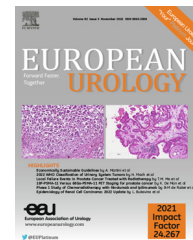




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## Platinum Priority – Editorial

Referring to the article published on pp. x–y of this issue

# Monkeypox and the Urologist: Playing an Important Role in This Emerging Global Outbreak

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In this issue of *European Urology*, Gomez-Garberi et al [1] report on a series of patients with monkeypox who presented to either the urology or internal medicine department at the University Hospital of San Juan de Alicante in Spain. They highlight the high frequency of genital symptoms and signs, and that urologists must be prepared to play a key role in diagnosing this infection. This report is timely as we witness a global outbreak and because, until now, many urologists might have been unaware of monkeypox.

Monkeypox is a viral zoonosis that is transmitted between humans or from an animal host, such as a rodent, squirrel, or nonhuman primate. Transmission is via direct contact with blood, bodily fluids, or cutaneous/mucosal lesions. Few individuals are hospitalised and very few die from the infection. Human infections were first diagnosed in 1970 and, up until the mid 2000s, seemed to be contained within central and west Africa. From 2003 onwards, an increasing number of cases outside of endemic areas, including Europe and North America, were identified. However, the number of new cases was low and most were self-contained. That was until 2021, when there were two reports of monkeypox in the USA for individuals who had visited Nigeria [2]. In May 2022, multiple cases of monkeypox infection were reported in Portugal, Spain, and Canada [3]. Over the next few days, cases were identified in Australia, the UK, Belgium, Switzerland, Israel, and the USA. At the time of writing, there have been 49 974 confirmed cases in 92 nonendemic regions (<https://www.cdc.gov/poxvirus/monkeypox/response/2022/world-map.html>), including 18 416 new diagnoses in the USA (Fig. 1).

The incubation period for monkeypox is usually between 6 and 13 d [4] and most infected individuals present with fever, headache, muscle aches, fatigue, and lymphadenopathy [5]. This last feature is a distinctive sign that can help in differentiating monkeypox from other viral illnesses with similar symptoms (eg, chicken pox, measles, and smallpox). Approximately 1–3 d after the fever starts, skin eruptions emerge on the face, extremities, and mucous membranes. Lesions can be located on the genital organs and, as detailed by Gomez-Garberi et al [1], it is these eruptions that may be the initial presenting symptom for many individuals. Treatment is mostly aimed at symptom relief, including shortening the duration of symptoms [6] and preventing further spread, including use of vaccination [7].

There are important take home messages for our readers. First, as demonstrated, an awareness of this diagnosis is important [1]. Gomez-Garberi et al [1] report that most individuals had genital eruptions, although one man presented with fever and penile oedema without a clear source. He had lymphadenopathy at presentation, but it was 21 d before skin lesions developed. Anogenital lesions were seen in most infected individuals (eg, 73% of those documented by the SHARE-net Clinical Group [4]) so this atypical presentation may be seen in many units. Second, in the current outbreak there are at-risk populations and awareness of these will help in identifying cases. Thornhill et al [4] reported 528 individuals with infection, of whom 98% were gay or bisexual, 75% were white, and 41% also had human immunodeficiency virus (HIV) infection; the median age was 38 yr. It was thought that transmission was mostly

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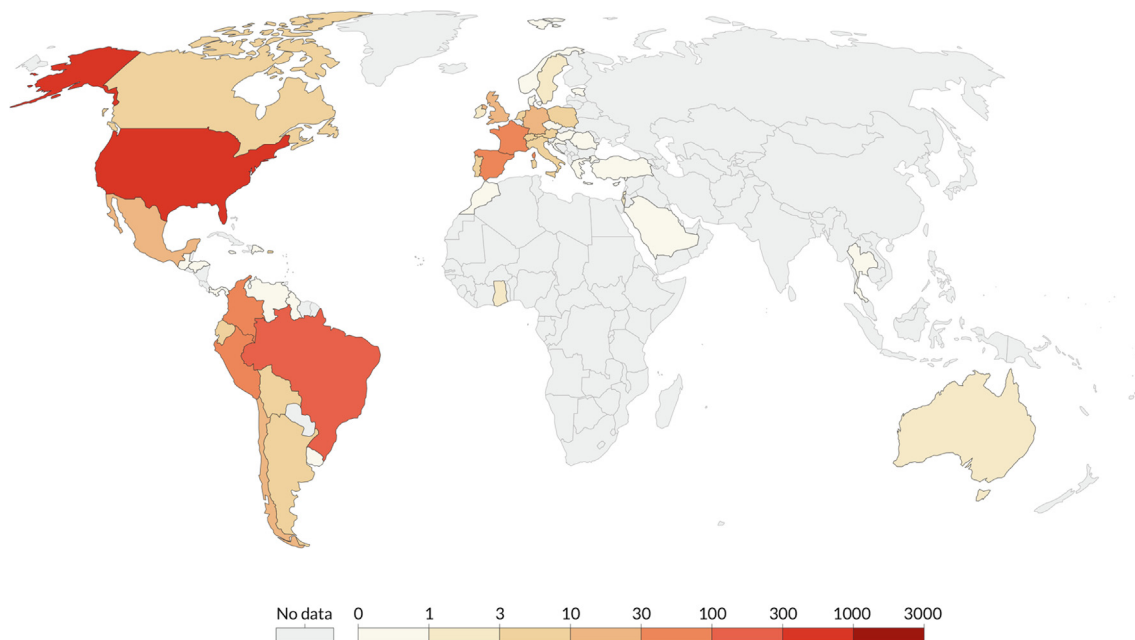


Fig. 1 – Global distribution of new monkeypox cases up to August 2022. Retrieved from <https://ourworldindata.org/explorers/monkeypox> [11].

via sexual activity, and the data from Gomez-Garberi et al [1] support this hypothesis (eg, 71% of those with infection were men who had sex with men, the median age was 42 yr, and HIV was found in 57%). Third, co-infection with other sexually transmitted diseases is common, so thorough screening is advocated. Finally, the authors helpfully detail steps that a urologist should take when identifying a case of monkeypox. A diagnosis should be confirmed (including any appropriate notifications) and symptoms treated. Patients should be managed with sensitivity (without stigmatisation) and encouraged to talk to their contacts (for education and enhanced testing) to reduce any local spread [4]. The duration of viral shedding (after resolution of lesions) is unknown, so the use of condoms for 8 wk is advocated.

Targeted vaccination has been introduced and it is hoped that studies will inform the best application [8,9]. Molecular epidemiology and genomics are unravelling why the viral demographics have changed and how this might have an impact in the future [10]. It is likely that these studies will deliver better treatments and effective vaccines. While the current monkeypox outbreak is a cause for concern, we should be measured in our response. In contrast to HIV and COVID-19, most individuals recover fully and fatalities are mostly rare. While some monkeypox strains do have higher rates of pathogenicity, vaccines exist. Our role as urologists will be to consider the diagnosis, confirm this

through testing, treat local symptoms and the patient with sensitivity, and then reduce the spread through education.

**Conflicts of interest:** The author has nothing to disclose.

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