Letters to the Editor

[The Editor is not responsible for the views expressed by the correspondents]

Growing Homophobia due to Monkeypox Outbreak in 2022

SIR, — The emerging multi-country monkeypox outbreak in 2022 has exacerbated the stigma revolving around homophobia and diseases associated with them.United Nations' Aids agency denounced the homophobic and racist reports on monkeypox spread in May[1]. Themodes of monkeypox virus transmission needs emphasis so that we can battle this growing fear in people due to misinformation and adequate response to the current outbreak can be made in an effective manner.

Monkeypox (MPX) is a zoonotic orthopoxvirus that was first isolated from a patient with suspected smallpox infection in the Democratic Republic of the Congo (DRC) in 1970[2]. According to latest WHO reports this year, there have been 3413 laboratory confirmed cases and one death from 50 countries/territories in five WHO Regions[3].

World Health Organisation (WHO) released a public health advise for homosexual, bisexual and other men who have sex with men and emphasised the need to stopstigmatising people as any human could get this disease and pass it onto another regardless of their sexuality. Transmission can occur from animal to human, human to human and from contaminated environments to humans. It is found to spread via direct contact with someone infected with a rash or scab, or contact with objects including clothing, beddings, or surfaces used by them. It can spread via respiratory droplets, bodily fluids including pus, oral, anal, and vaginal secretions[4].

Monkeypox is not a 'gay disease', although it is more frequently being diagnosed in this community in recent times because of several reasons. Around 40% of the homeless youth belong to the Lesbian, Gay, Bisexual, Transgender (LGBT) community due to strong rejection from their families. These people are more likely to have depression, use illegal drugs and haveunsafe sex. Racism and economic burden for this community is another important factor why they are susceptible to the spread of infections. Monkey pox rashes resemble skin lesions in sexually transmitted diseases including herpes, syphilis, and the generalised lymphadenopathy resembles diseases like Acquired Immunodeficiency Syndrome (AIDS). Because of the positive health seeking behaviour in homosexuals due to their preexisting high risk of sexually transmitted diseases, monkeypox cases have been found to be diagnosed in them more frequently at sexual health clinics[5]. Studies have shown that the discrimination of homosexuals in 1980's fuelled the AIDS pandemic as well[6].

Due to the growing number of monkeypox cases, the authors feel the urgent need for good quality education among the masses for disease burden reduction. Multiple social factors impact the health behaviour of homosexuals in our community. It is our responsibility to make them feel safe to seek health facilities whenever required. Schools and workplace education and behavioural modification should be ensured to prevent criminalising them.

Isolation of confirmed patients and local confinement of suspected cases, regular soap/alcohol based hand wash, disinfection of clothes and surfaces, wearing protective personal equipment (including gloves, masks, gowns, googles),keeping active lesions covered with clothing and most importantly proper knowledge has shown to decrease spread of this disease and is the best way to curb the worldwide outbreak of monkeypox.

REFERENCES

1 The Guardian. https://www.theguardian.com/world/2022/may/23/un-denounces-homophobic-and-racist-reporting-on-monkeypox-spread. Accessed 27 June 2022.
2 Moore M, Zahra F. Monkeypox. 2022 May 22. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan.
3 World Health Organization. https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON396 . Accessed 27 June 2022.
4 Centers for Disease Control and Prevention. https://www.cdc.gov/poxvirus/monkeypox/about.html. Accessed 27 June 2022.
5 World Health Organization. https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/public-health-advice-for-msm-on-monkeypox-22-may-2022.pdf?sfvrsn=7648499_29&download=true. Accessed 27 June 2022.
6 American Psychological Association. https://www.apa.org/pi/aids/resources/exchange/2012/04/discrimination-homophobia. Accessed 27 June 2022.

Mariam Ansar[1]
Arkaketan Chatterjee[2]
Sumit Roy Chowdhury[3]

Department of Medicine,
Medical College and Hospital,
Kolkata 700073
[1]MBBS, Junior resident and Corresponding Author
[2]MBBS, Junior resident
[3]MD, Senior Resident,
Department of Neuroanaesthesiology
and Critical Care,
All India Institute of Medical Sciences, Delhi

An Unusual Untoward Reaction to COVID-19 Vaccine-AZD 1222 (ChaAdOx1)

Sir, — A male 79 years is a practicing general surgeon in good health – non diabetic, non-hypertensive on no regular medication. Relevant past history of NSAID induced acute DU perforation 46 years back, operated, Robotic prostate surgery 16 years ago and Laparoscopic repair of right Inguinal hernia 8 years ago. He was given the first dose of COVID-19 Vaccine - AZD 1222 (ChaAdOx1) on 16th January 2021 at Paras HMRI Hospital, Raja Bazar, Patna. This was well tolerated except for mild low back ache and pain in right (non-injected arm), near the insertion of the deltoid, which lasted in diminishing order for a week to 10 days. Second dose of COVID-19 Vaccine - AZD 1222 (ChaAdOx1) was given on 15th February 2021 at the same institution followed by mild to moderate myalgia particularly in both the pectorals and right arm outer aspect. Developed bowel upset with semi watery stools and mild lower abdominal gripping, marked anorexia, no nausea or vomiting, no fever. Simultaneously gradual swelling, pain and redness started around the base of (L) big toe with increasing episodes of sharp pain involving the (L) forefoot. A detailed laboratory test was performed and the results are shown in Table 1.Swelling, erythema and pain kept on increasing, gradually extending up to the ankle. Nature of pain was sharp shooting initially on mild movement of the big toe but later even without movement and severe enough to cause marked loss of sleep. X-ray and CT with 3-D reconstruction done on 20.03.2021 (Fig 1A). It showed no fracture. He was examined by a senior Orthopedic Surgeon, advised Crepe bandage application,

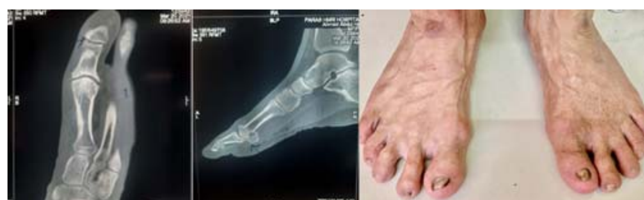

Fig 1 — (A) Representation of CT joints of the left foot with 3D reconstruction. (B) A clinical photograph of the feet after five months of the incident.

Note the absence of superficial veins on the left foot, hyperpigmentation, and mild wasting of interosseous muscles.

foot elevation and anti-inflammatory drugs. NSAID treatment was not followed regularly due to P/H of DU. Pain and swelling of (L) foot persisted making the patient bedridden for nearly 10 days, after which the swelling and pain gradually started decreasing (Fig 1A). Nearly two months after the 2nd vaccine dose, 5% pain and swelling was still present. Patient personally felt that it could be some sort of a non-infective teno-synovitis involving the extensor halluces tendon.There was also numbness of the (L) 1st interdigital space with desquamation of epidermis.

Patient had already planned for cataract surgery in his right eye. In the Pre-operation preparations routine tests were carried out on 23.02.2021.All the reports were within normal range except the Hepatitis C antibody report gave the result as Reactive (Table 2). This was very surprising as reports done on previous occasions were always negative for Viral Markers. The pathologist concerned (Dr S K) repeated the test and confirmed positivity and also did the viral load. (Report attached). The cataract surgery was carried out on 25.02.2021. There were no ophthalmic complains and as far as the eye was concerned patient was back to normal in three days. The pain in the left foot continued in a slowly diminishing pattern. The patient took no medication for the Hepatitis C report as he was certain of not taking any IV or IM Injection during the last one year. The only procedure during this period was one dental extraction done on 26.09.2020. On 08.04.2021 to reassess the situation HCV Viral Load Assay was repeated and came out to be Negative-Target not seen. For reconfirmation one sample was sent to another laboratory Oncquest and result was again negative.

Discussion — keeping in view the above history, it appears that the entire episode was an untoward reaction to the COVID-19 Vaccine - AZD 1222 (ChaAdOx1).

As of 13th August 2021, patient is absolutely pain free but the left forefoot still is slightly hyper pigmented, with very slight wasting of the small muscles of the forefoot and moderate loss of superficial veins in the (L) forefoot area (Fig 1B). Could the whole episode be the result of localized thrombosis involving the veins of the left forefoot? Or was it local oedema causing pressure on the neuro vascular supply.

[1]MS, FRCS, FICS, Director,
Department of General Surgery,
Paras HMRI Hospital, Patna 800014

Ahmad Abdul Hai[1]

Laboratory Data :

Variables	Normal Range (Adult)	On admission (23.2.2021)	After 45 Days (08.4.2021)
Haemoglobin Estimation (gm/dl)	13-17	13.5	13. 7
Total- Leukocyte Count (Cumm)	4000-10000	8050	8070
Neutrophils (%)	40-80	61.4	64.1
Lymphocytes (%)	20-40	26.8	25.9
Eosinophils (%)	1-6	2.4	2.1
Monocytes (%)	2-10	6.6	5.9
Basophils (%)	0-1	0.7	0.6
LUC (Large unstained cells)	NA	2.1	1.4
ESR (Erythrocyte Sed. Rate)	0<15	26	50
PCV –Haematocrit (%)	40-50	42.3	41.3
RBC Count (10^{12}/L)	4.5-5.5	4.45	4.38
MCV (f1)	77-95	95.1	94.3
MCH (pg)	25-33	30.3	31.2
MCHC (gm/dL)	31-37	31.9	33.1
RDW (cv%)	11.6-14.1	14	13.1
Platelet Count (Lakhs/Cumm)	1.5-4	1.88	2.42
Glucose–Random (mg/dL)	70-140	104	96
Createnine (mg/dL)	0.8-1.5	1.2	1.2
Uric Acid (mg/dL)	3.5-8.5	7.4	7.8
ASO Titer/Anti Streptolysin O Titer (1U/mL)	0<200	NA	<200

Table 2 — *Clinical findings*

Variables	Observation on 23.02.2021	Observation on 08.04.2021	Remark
CT-JOINTS WITTI3D	Degenerative arthritic changes seen in 1st metatarso-phalangeal joint in form of articular surface Sclerosis, marginal osteophytes and subchondral cysts of great toe. No fracture of phalanges / metatarsal bones seen. Mild soft tissue swelling seen around 1st metatarsophalangeal joint. Sesamoid bone seen near 1st metatarsophalangeal joint' Irregularity of articular surface involving 1st metatarsophalangeal joint with mild sclerosis, osteophytes and subchondral cyst.s/o Arthritic Changes		
Antibody to Hepatitis C virus	Reactive (3.83)	Not seen	Reactive >1.00
HCV RG RQ_PCR Assay for Hepatitis C virus RNA	34709 - IU/ml or 4.54 - log of HCV RNA was detected in the specimen.	Not seen	Detection Limit: 65 IU/mL or 1.81 log