

SKINimages

Anal Monkeypox Lesions

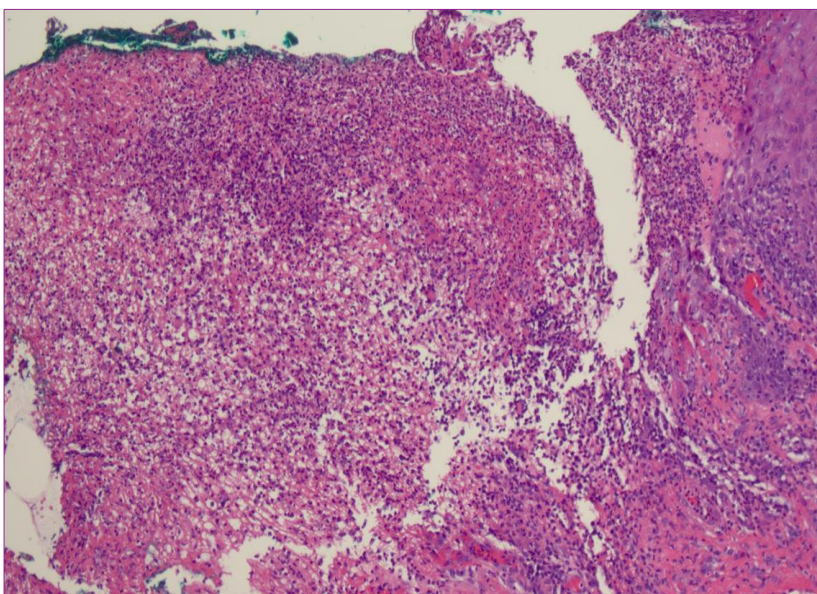
David Crasto, DO¹, Moises Lutwak, MD², Eduardo Krajewski, MD, FACS, FASCRS³, Eduardo Weiss, MD, FAAD⁴

¹Larkin Community Hospital South, South Miami, FL

²Broward Health Systems, Ft. Lauderdale, FL

³GastroHealth, Miami, FL

⁴University of Miami Miller School of Medicine, Miami FL



A middle-aged adult male with a history of well-controlled Human Immunodeficiency Virus (HIV) infection presented to the Emergency Department (ED) for new-onset perianal lesions. According to the patient, his symptoms began one week prior as an initial febrile illness with mild headaches followed by the development of small, painless bumps approximately 24 hours later. He denied any foreign travel or sick contacts but did however admit to recent sexual encounters with multiple new male partners.

On exam, multiple flesh-colored umbilicated papules with necrosis were observed on bilateral perianal skin (**Figure 1**). Remainder of the physical exam was unremarkable, including inguinal lymph node palpation, as well as initial diagnostic and laboratory studies in the ED. The patient was subsequently admitted for further investigation of suspected infectious etiology, including a perianal biopsy along with viral and bacterial cultures. Histopathology illustrated epidermal necrosis with an abundance of neutrophils and viral cytopathologic changes featuring

November 2022 Volume 6 Issue 6

multinucleated, syncytial keratinocytes (**Figure 2**). Cultures resulted negative for bacterial growth, as well as Adenovirus, Herpes Simplex Virus (HSV)-1, HSV-2, Cytomegalovirus (CMV), and Varicella Zoster Virus (VZV). Given the high index of suspicion for Monkeypox infection, a lesional swab was sent for polymerase chain reaction (PCR) and found positive for Orthopoxvirus DNA. Based on the history, clinical, and pathologic findings, coupled with the PCR results, a diagnosis of Monkeypox infection was made. Subsequent testing for sexually transmitted infections (STIs) was negative. One week later at follow-up, he reported complete resolution of the lesions.

Monkeypox is a zoonotic Orthopoxvirus endemic to central and western Africa first reported as an infection in humans in 1970. The clinical course of “classic” Monkeypox infection bears a striking resemblance to smallpox, causing much concern in its initial emergence as a human infection.¹ Typically, a prodromal illness characterized by fever, headache and myalgias precedes the onset of the Monkeypox rash which, in most cases, begins on the head with subsequent cephalocaudal spread and spontaneous resolution in 2-3 weeks.^{2,3} One study involving 282 patients reported the presence of lymphadenopathy as the most important distinguishing feature from smallpox and VZV.²

The 2022 global outbreak of Monkeypox is unique regarding several key features. Previously, affected individuals had a history of travel to a known endemic region. Furthermore, the prodrome is often times absent, or much milder, as compared to classic Monkeypox.^{1,3} Moreover, human to human contact appears to predominate disease transmission during this outbreak in contrast from animal to human.³ Men who have sex with men (MSM) are at a particularly

heightened risk, and anogenital lesions are frequently being reported.^{3,4} A recent study by Thornhill et al. described 528 infections across 16 countries; among these, 98% occurred in MSM and 73% presented with anogenital lesions. Preceding symptoms of fever and lymphadenopathy were most common (62% and 56%, respectively). Spontaneous resolution occurs within 2-3 weeks with scarring and atrophy typically seen at the sites of infection.³

Conflict of Interest Disclosures: None

Funding: None

Corresponding Author:

David Crasto, DO
Larkin Community Hospital South Miami
Phone: 954-807-9433
Email: davecrastodo@gmail.com

References:

1. Harris E. What to Know About Monkeypox. *JAMA* 2022 Jun;327(23):2278-9.
2. Jezek Z, Szczeniowski M, Paluku KM, Mutombo M. Human Monkeypox: Clinical Features of 282 Patients. *J Infect Dis*. 1987;156(2):293-8.
3. Thornhill JP, Barkati S, Walmsley S, J. Rockstroh, A. Antinori, L.B. Harrison, R. Palich, A. Nori, I. Reeves, M.S. Habibi, V. Apea, C. Boesecke, L. Vandekerckhove, M. Yakubovsky, E. Sendagorta, J.L. Blanco, E. Florence, D. Moschese, F.M. Maltez, A. Goorhuis, V. Pourcher, P. Migaud, S. Noe, C. Pintado, F. Maggi, A.-B.E. Hansen, C. Hoffmann, J.I. Lezama, C. Mussini, A.M. Cattelan, K. Makofane, D. Tan, S. Nozza, J. Nemeth, M.B. Klein, and C.M. Orkin, for the SHARE-net Clinical Group. Monkeypox Virus Infection across 16 Countries – April-June 2022. *N Engl J Med* 2022; DOI: 10.1056/NEJMoa2207323.
4. Sherman S. Monkeypox Genital Lesions. *N Engl J Med* 2022;387(1):66.