Supplemental Online Content

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This supplemental material has been provided by the authors to give readers additional information about their work.

eMethods 1: Investigator training for diagnosis and molluscum contagiosum (MC) lesion counts

Principal investigators, including pediatricians and dermatologists, diagnosed MC clinically, based on observation of the characteristic skin-colored pearly papules with or without umbilication; biopsies were not conducted. All participating investigators and evaluators received formal training in lesion recognition by inspection (ie, with/without magnification and palpation) and systematic lesion counting. Only treatable lesions, defined as active (raised, palpable) MC lesions that were at least 2 cm away from the ocular region, were counted. If agminated (clustered) lesions could not clearly be differentiated, then this was counted as 1 lesion. Investigators/evaluators were consistent with the method of counting lesions throughout the study.

Investigator training included differential diagnosis and recognition of residual post-resolution skin findings such as erythema, hyper- or hypopigmentation, and pitted scarring (indentation). All study personnel who performed lesion counts were required to pass an online training examination.

eMethods 2: Analyses of secondary endpoints

If the primary endpoint was statistically significant at $\alpha = .05$, then secondary efficacy endpoints were testing in the following hierarchical fixed-sequence: 1) percentage of patients achieving an MC lesion count of 0 or 1 at Week 12 using nonresponder imputation (NRI); percentage of patients achieving ≥90% reduction from baseline in the number of MC lesions at Week 12 using NRI; 3) percentage of patients with complete clearance of all MC lesions at Week 8; 4) percent change from baseline in the number of all treatable MC lesions at Week 4. NRI was used for missing week-12 lesion counts, and missing week-8 lesion counts were imputed using the monotone regression method based on previous lesion count assessments, treatment, investigator type (dermatologist vs other), household number of randomized patients (1 vs 2), baseline beginning-of-the-end (BOTE) score (0 vs ≥1), age, and baseline lesion count. A mixed model for repeated measures (MMRM) was used to analyze percent change from baseline in the number of treatable MC lesions at week 4. The model included treatment, visit, treatment-by-visit interaction, investigator type (dermatologist vs other), household number of randomized subjects (1 vs 2), baseline BOTE score (0 vs ≥1), age, and baseline lesion count as factors with an unstructured covariance matrix.

eTable 1. Local Skin Reaction Score

	Erythema	Flaking/ Scaling	Crusting	Swelling	Vesiculation/ Pustulation	Erosion/ Ulceration
0	Not present	Not present	Not present	Not present	Not present	Not present
1	Slightly pink	Mild, limited	Isolated crusting	Minimal, limited	Fine vesicles	Superficial erosion
2	Pink or light red	Moderate	Crusting <50%	Mild, palpable	Scant transudate or exudate	Moderate erosion
3	Red, restricted to treatment area	Coarse	Crusting >50%	Moderate	Moderate transudate or exudate	Marked, extensive
4	Red extending outside treatment area	Scaling extending outside treatment area	Crusting extending outside treatment area	Marked swelling extending outside treatment area	Marked transudate or exudate	Black eschar or ulceration