A man in his 30s presented to the emergency department with a 1-week history of mucopurulent anal discharge and tenesmus, as well as a 2-day history of pruritic perianal lesions. Physical examination revealed multiple subcentimeter vesicles and papulovesicles with central necrosis surrounding the anal opening (Figure). The patient did not have a fever and had no systemic symptoms. Palpable lymphadenopathy was present in the inguinal basin. The patient had traveled to Gran Canaria (Spain) the week before symptom onset, and he reported an unprotected sexual encounter with another man 5 days before symptom onset.

Samples were obtained from the rectum and perirectal skin for Neisseria gonorrhoeae, Chlamydia trachomatis, Treponema pallidum, and herpes simplex virus, the results of which were all negative. Serologic testing results for rapid plasma reagin and HIV were also unremarkable. Given clinical suspicion for monkeypox, a swab was obtained from an intact vesicle and sent for genomic amplification, the results of which returned as positive. Isolation measures were advised, and symptomatic treatment was initiated, with resolution of proctitis and crusting of vesicles occurring after approximately 1 week.

Monkeypox virus was first described in the 1950s and is considered endemic in parts of central and western Africa.1 Typical infection results in a generalized rash characterized by lesions that evolve through multiple stages, including macular, papular, vesicular, and pustular morphologies with umbilication. When diffuse, the rash follows a cephalocaudal progression, with lesions at a single site often in the same phase of development. The cutaneous symptoms are often accompanied by headaches, arthralgias, myalgias, fever, and lymphadenopathy. Incubation typically lasts 1 to 2 weeks following exposure. Several self-limited outbreaks have occurred in the US and UK during the last few years.2-4

In May 2022, a new outbreak of disease was noted to reach nonendemic countries, particularly affecting southern Europe. The clinical manifestations of this outbreak may differ from those previously described, as isolated genital and perianal presentations are increasingly identified.5

The virus may be spread directly by contact with lesions, respiratory secretions, or during prolonged intimate contact. While many of those who have been affected during the current outbreak are men who reported unprotected sexual encounters before clinical onset, any person in close contact with an infected individual is susceptible.3,4

Given the rapid spread of the 2022 outbreak, monkeypox should be considered in the differential diagnosis of generalized and localized umbilicated papules and vesicles. Prior known exposure to affected individuals and a sexual history should be considered. The differential diagnosis includes herpes virus, in its localized and generalized forms, other viral exanthems, syphilis, and other sexually transmitted infections when isolated in the anogenital area.4 Coinfection may also occur and should be tested for accordingly.

Regarding management, current World Health Organization recommendations include droplet and contact isolation for 21 days with symptomatic treatment for most cases. Use of antivirals could be considered for those with severe disease.4 Isolation of pets is also advised. Further research will be needed to assess other emerging therapeutic strategies in treating this new form of a long-known disease.

References

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ARTICLE INFORMATION
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