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Reply to “Comment on ‘Current outbreak of monkeypox: essentials for the dermatologist’”



To the Editor: We thank Pathania for his interest in our article. The suggestion of including a COVID-19–related papulovesicular eruption as a differential of monkeypox eruption seems prudent, especially in present times when monkeypox is an emerging disease while the COVID-19 pandemic continues to have a strong foothold.

The former is a rare COVID-19–specific skin eruption that presents with asymptomatic or mildly itchy, small, translucent papulovesicles that often lack central umbilication and heal without scarring.¹ Systemically, patients with COVID-19–related vesicular eruptions can have fever and respiratory symptoms but have lower rates of hospital admission and mortality than patients with other COVID-19–related morphologies such as livedo.¹

In contrast, monkeypox presents with larger papulovesicles to vesiculo-pustules, which are often tender and have associated lymphadenopathy. Lesions are yellow-white in color, with a central dell or crater, which eventually develops an overlying crust or eschar.² Interestingly, although monkeypox lesions appear vesicular or pustular on visual inspection, on palpation, they are firm, tough to deroof, and seldom reveal liquid/fluid contents and are, therefore, more appropriately termed “pseudovesiculopustules,” a feature shared by other pox viruses, such as smallpox and molluscum contagiosum.³ This may be explained by the predominantly large intracytoplasmic cell inclusions seen within this family of viruses as opposed to herpetic infections, which produce scarce intranuclear inclusions and acantholysis and clinically present with fragile superficial vesicles.⁴

Additionally, the exanthem in monkeypox has a centrifugal distribution involving hands, limbs, and face and is often preceded or accompanied by an enanthem involving oropharyngeal and anogenital mucosae—a clinical feature lacking in COVID-19–related papulovesicular eruption, which primarily involves the trunk, with no facial and mucosal lesions.¹⁻³ Single chancre-like mucosal lesions at probable inoculation sites can be the first and only cutaneous presentation in monkeypox.³ The majority of patients with monkeypox have mild constitutional symptoms, and the main reasons for hospital admission include pain management, particularly severe anorectal pain, and treatment of secondary skin infections.⁵ Additionally, the residual scarring

and dyschromia in lesional sites can significantly affect the quality of life.

As Pathania mentions, the current monkeypox outbreak has been concentrated in men who have sex with men, and intimate lesional skin contact is hypothesized as the likely mode of transmission. Whether monkeypox is a true sexually transmitted infection needs further research. Recent evidence demonstrated that among 32 confirmed cases of monkeypox tested for viral DNA in seminal fluid, 29 tested positive.⁵ In light of these findings, until we have definite evidence of transmission routes, men are advised to use condoms even beyond the completion of their isolation period, for a total duration of at least 8 weeks since symptom onset.⁵

In the current global scenario, with overlap between the multinational outbreak of monkeypox and the COVID-19 pandemic, Pathania’s point is well received that clinicians should be aware of the similarities in the cutaneous eruptions associated with these 2 diseases. In resource-limited settings, in which polymerase chain reaction testing for monkeypox may not be feasible, epidemiologic factors, lesional morphology, and the presence of an enanthem can serve as valuable differentiators.

Urmi Khanna, MD,^a Anuradha Bisnoi, MD,^b and Keshavamurthy Vinay, MD^b

From the Division of Dermatology, Department of Medicine, Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, New York^a; and Department of Dermatology, Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh, India.^b

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Correspondence and reprint requests to: Urmi Khanna, MD, Division of Dermatology, Department of Medicine, Albert Einstein College of Medicine/Montefiore Medical Center, 3411 Wayne Avenue, suite 2D Bronx, Bronx, NY 10467-2490

E-mail: urmi23kbanna@gmail.com

Conflicts of interest

None disclosed.

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