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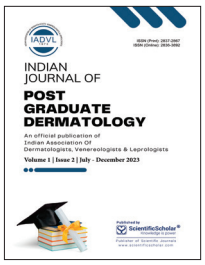

Correspondence

Monkeypox: Anecdotes from the UAE

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Quick Response Code:

Dear Editor,

We started seeing cases of atypical genital eruptions in our department from September of 2021. We were relatively clueless about the presentation of such genital lesions, then. The cases were treated with clinical suspicion of herpes genitalis. However, there was no resolution of lesions with adequate antiviral treatment. The condition was then treated empirically with antibiotics such as azithromycin and doxycycline without any relief.

During the same time, cases of monkeypox were reported in the western world.[1] We had a high degree of clinical suspicion in our patients. Since February 2022, all the suspected cases of monkeypox were subjected to DNA Polymerase chain reaction (PCR) testing from swabs collected from mucocutaneous lesions and throat as well. The samples were collected using polyester nylon or Dacron swab as cotton swabs were not acceptable for PCR testing. Viral transport medium tubes were also not suitable for the transport of swabs to the laboratory. Monkeypox being a communicable, notifiable and a recent disease, testing was only possible in Government laboratories and reports were obtained the same day.

The lesions were herpetiform crusted papules and pustules with central necrosis [Figure 1]. Many patients had lesions localised to the anogenital area and were accompanied with fever, myalgia and regional lymphadenopathy especially inguinal lymphadenopathy. The lesions spread to other sites like face, trunk and extremities especially fingers [Figure 2]. The lesions

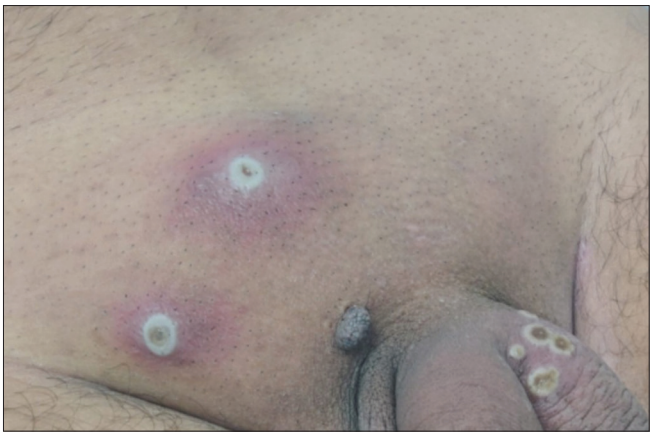

Figure 1: Herpetiform pustules on erythematous bases with central necrosis.

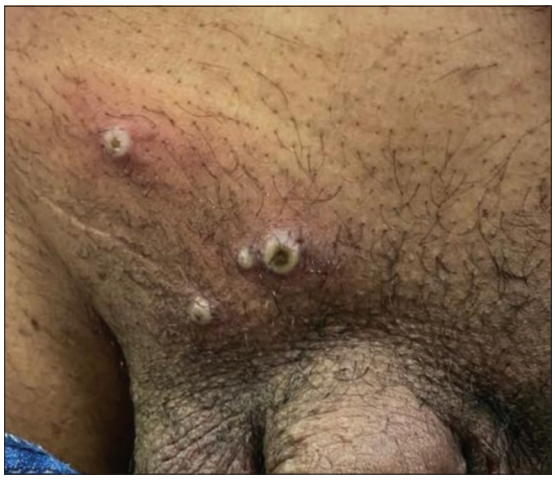

Figure 2: Lesions spreading to abdomen.

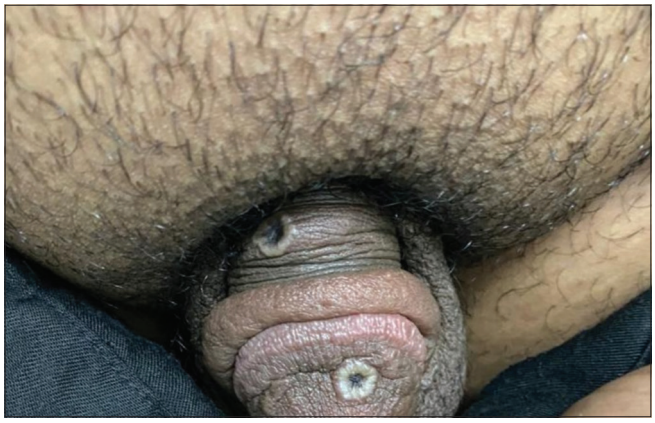

Figure 3: Pustules with central necrosis.

evolved from papulovesicles on erythematous base to turn pustular and later develop central necrosis [Figure 3]. They healed over 2–3 weeks.[2] All suspected cases were isolated for 3 weeks. Most of the cutaneous lesions healed without any sequelae except some with scarring and post inflammatory hyperpigmentation.

Majority of the cases belonged to the low income group, especially to the labour camps. Most patients were men who had sex with men and some had heterosexual contacts.[3] Rarely did we come across patients without any sexual contact. Interestingly, we have noticed that the incidence of this disease is low in females. We need further epidemiological studies as to why the cases are less reported in women. The most common age of presentation was 20–40 years of age.

Interestingly, we did not find any healthcare care professional contracting the disease due to patient care, raising suspicion that the disease was mostly transmitted due to sexual contact and close personal contact. We undertook precautions like COVID protocol when dealing with patients.

I am submitting two cases that presented with typical lesions seen in the genitals with regional lymphadenopathy. Both cases were confirmed by doing the DNA PCR test from the lesions. The lesions healed in 2 weeks with symptomatic management and prophylactic antibiotics. Although we have tried acyclovir in some patients, we believe that the drug does not alter the course of the disease.

Declaration of patient consent

Patient's consent not required as patients identity is not disclosed or compromised.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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