SURGICAL AND MEDICAL APPROACH TO LARGE CUTANEOUS LESIONS CAUSED BY MONKEYPOX INFECTION; A CASE REPORT

Burgueno-Vega, MD, Diana , Bizanti, MD, Anas

Introduction

Since the eradication of smallpox, vaccine administration stopped in 1980. However, many poxviruses have gradually built its own reputation.[6] Consequently, as of October 28, 2022, there were 76,806 confirmed cases of Monkeypox worldwide based on reports from 92 countries. Of those cases, 28,302 were reported to be in the United States.

Monkeypox has a prodrome of flu-like symptoms, lymphadenopathy for 1-4 days followed by firm, well-circumscribed skin lesions of 0.5-1 cm in diameter that present with pain followed by pruritus for 2-3 weeks.

The rash follows a similar progression as smallpox with macules turning into papules, vesicles then pustules that then undergo umbilication, crusting and desquamation. **The rash has also been reported to occur more often over the face, extremities**

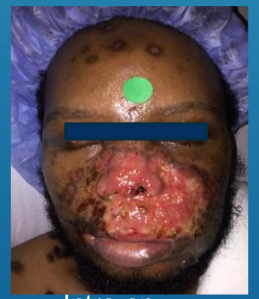
The disease process usually last 2-4 weeks with complete resolution of signs and symptoms, however a study showed that the most common sequelae following a monkeypox infection is pitted scarring of its associated skin lesions.[6,16]

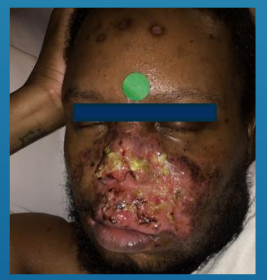
Case presentation:

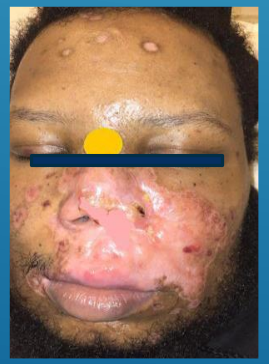
39 years old male with known Human Immunodeficiency Virus (HIV) and hypertension initially presented with complain of a growing lesion in the upper lip that started one month after he was discharged from the hospital. At that time he was managed for monkey pox and underwent three rounds of Tecovirimat. Also, he had several well healed papules in his trunk, but none in his face. He was given topical antibiotics, Bactrim and oral steroids with no relieve. However, despite these mentioned treatments the facial lesion continued to grow until it covered the entire nose, extending to both cheeks, including the nasal-labial fold and the upper lip. In addition of this large skin lesion, he also reported dyspnea on exertion and fatigued.

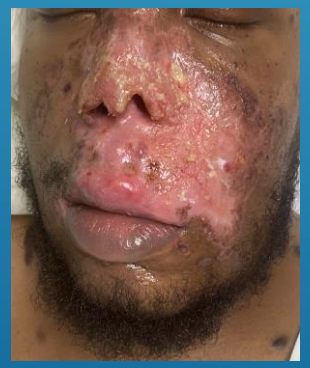
Cultures & Sensitivities:
Enterobacter Cloacea, sensitive to Cefepime, gentamycin and quinolones. (viral testing was not done)

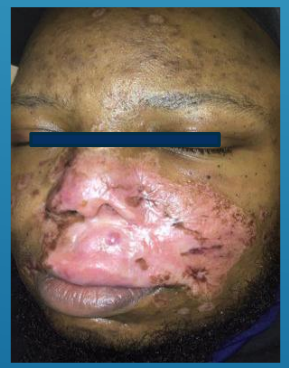

Day 0


Intra-op


POD 9


POD 27


5 weeks Post op


9 weeks Post op

Surgical management:

In the operating room the affected area was scrubbed vigorously using Betadine impregnated sponges and plastic brush. Only the areas with thicker and more tightly adhered scar were debrided sharply to the level of viable tissue using a scalpel.
Wound size: 11 X 9 cm.
After debridement, the area was irrigated with normal saline and dressed with adoptic impregnated with Santyl.

Post operative wound care:

Subsequent wound care consisted o Santyl, gentamycin and hydrocortisone cream 1%. After the eschar resolved the santyl was discontinues and this treatment continued until the wound was fully closed.

Discussion:

Monkey pox had been gradually spreading, the route of transmission is similar to small pox, but susceptible individuals had been unique including HIV patients and MSM. The skin lesion can initially be similar to small pox. However, the consequences of these skin lesions can be variable. Debridement of such lesion is not the conventional treatment, however this case proof it beneficial. The lack of deeper understanding about route of transmission can render physician susceptible to anchoring bias. When managing such a complicated rare case, providers should always keep a wide array of differentials and treatments.