Clinical Cases of Mpox

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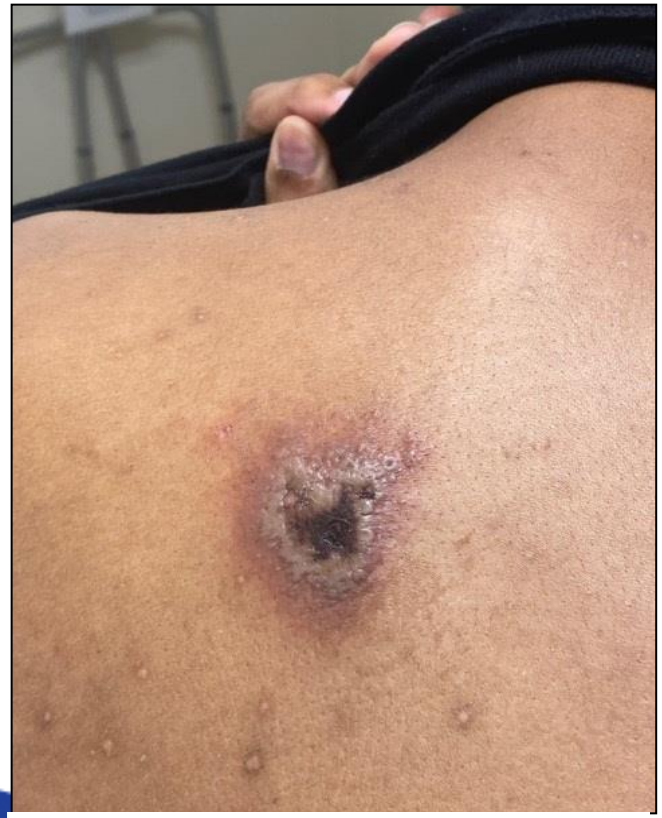
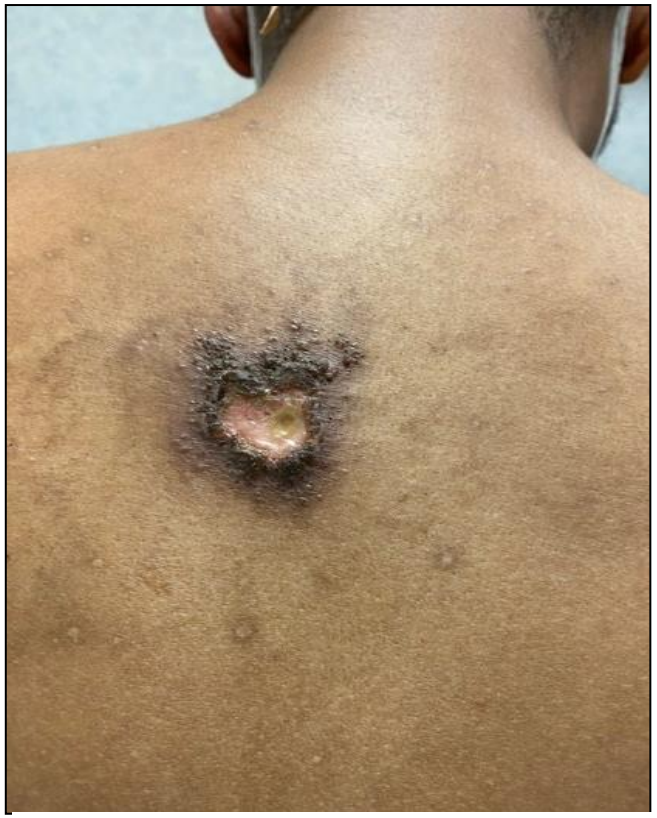
Case 1: Clinical presentation

- 36 y.o. man with HIV, off ART for one year.
- MSM with multiple recent casual partners.
- Two days of fatigue and myalgia
- Generalized painful rash.
- Urgent care visit x2, ER visit.

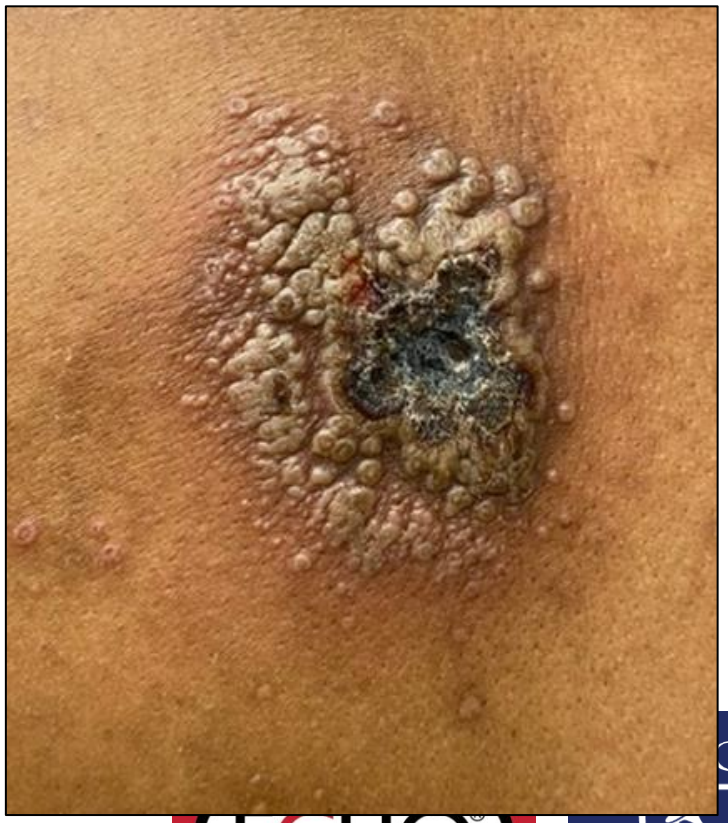
Progressive lesions in patient with HIV/AIDS -Back



Upon presentation



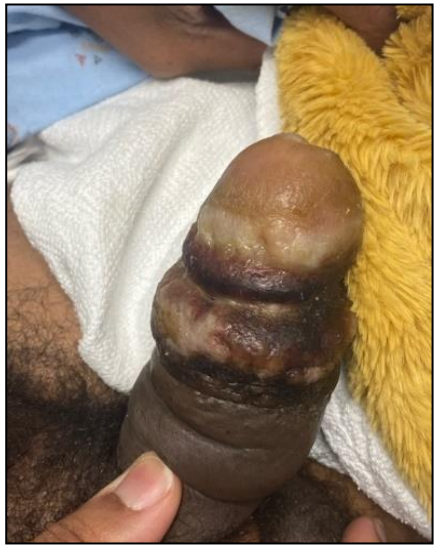
13 days of Tecovirimat

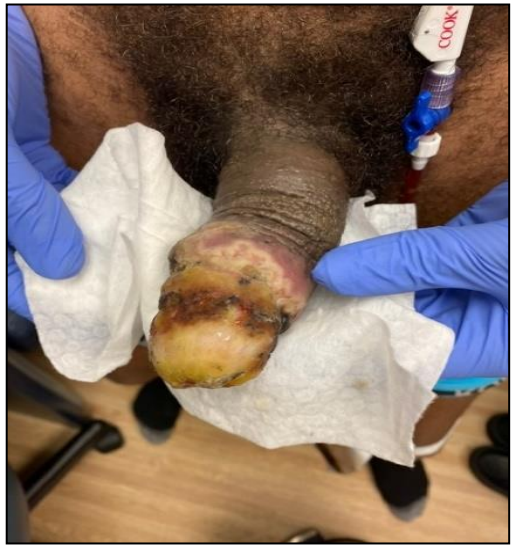


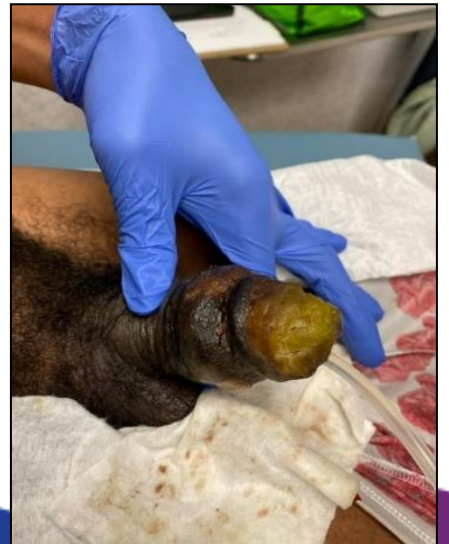
Second admission

Courtesy of Dr. Alex Dretler

Progressive lesions patient with HIV/AIDS- Penis





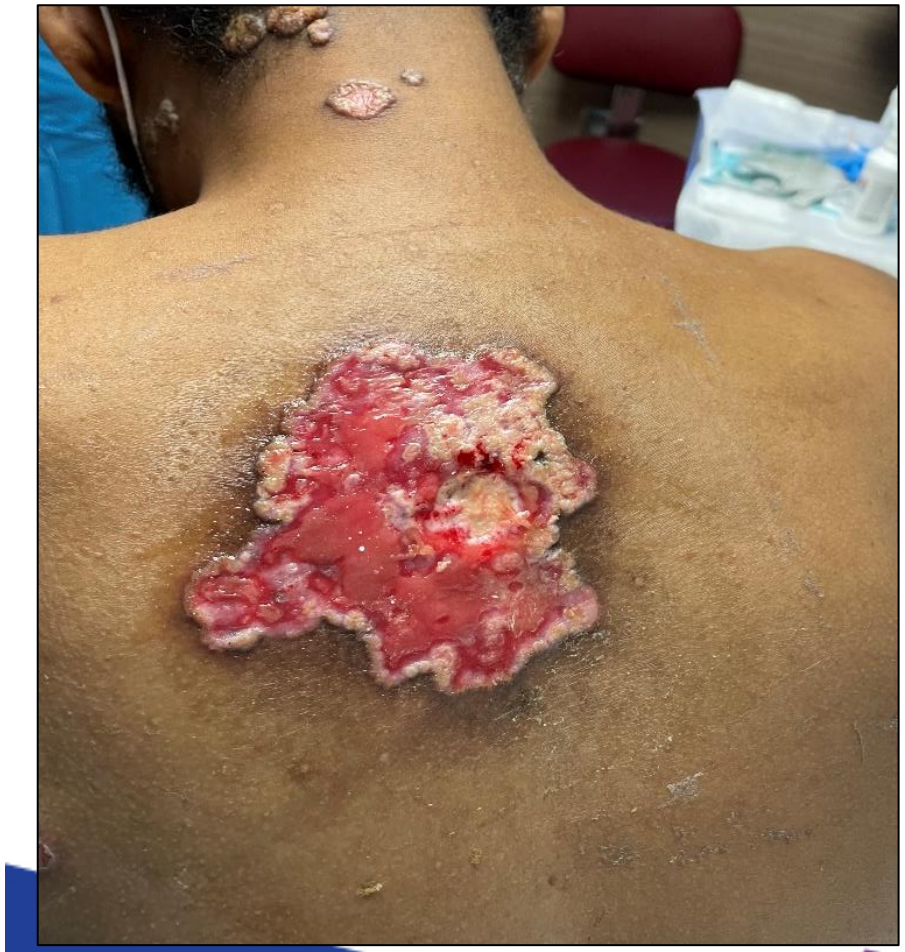


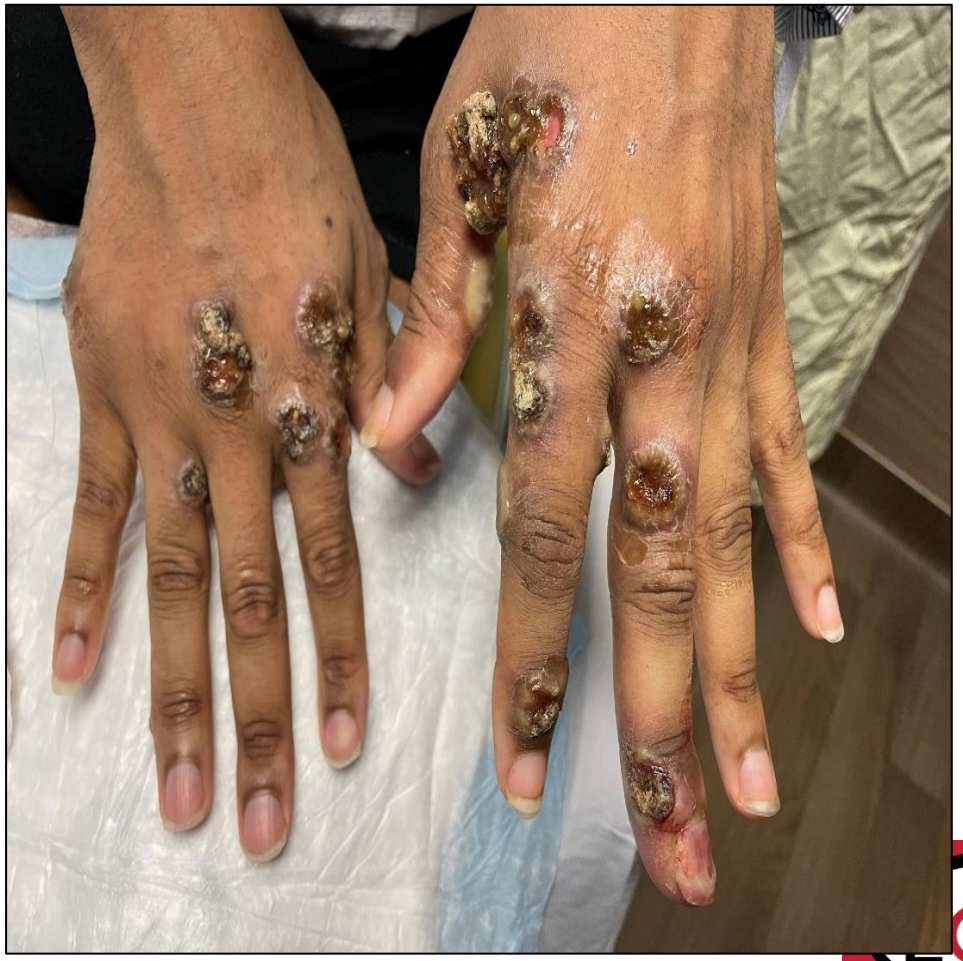
Upon presentati **13 days of Tecovirimat** **Second admission**

Severe progressive penile lesions
Penile edema and necrosis
Need for cystostomy

Treated with tecovirimat, VIVIG, MRSA Bacteremia

Protracted course of infection – Patient with AIDS





Outpatient – two months into disease course, lesions still not fully resolved.

Courtesy of Dr. Alex Dretler

Case 2 Mpox in the ICU – A patient with sore throat and fever

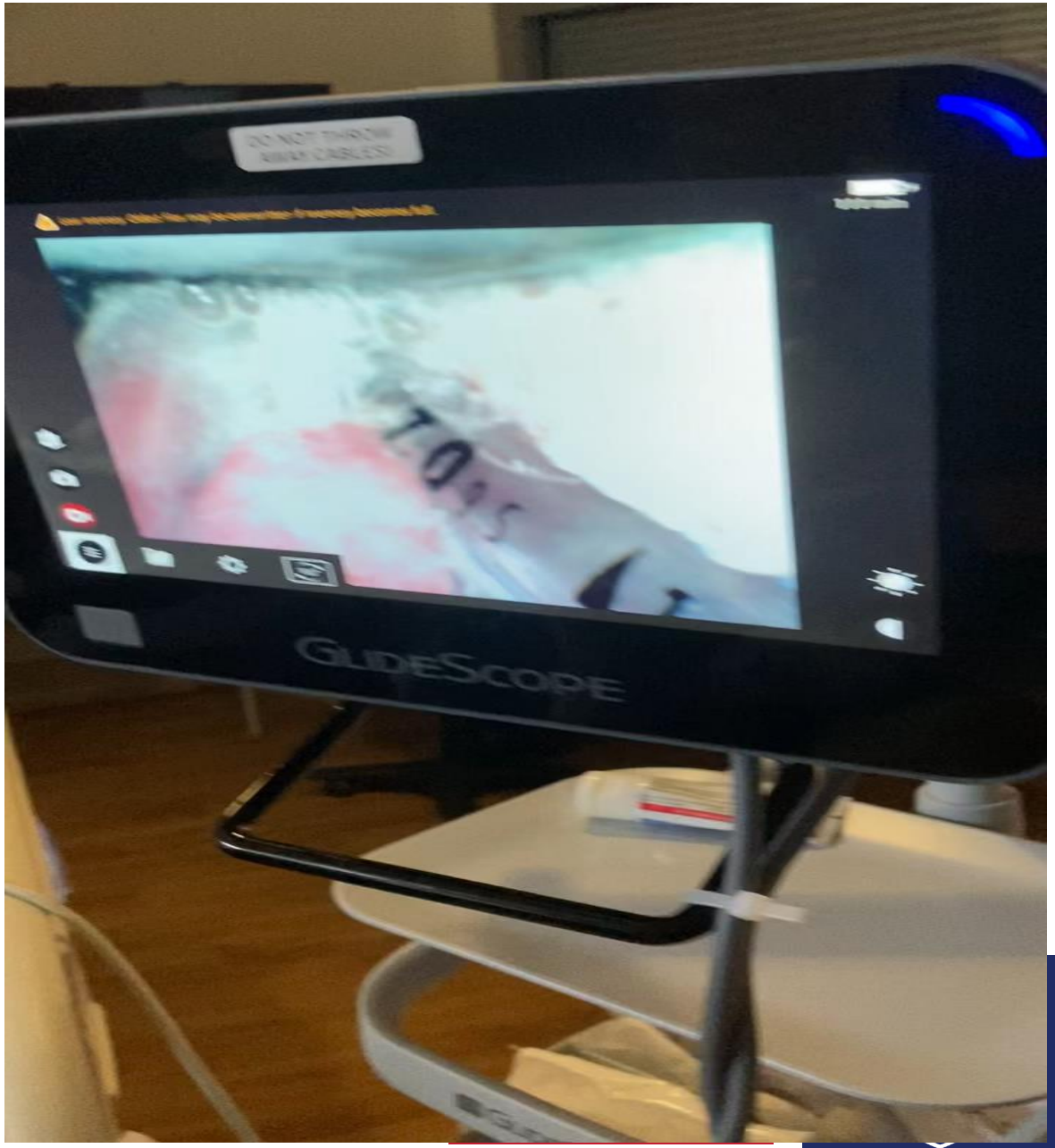
- Young male mid-thirties
- HIV+(CD4=384/13%)
- 1-day sore throat, fevers, malaise and difficulty breathing.
- Vitals: T35.5, BP 93/62, HR 71, RR 16 100% RA.
- **CT soft tissue neck - thickened epiglottis and tonsils, significant pharyngeal swelling R>L bilateral cervical LAD. Radiology read "Consistent with pharyngitis/tonsillitis, concern for epiglottitis"**
- Started on Decadron, Vancomycin and Zosyn. Blood cultures collected.

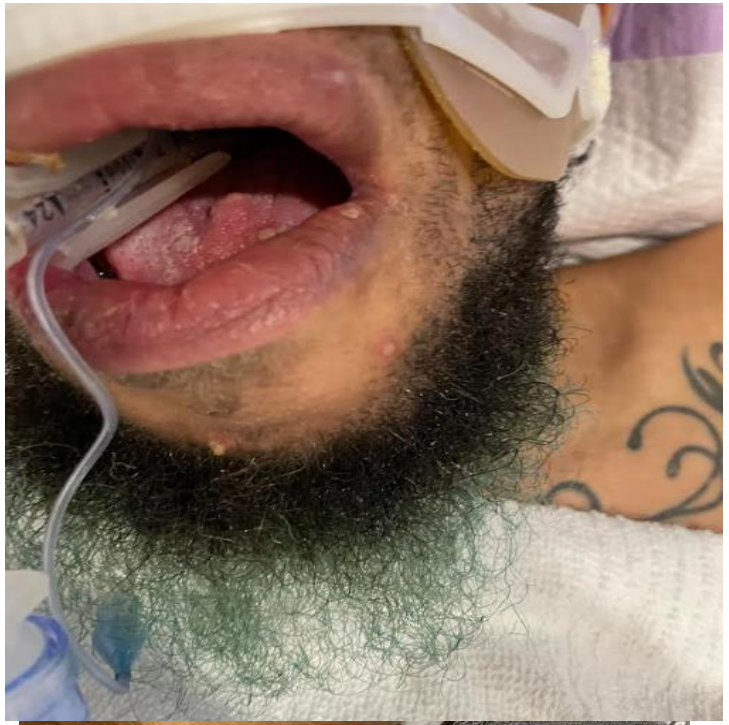
Rapid decompensation with loss of consciousness, intubated for airway protection

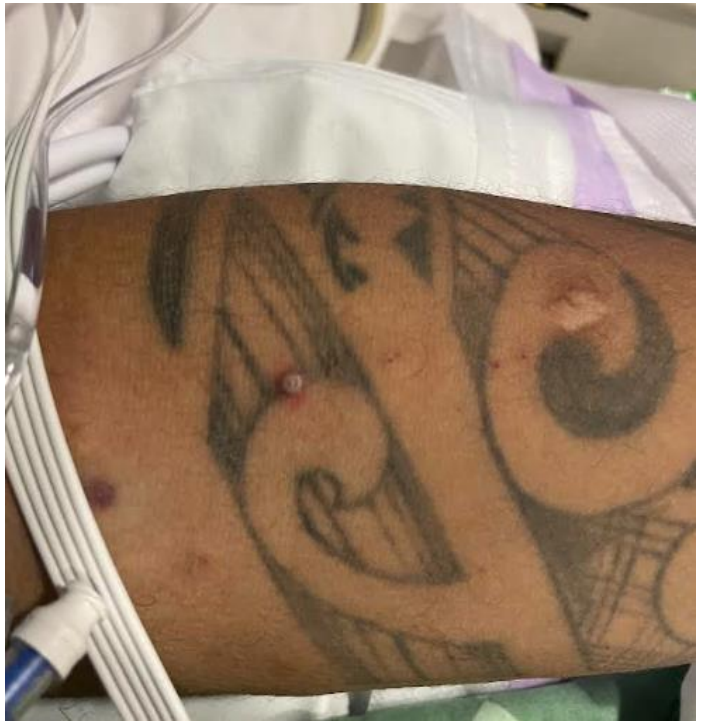
In the ICU

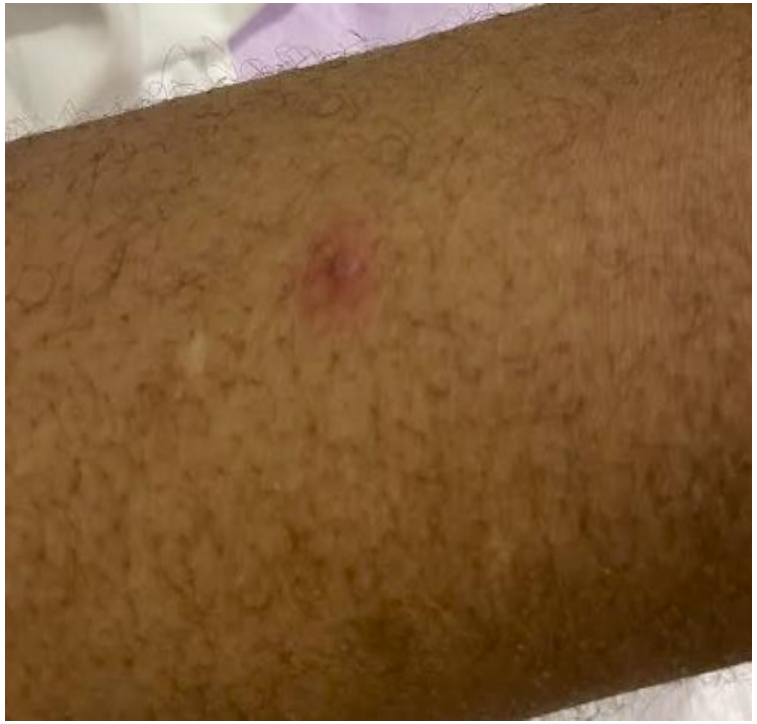
- Laryngoscopy by ENT:
  - R>L pharyngeal wall fullness
  - Fungating mass at level of the oropharynx with tonsillar exudate.
  - Minimal supraglottic/glottic edema appreciated.

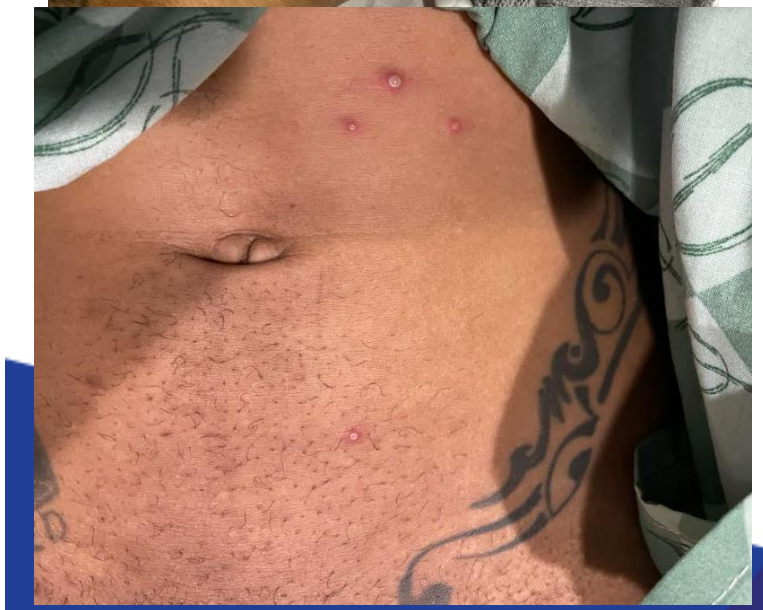
- ID was consulted for epiglottitis and fungating mass.











Multiple pustular lesions noted by ICU nurse

Infectious disease consult and clinical course

- Steroids discontinued
- Non-variola orthopox and monkeypox virus PCR testing sent.
- Patient started on Tecovirimat given high clinical suspicion .
- Throat culture and Group A strep testing, other cultures – negative → All antibiotics discontinued
- Monkeypox virus testing – eventually returned positive
- STI screening with positive Chlamydia on pharyngeal samples – treated with Doxycycline

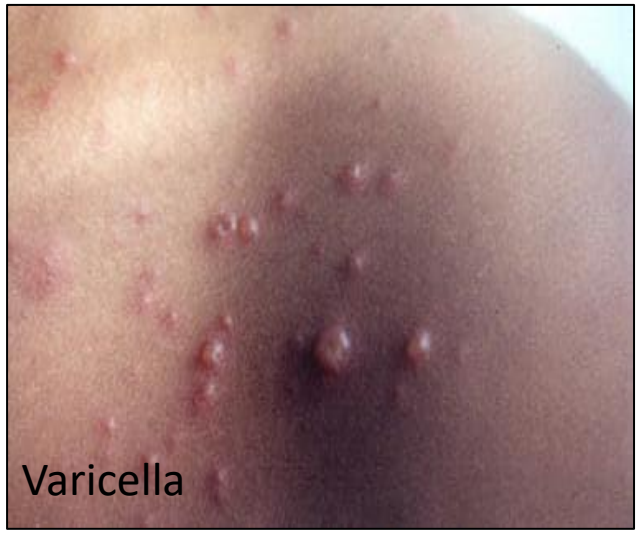
- **Further history obtained**:

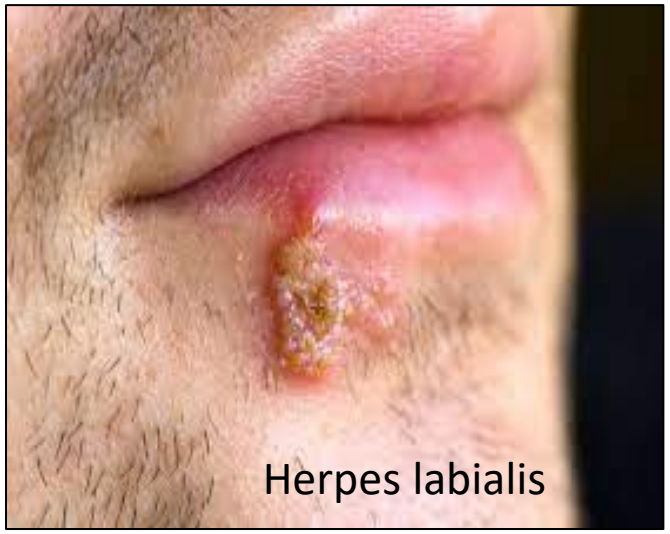
  Patient MSM with 1 new sexual partner in the 2 weeks prior to admission who was asymptomatic.

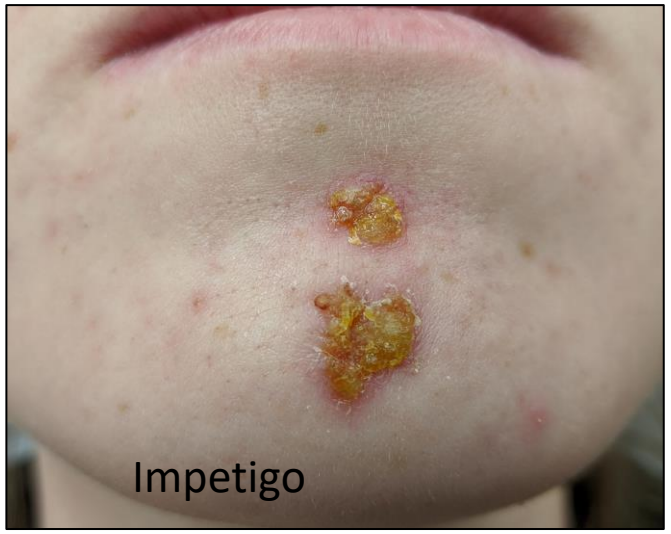
  Stopped ARVs 2 weeks prior to admission but was previously on Biktarvy with intermittent adherence .

Patient made complete recovery, and discharged - repeat outpatient laryngoscopy planned to evaluate resolution of fungating pharyngeal mass

Differential diagnoses – Monkeypox is a great mimic







- Other STIs – Syphilis, LGV, Chlamydia, Granuloma inguinale, Chancroid
- HSV1 and 2
- Varicella
- Other poxviruses e.g. Molluscum contagiosum
- Bacteria skin infections e.g. Impetigo
- Non-infectious skin lesions: erythema multiforme, pompholyx, aphthous ulcers.