2 sessions.[3]

Surgery has the highest success rate, with resolution in up to 95% of cases and recurrence rates ranging from 2% to 10%, depending on the approach.[2,4] It is, however, an invasive technique that can cause considerable adverse effects.[2] Cryotherapy has a cure rate of 61.1% and a recurrence rate of 10%.[2] Corticosteroid injection therapy combined with drainage and aspiration of cyst contents is associated with a cure rate of 50% to 64% and frequent recurrences.[2,4] Finally, carbon dioxide laser therapy is associated with a 66% cure rate and a 33% relapse rate.[2]

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Table 1 Summary of Clinical and Epidemiological Variants.

Sex	Age, y	Time Since Onset, mo	Location	Clinical Manifestations	Previous Treatment	Injections, No.	Adverse Effects	Follow-up at 6 wk	Follow-up at 12 wk
F	57	12	Fifth DIJ, left	Pain	None	1	Pain, discoloration	Resolution	Resolution
F	41	12	Third DIJ, left	Pain, inflammation	Triamcinolone acetonide, 40 mg/mL	2	Pain	Improvement	Recurrence
F	69	8	Second DIJ, right	Pain	None	1	None	Improvement	Resolution
F	49	20	Third DIJ, left	Pain	Triamcinolone acetonide, 40 mg/mL	1	Discoloration	Resolution	Resolution
F	79	24	Third DIJ, left	Pain, inflammation	None	1	None	Persistence	Persistence
F	50	24	Fourth DIJ, right	Pain, dystrophy	None	1	Pain	Improvement	Resolution
M	42	12	Third/second DIJs, left	Pain	Triamcinolone acetonide, 40 mg/mL	2	Pain	Resolution/improvement	Resolution/resolution
F	62	24	Third DIJ, right	Pain	None	1	Pain	Resolution	Resolution
F	47	4	Second DIJ, right	None	None	1	None	Resolution	Resolution
M	55	12	Second DIJ, left/first DIJ, right	Dystrophy	None	1	None	Resolution/resolution	Resolution/resolution
F	45	12	Second DIJ, left	Dystrophy	Triamcinolone acetonide, 40 mg/mL; surgery	2	Pain	Improvement	Resolution
F	42	3	Third DIJ, right	Pain	None	1	Inflammation	Resolution	Resolution
F	50	6	Second DIJ, right	Dystrophy	Triamcinolone acetonide, 40 mg/mL; surgery	2	Pain, joint stiffness	Improvement	Resolution

Abbreviation: DIJ, distal interphalangeal joint.

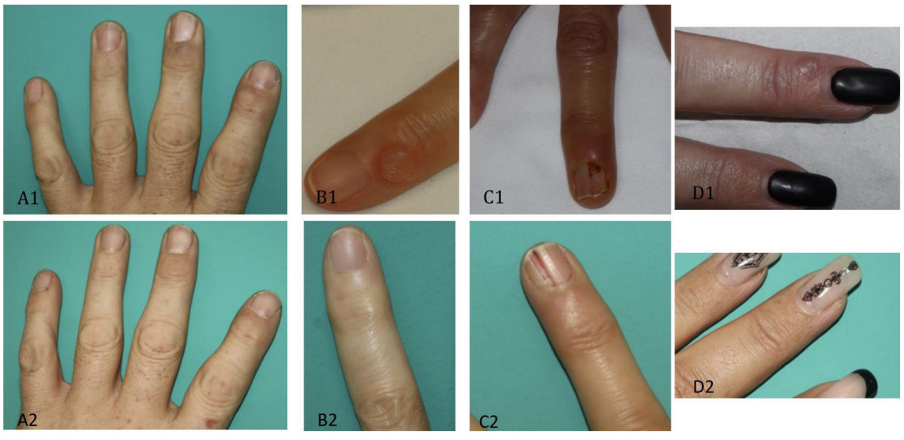

Figure 1 Pretreatment (1) and posttreatment (2) photographs of myxoid cysts in third left DIJ (A1,A2), fifth left DIJ (B1, B2), fourth right DIJ (C1, C2), and third left DIJ (D1,D2). DIJ indicates distal interphalangeal joint.

We have presented the largest Spanish series of digital myxoid cysts treated with polidocanol. We believe that polidocanol sclerotherapy is a good option for treating digital myxoid cysts, as it is minimally invasive and is associated with high cure rates and low recurrence and complication rates.

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Dermoscopy of Plantar Molluscum Contagiosum☆

Dermatoscopia de un molusco contagioso plantar

To the Editor:

We read with interest the article ''Molluscum Contagiosum on the Palms: An Uncommon Location''.[1] The authors describe an adult male with 2 molluscum contagiosum (MC) lesions on the right hand and perform a review of the literature of reported cases of palmoplantar MC.

We report the clinical findings and dermoscopic characteristics of a new case of plantar MC seen recently in a 10-year-old girl, with no past history of interest, who visited our department with stable asymptomatic lesions on the right foot that had appeared 4 months earlier. The patient did not recall having suffered any local trauma and had not undergone prior treatment. She used a swimming pool twice a week and had a personal history of plantar hyperhidrosis and atopic diathesis, with several episodes of dyshidrotic eczema and juvenile plantar dermatitis in the past 3 years.

The dermatologic examination revealed 2 dome-shaped erythematous papules with an umbilicated center measuring 2 mm in diameter, located on the instep and sole of the right foot (Figs. 1 and 2A). Dermoscopy revealed a yellowish round central structure and branching vessels in a crown distribution on the periphery (Fig. 2B).

The lesions were treated with curettage and histopathology confirmed the suspected diagnosis of MC. The lesion was revealed to be nodular in the form of endophytic lobules with a squamous epithelium with molluscum bodies maturing toward the surface (Fig. 3).

MC is a very common skin infection caused by the poxvirus *Molluscum contagiosum*. Transmission is by direct contact, fomites, or autoinoculation. It usually manifests as dome-shaped umbilicated papules that are whiteish or the same color as normal skin, measuring between 3 and 5 mm in diameter, and generally asymptomatic.[2]

It mainly affects 3 population groups: children, sexually active adults, and immunosuppressed persons. In children, MC lesions tend to be found on the torso and extremities, whereas in adults, they usually present in the genital region, lower part of the abdomen, pubis, and proximal surface of the thighs.[2,3] Regardless of age, subungual or interdigital involvement, or involvement of the conjunctival and oral mucosa and of the palmoplantar region is exceptional. Atypical clinical presentations (giant forms), extensive lesions, lesions on the face and neck, or other uncommon locations tend to occur particularly in the context of immunosuppression.[4,5]

The clinical diagnosis of plantar MC is more difficult, as the lesions tend to lack the usual clinical characteristics (they rarely present as umbilicate papules with a central keratin plug).[6] They present as single or multiple papules or nodules with varying coloration (normal skin, erythematous, brownish, translucent, or yellowish) and with a hyperkeratotic, verrucous, or crusted surface. Most patients have only 1 giant lesion ($\geq$ 1 cm in diameter), that is painful on walking.[1,7]

While infection with the MC virus is more frequent in childhood and in atypical locations in immunocompromised patients, most cases of palmoplantar involvement have been reported in immunocompetent adults. It may be that the thickness of the stratum corneum on the palms and soles makes entry of the poxvirus more difficult (it is much larger than the human papilloma virus). Moreover, local trauma and plantar hyperhidrosis may be predisposing factors.[1]

The differential diagnosis of plantar MC is broad and includes plantar warts, plantar corns, pyogenic granuloma,

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