Abstract Form

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Project Title:	A Case of Oral Monkeypox Leading to Perioral Edema Requiring Intubation

Research Category (please check one):

☐	**Original Research**	☒	**Clinical Vignette**	☐	**Quality Improvement**	☐	**Medical Education Innovation**

Abstract

Introduction:
We report an unusual presentation of monkeypox in a 50-year-old man living with HIV who presented with a tongue ulcer and a necrotic perioral lesion, complicated by airway edema requiring intubation.

Case Report:
A 50-year-old male presented to the emergency department with facial swelling for a few days, which he reported developed after sustaining a laceration to his left oral commissure. The patient described the initial wound as "papercut-thin" with progressive ulceration and swelling over the following few days. He also developed fevers peaking at 102° Fahrenheit, night sweats, and left-sided odynophagia. The patient endorsed a history of human immunodeficiency virus (HIV) and a history of receptive oral and anal sex with eight male partners in the last six months, most recently two weeks prior to presentation. Initial exam was notable for one 5mm tender ulcer on his left inferolateral tongue, and a 7mm necrotic lesion at the left oral commissure (Figure) with surrounding erythema, as well as left-sided cervical lymphadenopathy. After a few hours in the ED, he acutely decompensated with rapidly progressive perioral edema and concern for airway obstruction. Nasotracheal intubation was performed, and intravenous dexamethasone and empiric vancomycin and ceftriaxone were started. Polymerase chain reaction (PCR) tests were sent for ortho monkeypox and herpes simplex viruses from the oral lesion, as well as tests for HIV (confirmatory), syphilis, chlamydia, and gonorrhea. The patient's swelling and induration improved over the next day, and he tolerated extubation and weaning to room air. The monkeypox PCR returned positive. HIV positivity was confirmed, with all other tests negative. The patient was instructed to isolate until his lesions fully resolved and was treated with 600mg oral tecovirimat twice daily for 14 days. His symptoms resolved quickly without residual effects.

Discussion:
This case illustrates an atypical presentation of monkeypox, with two isolated oral lesions, and an unusual complication, namely intubation due to perioral edema. In the recent global outbreak, the human monkeypox infection is characterized by prodromal systemic symptoms including fever and chills, followed by the appearance of multiple skin lesions and rash most commonly in the anogenital region. The majority of reported cases have been in men who have sex with men (MSM), and it is suspected that approximately 95% of these infections occurred through sexual activity. Our case was atypical as our patient presented first with fevers, then with development of only two oral lesions followed by severe perioral edema.

Conclusion:
Therefore, clinicians should maintain a high index of suspicion for monkeypox in patients in isolated new skin lesions, even if not characteristic for monkeypox, especially if a patient has risk factors including MSM or HIV. Although most monkeypox cases are mild, self-limiting, and do not have serious complications. clinicians should also consider monitoring closely for airway compromise in patients with oral lesions who have risk factors for monkeypox.

Figure: