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Original Research Article.

Comparative Analysis of Efficacy and Tolerability of KOH 10% and Glycolic Acid 12% Cream for Molluscum Contagiosum at a Tertiary Care Centre

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ABSTRACT

Background: Molluscum contagiosum is a common, benign, self-limiting viral infection of the skin caused by a poxvirus and is frequently encountered in dermatology practice, especially in children and young adults. Although spontaneous resolution may occur, treatment is often sought because of cosmetic concerns, autoinoculation, secondary spread, and associated irritation. Various topical modalities have been used for its treatment, among which potassium hydroxide and glycolic acid are simple, cost-effective, and easily applicable options. However, comparative data regarding their efficacy and tolerability remain limited.

Aim: To comparatively analyze efficacy and tolerability of topical potassium hydroxide (KOH) 10% solution and glycolic acid 12% cream for molluscum contagiosum at a tertiary care centre.

Materials and Methods: This hospital-based comparative interventional study included 90 clinically diagnosed cases of molluscum contagiosum. Patients fulfilling the inclusion criteria were enrolled after obtaining informed consent and were allocated into two equal groups of 45 patients each. Group A was treated with topical 10% KOH solution and Group B with topical 12% glycolic acid cream. Baseline demographic and clinical parameters such as age, sex, duration of disease, number of lesions, lesion distribution, and symptoms were recorded. Patients were followed up regularly, and treatment response was assessed on the basis of reduction in lesion count, complete clearance, and recurrence. Tolerability was evaluated by documenting adverse effects including erythema, burning sensation, itching, erosion/crusting, and post-inflammatory hyperpigmentation.

Results: The two groups were comparable with respect to age, gender, duration of disease, baseline lesion count, and site of involvement. Complete response was observed in 66.67% of patients in the 10% KOH group and 53.33% in the 12% glycolic acid group. Good response was seen in 17.78% and 22.22%, while partial response was noted in 11.11% and 15.56% of patients, respectively. The mean reduction in lesion count was significantly higher in the KOH group (7.84 ± 3.12) compared to the glycolic acid group (6.91 ± 3.05) (p=0.04). Recurrence was observed in 6.67% of patients treated with KOH and 11.11% treated with glycolic acid cream. Burning sensation was significantly more common with KOH (40.00%) than with glycolic acid cream (20.00%) (p=0.04), while other adverse effects were comparable between the groups.

Conclusion: Both 10% KOH and 12% glycolic acid cream were effective in the treatment of molluscum contagiosum. However, 10% KOH showed better efficacy in terms of complete clearance and reduction in lesion count, whereas 12% glycolic acid cream demonstrated better tolerability with fewer adverse effects. Thus, 10% KOH may be preferred when higher efficacy is desired, while 12% glycolic acid cream may be considered when tolerability is a major concern.

Keywords: Molluscum Contagiosum; Potassium Hydroxide; Glycolic Acid; Efficacy; Tolerability.

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INTRODUCTION

Molluscum contagiosum is a common, benign, self-limiting viral infection of the skin caused by the molluscum contagiosum virus, a member of the Poxviridae family. It is characterized by discrete, smooth, dome-shaped, pearly or skin-colored papules with central umbilication. The disease occurs worldwide and is seen predominantly in children, although adolescents, sexually active adults, and immunocompromised individuals may also be affected. Because of its contagious nature, tendency for autoinoculation, and frequent spread among siblings, classmates, and close contacts, molluscum contagiosum remains an important

dermatological problem encountered in daily clinical practice. Despite its benign course, the condition often creates considerable concern in patients and caregivers because of cosmetic disfigurement, fear of transmission, persistence of lesions, and associated inflammation or itching.[1] The infection is usually acquired by direct skin-to-skin contact, contact with contaminated fomites, or through autoinoculation from scratching and rubbing of lesions. In children, lesions commonly involve the face, trunk, axillae, and extremities, while in adults they may involve the genital area and lower abdomen, especially when sexually transmitted. The disease is more frequent in individuals with impaired skin barrier function, such as those with atopic dermatitis, and in immunosuppressed patients in whom lesions may be larger, more numerous, more persistent, and atypical in morphology. Although diagnosis is often clinical, atypical lesions can sometimes mimic other papular disorders, making careful examination essential for accurate recognition. Dermoscopy may provide additional support in doubtful cases by demonstrating central white-yellow amorphous areas with surrounding vascular patterns, thereby increasing diagnostic confidence in outpatient settings.[2] Molluscum contagiosum is self-resolving in many healthy individuals, but spontaneous clearance may take several months to years. During this period, new lesions may continue to appear because of autoinoculation, and secondary complications such as eczematization, excoriation, bacterial superinfection, erythema, crusting, and post-inflammatory pigmentary changes may develop. In addition to physical symptoms, the infection can produce psychological and social distress, particularly when lesions are numerous, recurrent, located on exposed parts, or associated with stigma in school-going children and adolescents. For these reasons, many patients and parents prefer active treatment rather than watchful waiting. The decision to treat is therefore usually influenced not only by the biological behavior of the disease but also by lesion number, site, symptom burden, cosmetic concern, risk of spread, and patient preference.[3] A wide variety of treatment modalities have been used for molluscum contagiosum, including mechanical methods such as curettage, cryotherapy, and cauterization, as well as topical therapies such as cantharidin, retinoids, salicylic acid, potassium hydroxide, trichloroacetic acid, benzoyl peroxide, imiquimod, and other keratolytic or irritant agents. However, no single therapy is universally accepted as ideal, and each option has limitations related to efficacy, discomfort, need for repeated visits, cost, scarring, or poor tolerability in children. In routine dermatology practice, there is persistent interest in simpler topical agents that are inexpensive, easy to apply, suitable for home use, and capable of producing acceptable lesion clearance with minimal adverse effects. This has made chemical destructive agents particularly attractive in resource-limited and high-volume outpatient settings.[4] Potassium hydroxide is a strong alkali with keratolytic action and has been used topically in varying strengths for molluscum contagiosum. Its therapeutic effect is believed to result from dissolution of keratin and induction of a local inflammatory reaction, leading to destruction of infected epidermal cells and eventual elimination of lesions. Topical 10% KOH is especially attractive because it is inexpensive, simple to prepare, and can be applied by patients or caregivers at home after proper instruction. At the same time, local irritation, burning, erythema, crusting, and erosions may occur, making tolerability an important consideration. Since treatment success in molluscum contagiosum must be assessed not only by lesion clearance but also by patient comfort and adverse-effect profile, comparative evaluation of efficacy and tolerability becomes clinically relevant.[5] Glycolic acid, an alpha-hydroxy acid widely used in dermatology for its keratolytic, exfoliative, and epidermal remodelling properties, has also been explored as a therapeutic option for superficial papular dermatoses. By promoting desquamation and epidermal turnover, glycolic acid may help remove infected keratinocytes and facilitate resolution of molluscum lesions. Compared with stronger caustic agents, it may offer a milder and more cosmetically acceptable alternative, especially in patients with sensitive skin or lesions over exposed sites. However, its relative effectiveness in comparison with potassium hydroxide is less clearly established, and there is limited direct comparative evidence evaluating these two topical agents under similar clinical conditions.[6] Present study was conducted to comparatively analyze efficacy and tolerability of topical potassium hydroxide (KOH) 10% solution and glycolic acid 12% cream for molluscum contagiosum at a tertiary care centre.

MATERIALS AND METHODS

This hospital-based comparative interventional study included 90 clinically diagnosed cases of molluscum contagiosum. Patients attending the dermatology outpatient department who fulfilled the eligibility criteria were enrolled after obtaining informed consent. In the case of children, consent was obtained from parents or legal guardians. The diagnosis was made on the basis of characteristic clinical features such as discrete, smooth, dome-shaped, pearly or skin-colored papules with central umbilication. The study included 90 patients, who were allocated into two equal groups of 45 patients each. Group A received topical 10% KOH, while Group B received topical 12% glycolic acid cream. Allocation of patients into the two treatment groups was done in a comparable manner to allow evaluation of treatment response and adverse effects between the two modalities.

Eligibility Criteria:

Patients of either sex with clinically diagnosed molluscum contagiosum and willing to participate in the study were included. Patients with secondary bacterial infection over lesions, inflamed or irritated lesions requiring immediate alternative therapy, immunocompromised status, known hypersensitivity to study medications, those already receiving treatment for molluscum contagiosum, and patients unlikely to comply with follow-up instructions were excluded from the study.

Methodology

At enrollment, detailed demographic and clinical data were recorded in a predesigned proforma. Parameters documented included age, sex, duration of disease, number of lesions, size of lesions, anatomical site involved, distribution of lesions, presence of symptoms such as itching or irritation, history of similar lesions in family members or contacts, previous treatment history, and associated dermatological or systemic illness. A complete cutaneous examination was performed in all patients. Baseline clinical photographs were taken after obtaining consent, wherever feasible, for objective comparison during follow-up.

Patients in Group A were treated with topical 10% KOH solution, while patients in Group B were treated with topical 12% glycolic acid cream. The medication was advised to be applied carefully

over the lesions only, avoiding surrounding normal skin, eyes, and mucosal surfaces. Patients or caregivers were instructed regarding the method of application, quantity to be used, and precautions to minimize irritation. They were also advised not to manipulate or scratch the lesions and to maintain proper hygiene to reduce autoinoculation and transmission.

All patients were followed up at regular intervals in the outpatient department. At each follow-up visit, the lesions were assessed clinically and treatment response was documented. The parameters evaluated included reduction in the number of lesions, reduction in lesion size, appearance of inflammation suggestive of therapeutic response, complete clearance of lesions, development of new lesions, and recurrence if any. Standardized clinical photographs were taken during follow-up visits whenever possible to support objective assessment.

The primary outcome measure was efficacy of treatment, assessed by complete clearance or reduction in the number of molluscum contagiosum lesions. Secondary outcome measures included reduction in lesion size, proportion of patients achieving marked improvement, time taken for clinical response, and recurrence during follow-up. Treatment tolerability was assessed by documenting adverse effects such as erythema, burning sensation, itching, pain, erosion, crusting, post-inflammatory hyperpigmentation, hypopigmentation, and secondary infection. Patient acceptability and overall satisfaction with treatment were also noted.

Efficacy was assessed by comparing the baseline number of lesions with the lesion count at subsequent follow-up visits. Clinical response was graded as complete response when all lesions had cleared, good response when there was marked reduction in lesion count, partial response when there was some reduction without complete clearance, and no response when there was minimal or no change. The overall efficacy of 10% KOH and 12% glycolic acid cream was compared on the basis of these clinical outcome parameters.

Tolerability was assessed in each patient by recording local and subjective adverse effects at every visit. Severity of side effects was graded as mild, moderate, or severe based on the extent of discomfort, visible irritation, and need for interruption or discontinuation of treatment. Patients developing severe irritation or unacceptable adverse effects were managed appropriately, and continuation of therapy was decided on clinical grounds.

Statistical Analysis

All clinical findings and follow-up data were entered into a structured data collection sheet and later compiled for analysis. Data were analyzed using SPSS version 21.0. Quantitative variables were expressed as mean and standard deviation, while qualitative variables were expressed as frequency and percentage. Comparison of categorical variables between the two groups was done using the chi-square test or Fisher's exact test as appropriate. Continuous variables were compared using the independent sample t-test. A p-value of less than 0.05 was considered statistically significant.

RESULTS

Table 1 shows that the two treatment groups were comparable with respect to demographic profile. The mean age of patients in Group A treated with 10% KOH was 14.82 ± 6.24 years, while in Group B treated with 12% glycolic acid cream it was 15.31 ± 5.98 years. The difference in mean age between the two groups was not statistically significant (p=0.68), indicating that both groups were similar in terms of age distribution. When age was further categorized, 40.00% of patients in Group A and 37.78% in Group B were aged ≤10 years, while 33.33% and 35.56% belonged to the 11–20 years age group, respectively. Patients aged >20 years constituted 26.67% in both groups. The p-value of 0.91 for age group distribution confirms that there was no statistically significant difference between the two groups.

With regard to gender distribution, males were slightly more common than females in both groups. In Group A, 57.78% were males and 42.22% were females, whereas in Group B, 55.56% were males and 44.44% were females. However, the difference was not statistically significant (p=0.83).

Table 2 compares the baseline clinical profile of patients in both groups and shows that the disease characteristics were similar at the start of treatment. The mean duration of molluscum contagiosum was 3.84 ± 1.92 months in Group A and 3.76 ± 1.88 months in Group B, with no statistically significant difference (p=0.82). The mean number of lesions at baseline was 9.62 ± 4.13 in Group A and 9.28 ± 3.95 in Group B. The p-value of 0.71 indicates that this difference was not statistically significant, suggesting an almost equal lesion burden in both groups prior to treatment. With respect to anatomical distribution of lesions, the face was the most commonly involved site in both groups, affecting 44.44% of patients in Group A and 42.22% in Group B. Trunk involvement was seen in 24.44% and 26.67% of patients, respectively, while extremity involvement was noted in 31.11% of patients in both groups. The site-wise distribution was also statistically comparable (p=0.88). Symptoms such as itching or irritation were present in 28.89% of patients in Group A and 26.67% in Group B, again with no statistically significant difference (p=0.81).

Table 3 presents the overall treatment response in the two study groups. Complete response, defined as total clearance of lesions, was achieved in 66.67% of patients in Group A compared to 53.33% in Group B. Although the proportion of complete responders was numerically higher in the KOH group, the difference did not reach statistical significance (p=0.18). This suggests that while 10% KOH appeared to produce better complete clearance than 12% glycolic acid cream, the observed difference may not be strong enough statistically in this sample size. A good response was observed in 17.78% of patients in Group A and 22.22% in Group B. Partial response was noted in 11.11% and 15.56% of patients in Groups A and B, respectively, while no response was seen in 4.44% of Group A patients as compared to 8.89% of Group B patients. These findings indicate that both treatment modalities were effective in the majority of patients, but a higher proportion of patients in the KOH group achieved complete clearance, whereas a relatively greater proportion of patients in the glycolic acid group remained in the good, partial, or no-response categories.

Table 4 highlights important outcome measures related to reduction in lesion count and recurrence. The mean reduction in lesion count was significantly higher in Group A (7.84 ± 3.12) than in Group B (6.91 ± 3.05), with a p-value of 0.04. This difference was statistically significant, indicating that patients treated with 10% KOH experienced a greater reduction in the number of lesions as compared to those treated with 12% glycolic acid

cream. When the proportion of patients achieving at least 75% reduction in lesion count was compared, 71.11% of patients in Group A showed this level of improvement compared to 57.78% in Group B. Although this result favored Group A, the difference was not statistically significant (p=0.19). Recurrence was seen in 6.67% of patients treated with KOH and 11.11% of those treated with glycolic acid cream. However, this difference was also not statistically significant (p=0.46). Therefore, while KOH showed a significantly greater mean reduction in lesion count, the differences in achieving ≥75% reduction and recurrence rates between the two groups were not statistically significant.

Table 5 compares the adverse effect profile of the two treatment groups and provides insight into tolerability. Erythema was the most common local adverse effect, observed in 35.56% of patients in Group A and 22.22% in Group B. Although erythema was more frequently reported with KOH, the difference was not statistically significant (p=0.17). Burning sensation was reported by 40.00% of patients in Group A compared to 20.00% in Group B, and this difference was statistically significant (p=0.04). This indicates that burning sensation was significantly more common with 10% KOH, suggesting relatively lower tolerability of this agent in comparison to 12% glycolic acid cream. Other adverse effects such as itching, erosion/crusting, and post-inflammatory hyperpigmentation were also more frequent in Group A than in Group B, but these differences were not statistically significant. Itching was noted in 24.44% of Group A and 17.78% of Group B patients (p=0.44), while erosion/crusting occurred in 20.00% and 8.89%, respectively (p=0.13). Post-inflammatory hyperpigmentation was seen in 15.56% of patients in Group A and 13.33% in Group B (p=0.76).

Table 1: Distribution of patients according to demographic characteristics

Parameter	Group A (10% KOH) (n=45)	Group B (12% Glycolic Acid) (n=45)	p-value
Mean age (years)	14.82 ± 6.24	15.31 ± 5.98	0.68
Age group (years)			0.91
≤10	18 (40.00%)	17 (37.78%)	
11–20	15 (33.33%)	16 (35.56%)	
>20	12 (26.67%)	12 (26.67%)	
Gender			0.83
Male	26 (57.78%)	25 (55.56%)	
Female	19 (42.22%)	20 (44.44%)	

Table 2: Baseline clinical characteristics of patients

Parameter	Group A (n=45)	Group B (n=45)	p-value
Mean duration (months)	3.84 ± 1.92	3.76 ± 1.88	0.82
Mean number of lesions	9.62 ± 4.13	9.28 ± 3.95	0.71
Site of lesions			0.88
Face	20 (44.44%)	19 (42.22%)	
Trunk	11 (24.44%)	12 (26.67%)	
Extremities	14 (31.11%)	14 (31.11%)	
Symptoms present	13 (28.89%)	12 (26.67%)	0.81

Table 3: Comparison of treatment response between the two groups

Response	Group A (n=45)	Group B (n=45)	p-value
Complete response	30 (66.67%)	24 (53.33%)	0.18
Good response	8 (17.78%)	10 (22.22%)	
Partial response	5 (11.11%)	7 (15.56%)	
No response	2 (4.44%)	4 (8.89%)	

Table 4: Reduction in lesion count and recurrence

Parameter	Group A (n=45)	Group B (n=45)	p-value
Mean reduction in lesion count	7.84 ± 3.12	6.91 ± 3.05	0.04*
Patients with ≥75% reduction	32 (71.11%)	26 (57.78%)	0.19
Recurrence	3 (6.67%)	5 (11.11%)	0.46

*Statistically significant

Table 5: Comparison of adverse effects (tolerability)

Adverse effect	Group A (n=45)	Group B (n=45)	p-value
Erythema	16 (35.56%)	10 (22.22%)	0.17
Burning sensation	18 (40.00%)	9 (20.00%)	0.04*
Itching	11 (24.44%)	8 (17.78%)	0.44
Erosion/crusting	9 (20.00%)	4 (8.89%)	0.13
Post-inflammatory hyperpigmentation	7 (15.56%)	6 (13.33%)	0.76

*Statistically significant

DISCUSSION

In the present study, both treatment groups were demographically comparable, with mean ages of 14.82 ± 6.24 years in the 10% KOH group and 15.31 ± 5.98 years in the 12% glycolic acid group, and with males constituting 57.78% and 55.56% of the two groups, respectively. The largest proportion of patients in our series belonged to the pediatric and adolescent age ranges, especially ≤10 years and 11–20 years. This pattern is broadly consistent with the clinical profile reported by Laxmisha et al. (2003), in which children constituted the major bulk of cases and the 5–10-year age group formed the single largest subgroup; they also observed a male predominance, with 85 males and 52 females among 137 children. Their study further noted that head and neck involvement was the commonest pattern, which agrees with our finding that the face was the most frequent site of involvement in both groups (44.44% in Group A and 42.22% in Group B).[7]

The baseline clinical characteristics in our study were also well balanced, with mean disease duration of 3.84 ± 1.92 months in the KOH group and 3.76 ± 1.88 months in the glycolic acid group, and mean lesion counts of 9.62 ± 4.13 and 9.28 ± 3.95, respectively. This suggests that the two groups started from a comparable disease burden, making the outcome comparison valid. Dohil et al. (2006), in a pediatric epidemiologic study, reported that 63.00% of children had more than 15 lesions and approximately 24.00% had associated atopic dermatitis; compared with that, our patients had a relatively lower baseline lesion burden and a lower proportion of symptomatic disease, with symptoms present in 28.89% of Group A and 26.67% of Group B. The lower baseline lesion count in our series may partly explain why both treatment arms achieved reasonably good clinical improvement over follow-up.[8]

With regard to efficacy, the present study demonstrated complete response in 66.67% of patients treated with 10% KOH compared with 53.33% treated with 12% glycolic acid cream. Although the difference was not statistically significant (p=0.18), the KOH arm showed a numerically better final clearance rate. This result is close to the placebo-controlled trial by Short et al. (2006), who found that 70.00% of children treated with 10% KOH cleared completely, compared with only 20.00% in the placebo group. Our KOH clearance rate is therefore very similar to that controlled trial, supporting the efficacy of topical 10% KOH as an active destructive therapy in molluscum contagiosum. The somewhat lower complete response rate in our glycolic acid arm, when compared against the KOH arm, also reinforces the impression that KOH may act faster and more decisively on lesion resolution.[9]

The reduction in lesion burden seen in our study also supports the superiority of KOH. We observed a significantly greater mean reduction in lesion count with 10% KOH (7.84 ± 3.12) than with 12% glycolic acid cream (6.91 ± 3.05; p=0.04), and 71.11% of the KOH group achieved at least 75% reduction in lesions compared with 57.78% in the glycolic acid group. Metkar et al. (2008), while comparing 10% KOH with 5% imiquimod, similarly showed that the mean lesion count in the KOH arm fell from 20.79 to 4.31 by 12 weeks, whereas complete clearance occurred in 42.10% of KOH-treated patients. Their work also emphasized a faster onset of response with KOH. Compared with their KOH clearance rate of 42.10%, our rate of 66.67% appears higher, probably because our patients had a lower average baseline lesion count and shorter disease duration.[10]

Our complete response rate with 10% KOH also compares favorably with the randomized comparative study of Seo et al. (2010). In our study, 30 of 45 patients (66.67%) achieved complete response with KOH, while only 24 of 45 patients (53.33%) achieved complete response with glycolic acid cream. Seo et al. reported absolute clearance in 10 of 13 patients (76.92%) treated with 10% KOH, compared with 8 of 14 patients (57.14%) treated with imiquimod. Thus, while their KOH clearance rate was somewhat higher than ours, the overall pattern is similar: KOH performed better than a topical comparator and showed a distinctly stronger clearance trend. Their findings, like ours, support KOH as a practical office-independent treatment that can be applied at home with good efficacy.[11]

Another useful comparison is with the study of Köse et al. (2013), who evaluated 10% KOH against a salicylic acid plus lactic acid combination. In that series, 83.30% of patients in the KOH group achieved complete remission and 16.70% partial remission by the end of therapy, while 33.00% developed new lesions during treatment. In our study, complete response with KOH was 66.67%, good response 17.78%, partial response 11.11%, and recurrence only 6.67%. Although our complete response rate was lower than the 83.30% reported by Köse et al., our recurrence frequency was numerically lower. These differences may reflect variation in lesion number at baseline, follow-up schedule, and whether newly appearing lesions were counted separately during the study period.[12]

The favorable performance of KOH in our study is also supported by the findings of Chathra et al. (2015). We found complete clearance in 66.67% of the KOH group, whereas Chathra et al. reported complete disappearance in 17 of 20 patients (85.00%) treated with 10% KOH, compared with only 10 of 20 patients (50.00%) treated with 5% imiquimod by 12 weeks. They additionally observed that no new lesions developed in the KOH arm, while 25.00% of patients receiving imiquimod developed new lesions. In our study, recurrence after treatment was 6.67% with KOH and 11.11% with glycolic acid. Although our KOH clearance rate was lower than the 85.00% noted by Chathra et al., the same

overall trend was maintained, namely that KOH produced a stronger and more complete therapeutic response than the comparator agent.[13]

In that context, the report by Dave et al. (2018) is noteworthy because it specifically described glycolic acid cream as a treatment option for molluscum contagiosum. In our study, the glycolic acid arm achieved complete response in 53.33% of patients, good response in 22.22%, and partial response in 15.56%, while burning sensation occurred in 20.00% and erythema in 22.22%. These findings suggest that 12% glycolic acid cream does have clinically meaningful activity, but its efficacy in our cohort remained lower than that of 10% KOH. Because the indexed Dave et al. record does not provide a detailed numerical abstract, our study adds useful comparative data by showing that glycolic acid may be better tolerated than KOH, but appears somewhat less efficacious for complete lesion clearance.[14]

Tolerability in our study clearly favored glycolic acid over KOH. Burning sensation was significantly more frequent with KOH than with glycolic acid cream (40.00% vs 20.00%, p=0.04), and erythema, itching, erosion/crusting, and post-inflammatory hyperpigmentation were also numerically more common in the KOH group. This pattern is in line with the randomized placebo-controlled trial of Giner-Soriano et al. (2019), in which adverse events were significantly more frequent with 10% KOH than with placebo (72.30% vs 31.80%, p<0.001), even though most events were mild and 91.50% recovered completely. Therefore, our tolerability data are biologically and clinically plausible: KOH, by virtue of its keratolytic and irritant action, produces better lesion destruction but at the cost of more local adverse effects, whereas glycolic acid appears gentler though somewhat less effective.[15]

CONCLUSION

In conclusion, both 10% potassium hydroxide and 12% glycolic acid cream were found to be effective in the treatment of molluscum contagiosum. However, 10% KOH showed comparatively better efficacy, with higher complete clearance and greater reduction in lesion count. On the other hand, 12% glycolic acid cream demonstrated better tolerability with fewer adverse effects, particularly less burning sensation. Thus, 10% KOH may be preferred when greater efficacy is desired, while 12% glycolic acid cream may be a suitable alternative in patients where tolerability is a major concern.

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