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Monkeypox: A Guide for Dermatologists Amid a Global Outbreak

Dr. Greenberg:
You're listening to DermConsult on ReachMD. I'm Dr. Michael Greenberg. And we recently spoke with Dr. Esther Freeman and Dr. Steven Chen, who shared what dermatologists need to know about monkeypox. Let's hear from them now.

Dr. Chen:
When we're thinking about what dermatologists need to know about monkeypox, I think the most important thing for all of us as a field to think about is just having a high index of suspicion. Unlike other viral diseases, for example, COVID-19, which we've all been living through for the last 2 years, monkeypox is very much a dermatologic manifestation that comes to mind right away, and I think that's the first and foremost thing that everyone's thinking about when they think of this disease. For us as dermatologists, I think that there are new reports coming out, specifically from the CDC recently, that the classic examples of monkeypox are not necessarily seen in every single patient and that there are atypical or more unusual presentations, for example, solitary lesions that happen in the inguinal area, on the penis, in the vulva, those types of areas that might not necessarily make us think of monkeypox right away, but I think it's important for all of us to really be thinking about that on our differential now that we're seeing more and more cases.

Of course, it's important for us to think about what the classic presentation is, which is a progression, which is unusual for this disease compared to a lot of our others. It has almost every primary lesion that we can think of. It starts with an enanthem in the mouth, progresses to macules on the skin, then to papules, then to vesicles, then to pustules, and then finally, they crust up, but that whole process takes about 1 to 2 days in each stage except for the pustular phase that takes a little bit longer. It takes about 5 to 7 days. But all of that is preceded by an influenza-like illness, the fever, the malaise, the joint aches, and then the enanthem in the mouth, and classically, it starts on the face, and then it starts to distribute down the arms. My caveat here is this is based on what I've read and based on what people have reported, but there's just not that many cases that all of us have seen, but I think we just have to really be thinking about this when we evaluate a patient that we think has a viral process that's going on. I'm sure Dr. Freeman has more to add.

Dr. Freeman:
Yeah. I think that, as you said, Steven, we're not necessarily sure that we're going to be seeing entirely the classic presentation. I think also, when you think about what's been written about this disease, you have to remember that there are 2 different viral clades; so there is the Central-African clade and the Western-African clade, which are slightly different. What we are seeing here in the United States right now is the Western-African clade which thankfully has lower case fatality rate, so good news certainly. But I think also there may not be enough in the literature to tell us how differently these may present on the skin. So, Steven, I really like your point that we need to have a high index of suspicion. Our role really is to stop cases, and as dermatologists, we're really perfectly poised to do that because we can recognize signs and symptoms earlier potentially.

That being said, what I do want to add on is this concept we always think of in medicine, which is when you hear hoofbeats, you know, think horses and not zebras, and so just to remind all of us that there are a lot of other vesicular rashes out there. And the question I get a lot now is, you know, maybe all of this zoster is actually monkeypox, and I'm like, no, we still have zoster and shingles and other vesicular eruptions that are not monkeypox. And so, certainly, the likelihood is that it may turn out to be something more benign, but I think it's really important, as you said, to have that high index of suspicion, but just also just to remember our differential around things like zoster and other vesicular eruptions.

Dr. Chen:
Yeah. If I can share an example without sharing any patient details, I will just say that the question of monkeypox comes up quite often now on inpatient consults for a lot of these rashes, and when I'm approaching a patient, if a patient very clearly has a classic presentation for something else like disseminated zoster for eczema herpeticum, I'm not going down that monkeypox rabbit hole. It's those patients where things just don't happen to fit with something that we're classically trained with, and then you kind of have to dig back to what does monkeypox classically look like, what are the atypical presentations like, and that's where you don't have a very clear answer. It's just important to consider it and to not miss that opportunity for diagnosis.

Dr. Freeman:
And so Steven did a great job of going into detail of the morphology, but things to be aware of with monkeypox is that it has a much longer incubation period than a lot of our other diseases. Keep in mind that the interval from infection to onset of symptoms really can range anywhere from 5 to 21 days, so it can be really a long delay.

And I think the other thing to point out in this particular case, which is I think going to be helpful for us, is that with these pox viruses, they generally don't tend to transmit before they're symptomatic, which is great. The first presentation is fever, and then usually the rash starts 1 to 3 days after the fever, but the rash does start pretty early on. I think this is really just why it's important to highlight our role as dermatologists that rash is early, and rash is also a time when the patient is infectious, and so if you're seeing these lesions, that's actually an infectious patient, and then it tends to be that people become like less infectious or not infectious when they are crusted over much, but they actually can remain infectious for several weeks.

There are 3 main modes of transmission that I think are worth reviewing. The first is respiratory droplets and aerosols, and this is really from prolonged face-to-face contact, so, for example, household contacts where you're really being in close proximity to someone. Number 2 is contact with bodily fluids or monkeypox lesions, and this is particularly relevant to dermatologists since this would be direct contact with a monkeypox lesion. And then the third, we think is probably less important but it's still there is the indirect contact with items that have been contaminated, with fluids or sores, such as clothing or bedding.

Dr. Chen:
I think at this point really the idea is that it's supportive care really for monkeypox, but then there's also a new monkeypox vaccine that has come out, and that's pretty important. I know that's been used now for post-exposure prophylaxis for healthcare workers.

Dr. Freeman:
There are actually 2 different smallpox vaccines. And so there's the traditional smallpox vaccination that's been around for a long time that was used in our mass vaccination campaigns in the past and there are some challenges with that vaccine, which is a live vaccine and is actually a replicate of vaccine, so you can potentially spread to other lesions in your body. That is the vaccine that has the largest U.S. stockpiles. Then there is this newer vaccine that Steven was mentioning that has been approved. It's not as widely available in the U.S., so it's not something that everyone is going to suddenly get vaccinated with tomorrow just because there's not the same large stockpile as there is of the older vaccine, but that newer vaccine does have some advantages in that it's still a live vaccine but it's not replicative, so it doesn't have that same ability to spread elsewhere in the body, and they are indeed looking at that for something called the "ring of vaccinations." The idea with the ring vaccination that Steven brought up is the idea that if you have a close contact of someone who has monkeypox and the concern is about exposure, that you would actually vaccinate the people in very close contact, and so they're doing that potentially with healthcare workers, and they're doing that with close contacts of infected patients.

I think the second point is about actual treatment. So generally, the biggest thing is supportive care and there are some effective therapeutics that have been developed that are not as widely available, so the antiviral ST-246 was developed for smallpox but is also effective for monkeypox. So there are, I think, some things in the future, but these are not widely available that you're suddenly going to like go to CVS and pick one of these up.

Dr. Chen:
I think the best thing that can happen right now is for dermatologists to really get accustomed to the idea of what they would do if they saw a patient that they suspected had monkeypox. We've already talked a little bit about thinking through when you approach a patient,

you know, thinking about horses when you hear hoofbeats and really acting like we normally would as dermatologists, but when there is that atypical case where there is that presentation that doesn't fit anything else and it could fit with something like monkeypox, then I think the next step is for us to kind of proactively think about what is the next step.

And so a few dermatologists have actually reached out to me through social media asking about this, just how do you actually diagnose a case of monkeypox, and it's important for us to know that it's really from a swab of one of the skin lesions, and then you actually send for a PCR test; but as you can imagine, the monkeypox PCR test is probably not widely available in every single hospital, every single lab, and so that's where it's going to change depending on where everyone might be geographically located. What I mean by that is, yes, of course, the CDC has central testing, and that's important, but also state labs also have the ability to test for monkeypox as well, so it's important to think about where you live, what the process is for collecting that? What swabs do you use? What culture media do you use in order to actually transport that to the state lab? And that's going to change a little bit based on where everyone is. So a little bit of due diligence in figuring that out is helpful. If you work at a large academic hospital center, that stuff is all probably already kind of thought of and prepared for you from infection control, but if you're in a private clinic, if you are not necessarily associated or affiliated with a large hospital, I think this is a time to perhaps reach out to colleagues at the large hospital so that you can get a sense of what's done there and then actually partner so you say, "Hey, if I see a potential case, how can I get these samples either to you or to the state lab?"

Dr. Chen:
And I think the other piece of this in terms of being prepared is also thinking about things about how to protect yourself, right? The PPE that's required when you see a potential monkeypox patient. I can't believe I'm about to say this, but the silver lining of the COVID pandemic is that we now know and are supplied, most of us, with the PPE that's necessary. So, if you look at what the CDC shares, their recommendation for PPE when faced with a patient that might have monkeypox is the use of disposable gowns and gloves for patient contact, the use of a NIOSH-certified N95 and the use of eye protection, face shields and goggles, which, we are all very familiar with that set of PPE at this point.

Dr. Freeman:
I think that I would just wrap up by saying that dermatologists really do have a central role in outbreak response and outbreak control. I think the reason that we're so worried is because we don't want this to turn into a larger outbreak, and I think we have the opportunity as dermatologists to really be able to stop cases and transmission because we can recognize signs and symptoms, and as a dermatologist, you may have local media reaching out to you; you may have other local groups reaching out to you about monkeypox; and I think really directing them towards board certified dermatologists and the American Academy of Dermatology or "find a dermatologist" tool can be helpful because you yourself may become your local expert in monkeypox in your environment.

Dr. Chen:
I completely agree. I think that we are uniquely situated to really contribute to doing our part to help diagnose cases and to really try to curb spread if we are vigilant. I think the other thing that I would really recommend is to really be on the lookout for new information as this continues to evolve. I think that we're going to hear much more in the coming days to weeks about all the things that we've kind of talked about here, but just with more specificity and more clarity, and I think it's just important for all of us to really keep our ears open and learn about that so that we are best informed when our patients come to us either with concerns with the rash. We can do a lot to allay some of these fears in the public and for our patients.

Dr. Greenberg:
That was Dr. Esther Freeman and Dr. Steven Chen sharing what dermatologists need to know about monkeypox. To find other episodes in our series, visit reachmd.com/dermconsult where you can Be Part of the Knowledge. Thanks for listening.