



Reply to: “Comments on the article ‘Monkey pox and female sexual health’”

Respuesta a: “Comentarios acerca del artículo “Viruela del mono y la salud sexual femenina””

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Mr. Editor:

We thank Drs. Kleebayoon and Wiwanitki for their interest in our letter (1); we found here an excellent opportunity to discuss some additional thoughts from researchers with experience in this specific topic, which can contribute to further understand the monkeypox (Mpox) infection. Since the interaction through the journal provides an academic forum, we want to explore some topics mentioned by the authors in order to promote scientific discussion and improve the understanding of those topics.

As the correspondence authors stated, there are other issues to consider with the aim of preventing the infection (2). Besides control measures, they raise an important point: the participation of experts who are familiar with the subject. According to a study concerning co-infections, practitioners need to be aware when evaluating patients with rectal signs and symptoms, that they should consider Mpox and the possibility of concurrent rectal sexually transmitted infections (STIs) (3). The authors’

consideration that rectal signs and symptoms can precede rash onset, occur even in the absence of a rash, or be unrecognized due to the anatomic site or the small number of lesions will help guide Mpox virus detection and new diagnostic approaches (3). Even though several cases have demonstrated the co-existence of STIs and Mpox (4,5), it remains unknown whether concurrent STIs contribute to Mpox spreading or alter its clinical expression. In the current situation, it is necessary to consider the diagnosis of monkeypox in all patients with typical rash and people with high risk sexual behavior, especially with recent sexual contacts in places of disease outbreaks, in order to avoid significantly delayed diagnosis or omission (6).

On the other hand, the high reported prevalence of human immunodeficiency virus (HIV) and other STIs reveals the importance of exploring other infections besides HIV (3). A recent study performed in eight counties in the USA assessed 1,969 individuals with Mpox diagnosis and found that people with Mpox and HIV infection had more commonly received an STI diagnosis in the preceding year (48 %) than those without HIV infection (37 %) (3), highlighting the impact of a co-infection in patients with monkeypox. Among STIs reported, Gonorrhea, Chlamydia and Syphilis were the most

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significant (3). Case reports demonstrating the co-existence of Mpox and Syphilis (4,5), evidenced an interplay between *Treponema pallidum* and Mpox virus, which may also explain a proportion of Mpox cases presenting with morbilliform/maculopapular rashes. This feature was not reported in previous outbreaks. This unusual manifestation has been observed among 3.8 % – 13.7 % of Mpox patients, and the reports showed concurrent syphilis in up to a third of such cases (5). Besides, this co-existence was observed in patients with a previous HIV infection (6,7).

Finally, taken together, all the scientific information available allows us to propose that the better we understand the life cycles of microorganisms, the interaction between them, the ways of transmission and forms of prevention, as well as diagnosis, the more we will be able to implement more adequate controls in future pandemics.

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