

An unexpected cause of proctitis

Una causa inesperada de proctitis

We present the case of a 34-year-old man with no known drug allergies or medical/surgical history of interest, who came to A&E on 20 July 2022 with a three-day history of very severe proctal-gia and rectal tenesmus combined with fever of up to 38°C. He did not report respiratory or urinary symptoms. He had started treatment with paracetamol 650 mg every 8 h, without improvement. He reported having had risky sexual relations with other men in the previous month. On physical examination, no external signs of perianal inflammation were observed, but it was impossible to perform a digital rectal examination due to the pain. Blood analysis showed slight leukocytosis (12,500/mm³) with neutrophilia (85%).

Given the suspicion of a perianal abscess, it was decided to carry out a surgical exploration in the operating room under spinal anaesthesia. An endoanal ultrasound was performed, which revealed mucosal thickening with no obvious collections (Fig. 1A). The digital rectal examination identified a thickening of all the anal columns, without clear bulges. Visual inspection with speculum revealed extensive ulcerations throughout the mucosa of the anal canal, which were biopsied. A CT of the abdomen and pelvis was performed, which showed mucosal thickening of the lower and middle rectal wall (Fig. 1B).

After 48 h, the patient manifested vesicular lesions with an erythematous base in the acral, genital and perianal regions (Fig. 1C). A PCR of the vesicle fluid and rectal exudate was performed with a positive result for monkeypox. Both serology for syphilis, HIV, HBV and HCV, as well as rectal PCR for *Chlamydia trachomatis*, gonococcus, HSV and *Treponema pallidum* were negative. Subsequently, the patient responded favourably to treatment, requiring continuous intravenous analgesia with opioids for the first few days, and was discharged from the hospital after eight days of admission. The result of the biopsies was ulcerated mucosa with chronic inflammation and reactive epithelial changes.

Monkeypox, or mpox, is a zoonotic viral disease caused by the monkeypox virus, which belongs to the *Orthopoxvirus* genus of the *Poxviridae* family. The virus was first identified in the 1950s and

the first infection in humans was described in the 1970s in what is now the Democratic Republic of the Congo. The first outbreak in the West occurred in the United States in 2003, and since then sporadic cases have been described in non-endemic countries up to the current global outbreak described in May 2022.¹

Transmission to humans occurs through contact with fluids from an infected animal or through its bite. Person-to-person transmission occurs through close contact with lesions, bodily fluids, respiratory droplets or contaminated objects. The incubation period is usually 12 days, ranging from 5 to 24 days.¹

Clinical signs and symptoms include fever, headache, myalgia and lymphadenopathy. From one to five days after the associated fever, characteristic skin lesions appear in the form of a maculopapular rash that develops into vesicles, pustules and crusts. The most affected regions are the face, the palms and soles, the oral mucosa and the genitalia.²

A suspected diagnosis is established by epidemiological history in the last 21 days associated with characteristic symptoms. A confirmed diagnosis is made by isolating the virus genome in a sample of the lesions. It is usually a self-limiting disease and treatment is symptomatic, based on pain control, and may require anything from oral analgesics to intravenous opioids in more severe cases.¹

Rectal involvement in the form of proctitis is a complication that can occur in up to 25% of patients with monkeypox virus infection.² Its symptoms include proctal-gia, rectal tenesmus, purulent discharge or bleeding, which may or may not be associated with vesicular or pustular lesions in the perianal area.³ Patients with proctitis usually have a history of receptive anal sex and present with systemic symptoms before the appearance of skin lesions.¹

In case of suspicion, a PCR of the skin or rectal lesions will establish the diagnosis. Proctoscopy, if the pain can be tolerated, may reveal inflamed or friable rectal mucosa. The differential diagnosis in patients with perianal lesions includes venereal lymphogranuloma, primary syphilis and herpes simplex virus. If the patient also has proctitis, chlamydia and gonorrhoea should be added. In cases of suspected perforation, magnetic resonance imaging is the test of choice.¹



Figure 1. A) Endoanal ultrasound image showing mucosal thickening without collections suggestive of an abscess (indicated between arrows). B) Axial section of CT of abdomen and pelvis with oral and intravenous contrast showing thickening of the rectal wall (indicated with arrows). C) Pustular lesions in the perianal region six days after onset.

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