

Clinical and virological features of first human Monkeypox cases in Germany

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Case Report

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Abstract

In May 2022, human monkeypox infections including human-to-human transmission were reported in a multi-country outbreak in Europe and North America. With the first two German cases, we are providing clinical and virological findings, including the detection of monkeypox virus DNA in blood and semen. It is important to raise awareness among health professionals of the rapid and correct identification and diagnosis of this disease, which is probably still under-reported in Europe.

We describe the first two cases of monkeypox (MPX) infections in Germany to highlight the importance of recent developments for health professionals worldwide and to share further observations related to human-to-human transmission in these cases. MPX is an orthopoxvirus infection that, with the exception of a few imported cases in the past, was previously thought to be endemic only in West and Central African countries [1, 2]. Beginning in 2018, the United Kingdom (UK) Health Security Agency has reported several imported cases associated with travellers from these countries [3]. One case reported on May 7, 2022, had a travel history to Nigeria. However, the two other cases within a family reported on May 13, 2022, neither had a travel history nor an epidemiological link to the previous case. On May 17, 2022, four additional UK cases were reported involving individuals who described themselves as belonging to the group of men who have sex with men (MSM). Subsequent testing for monkeypox virus (MPXV) in symptomatic MSM patients reporting to sexual health and sexually transmitted disease (STD) clinics in the UK and elsewhere revealed an increasing number of confirmed MPX cases in Europe [1].

Clinical Description

Patient #1, a 26-year-old MSM sex worker, currently residing in Portugal first presented to a metropolitan STD outpatient clinic in Munich, Germany, on May 17, 2022. He had previously received a note from a man with whom he had sexual intercourse on May 9. The latter had informed him of a skin rash and suspected syphilis infection. The patient reported living with human immunodeficiency virus (HIV) infection since 2017 and is currently immunologically well controlled and stable on combination treatment with bictegavir, emtricitabine, and tenofovir alafenamide.

On initial presentation, patient #1 complained of malaise since May 13, fever, mild joint, muscle, and back pain, and headache. He also reported dysphagia and the observation of white spots on his tonsils (Fig. 1A). Samples were collected for common STD screening. Two days later, patient #1 had developed several papular skin lesions on the trunk, extremities, and head (Fig. 1B). One lesion on the right wrist was particularly conspicuous (Fig. 1C). In light of recent cases in several other European countries, a MPXV infection was suspected. Swabs from pustules, as well as serum and plasma samples, were collected and sent to the Bundeswehr Institute of Microbiology (IMB) for MPXV specific diagnostics. Local health authorities were notified about a suspected case of MPX.

Patient #2, a 32-year-old man, presented to his primary care physician on May 19, complaining of fever up to 39.0 degree Celsius, fatigue, and cough. Two days later, he developed inguinal lymphadenopathy,

anal pain, and multiple vesicular skin lesions on the entire trunk (Fig. 1D). He reported having had repeated unprotected homosexual intercourse between May 1 and 17, 2022.

Both patients were transferred to the isolation ward of the Munich Clinic Schwabing, one out of seven Competence and Treatment Centres for highly contagious infectious diseases in Germany. The further course of disease to date was mild in both patients. No specific treatment was required other than topical zinc oxide suspension.

Laboratory Analysis

The virological screening at IMB for orthopoxvirus infections employs a molecular biological and serological algorithm using EN ISO 15189 accredited diagnostic methods. Patient samples were examined with a qPCR assay for simultaneous detection of all orthopoxvirus species (RealStar Orthopoxvirus Kit, Altona Diagnostics, Germany) and positive samples were further tested with a MPXV-specific qPCR [4].

All swab samples tested positive in both qPCR assays (Fig. 2). Interestingly, blood samples also tested positive for MPXV DNA, indicating viremia in the respective stadium of infection as described before for MPX [5]. The known potential for MPX transmission through large oral droplets was confirmed by the detection of the virus in throat swabs of both patients. Notably, all semen samples showed positive MPXV qPCR results with viral DNA concentrations comparable to blood, while all urine samples tested negative. Highest viral concentrations were found in both patients in skin swabs from the pustules (Table 1 and Fig. 1).

Table 1
Overview of orthopoxvirus diagnostics from patient #1 and patient #2

Patient	Type of specimen	Date of sampling (2022)	qPCR results		Growth in cell culture (VeroE6)
			OPV cq values	MPXV cq values	
#1	Swab wrist pustule	19 May	20,15	27,2	Cpe after 2 dpi
#1	Swab head pustule	19 May	31,1	37.11	No growth
#1	EDTA blood	19 May	29,8	42,18	No growth
#1	EDTA blood	20 May	31,5	43,00	No growth
#1	Swab oral lesions	20 May	23,36	31.13	NA
#1	Skin swab	20 May	13,79	21.72	NA
#1	Skin swab	20 May	24,51	32.76	NA
#1	EDTA blood	22 May	Inhibition	44,15*	No growth
#1	Urine	22 May	Negative	Negative	No growth
#1	Swab oral lesions	22 May	17,39	25.58	NA
#1	Skin swab	22 May	12,96	20.65	NA
#1	Semen	22 May	28,24	37.09	No growth
#2	EDTA blood	23 May	27,26	36,17	No growth dpi 4
#2	Skin swab	23 May	18,28	25,05	NA
#2	Semen	24 May	30,27	44,96	No growth dpi 4
#2	Urine	24 May	Negative	Negative	No growth dpi 4
#2	Swab oral lesions	24 May	29,11	38,52	NA

NA: not applicable due to inactivating compounds in the original material (eNAT™ medium); cpe: cytopathogenic effect; dpi: days post infection; no growth: cell cultures were incubated for 7 dpi and were monitored visually and by MPXV qPCR. *Inhibition: cq values not reliable due to inhibitory compounds in the original material, therefore this material was excluded for calculation of copies/mL.

Swabs from pustules, EDTA blood, and semen were used for simultaneous virus isolation in Vero E6 cell cultures. After two days, cell cultures from pustule material showed a cytopathogenic effect typical of

orthopoxviruses (Fig. 2A), which was confirmed by MPXV qPCR. This indicates that a sufficient amount of infectious virus was present in the pustules to infect cells in culture and thus to be passed on by smear infection. All other cell cultures of patient #1 (semen, plasma, urine) remained negative.

On the day of hospital admission, IgG antibodies against orthopoxviruses were not detectable in both patients by an immunofluorescence assay using vaccinia virus-infected MA104 cells, indicating a suboptimal or still developing antibody response. After two weeks, on May 30, Patient #1 showed seroconversion with an orthopoxvirus IgG antibody titre of 1:80.

A summary of the molecular and serological results obtained in both patients is shown in Table 1 and Figs. 2&3.

As with other previously reported cases, analysis of the Illumina sequenced viral genomes of patient #1 (AccNo: ON568298) resulted in an assignment to the West African MPXV clade. (Fig. 4). Both show genetic relationship to sequences from Portugal, Belgium, and the USA sampled in May 2022, but differ markedly from UK isolates of the same clade from the 2018 outbreak [6].

Discussion

The described first two cases of MPX in Germany follow the pattern of recent MPX cases observed in North America and Europe. Most of them have not been associated with travel to countries where MPX is known to be an endemic zoonosis [7–9]. While in the past transmission to humans was mainly through infected animals [10], current cases are predominantly, but not exclusively, transmitted between MSM.

As already known, close physical contact seems to be the main factor for human-to-human transmission. However, our clinical and virological investigations of the first two human MPX cases in Germany have revealed further findings that may be important for the monitoring and assessment of the ongoing MPX outbreak:

Interestingly, the enoral lesions on the tonsils were the supposed first visible manifestation of MPX in patient #1. Such lesions have been described previously for MPX in animal models as part of the involvement of the lymphatic tissue [11]. Because oral mucosal lesions (enanthem) occur in many virus infections of humans, including SARS CoV-2 [12], it seems important to generally watch out and sample pharyngeal alterations, when typical skin lesions may not yet be visible.

The detection of MPXV DNA in semen, which we describe here for the first time, has never been reported for human MPX before. However, it is known from animal studies in mice that replicating vaccinia virus exhibits tropism for testicular and ovarian tissue [13, 14]. In our studies, we were able to isolate MPXV only from the contents of skin pustules. This confirms the importance of close (skin) contact as the main route of transmission. Other, as yet unknown, routes of transmission of MPXV to humans should nevertheless be further investigated.

Of note is also that the skin disease of the initial sexual partner of patient #1 was apparently not brought into connection with MPX, but with syphilis. Unfortunately, it remained unclear whether this individual was also tested for a MPXV infection later on. This observation underlines the importance of raising awareness of MPX as a new differential diagnosis of skin efflorescences in individuals who have not travelled to Africa. The emerging changes in the epidemiology of MPX [15] should be taken into account to properly identify individuals with mild and atypical clinical presentations of this human-to-human transmitted disease and to prevent its further spread.

Declarations

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Ethical approval statement

All patients provided informed consent to the use of their data and clinical samples for the purposes of the present study. Institutional review board clearance for the scientific use of patient data and samples has been granted to the treating institution by the ethics committee at the Medical Faculty of the Ludwig Maximilian University (LMU) of Munich (vote 22-0493).

Conflict of interest

CDS reports grants and personal fees from AbbVie, grants, fees and non-financial support from Gilead Sciences, grants and personal fees from Janssen-Cilag, grants and personal fees from MSD, grants from Cepheid, personal fees from GSK, grants and personal fees from ViiV Healthcare, during the conduct of the study; fees from AstraZeneca, other from Apeiron, grants, personal fees and non-financial support from BBraun Melsungen, grants, personal fees from BioNtech, personal fees from Eli Lilly, personal fees from Formycon, personal fees from Molecular partners, grants and personal fees from Eli Lilly, personal fees from Roche, personal fees from SOBI.

All other authors declared no conflicts of interest.

Authors' contributions

Sebastian Noe, Michael Seilmaier, Thomas Fenzl, Jochen Schneider, Christoph Spinner and Clemens-Martin Wendtner were involved in clinical diagnosis and treatment of the patients. Sabine Zange, Markus Antwerpen, Joachim Bugert and Roman Wölfel were involved in virological diagnostics and genome sequencing. Sebastian Noe, Sabine Zange, Joachim Bugert, Clemens-Martin Wendtner and Roman Wölfel collated and reviewed the relevant data from the case, and wrote the first draft. All authors discussed the article's content and approved of the final version.

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Figures



Figure 1

A Enoral lesions (right tonsil) visible already at first presentation of patient #1, **B, C, D** Both patients developed 10-12 initially vesicular, later pustular skin lesions distributed over the entire body. Many of these lesions were umbilicated, and all were at the same general stage of development. Upon opening of the lesions, the typical septate structure of pox lesions became apparent.

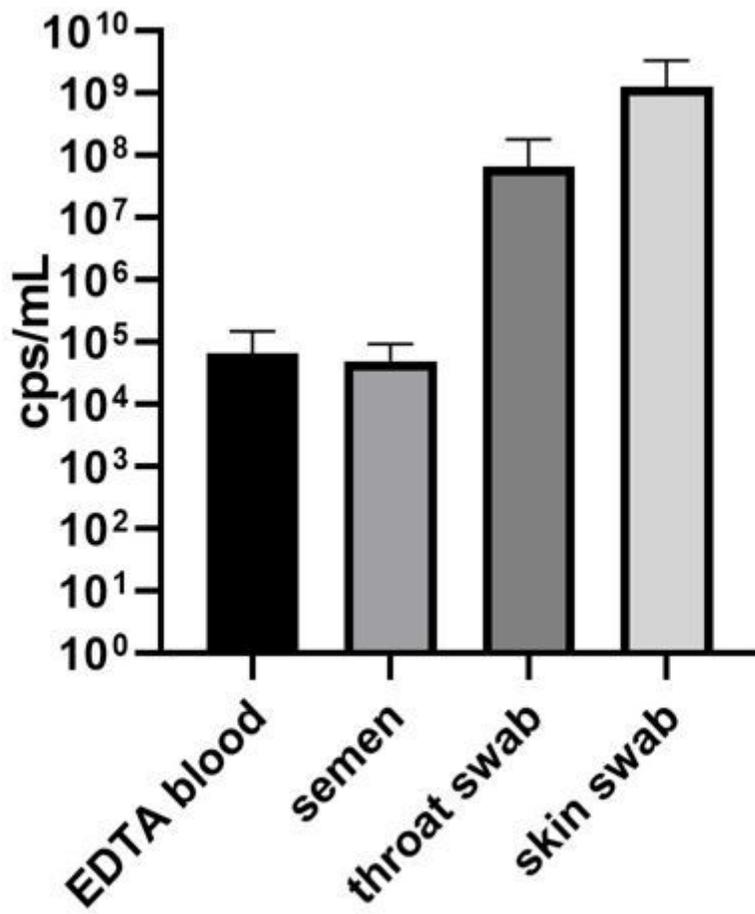


Figure 2

Histogram Plot of MPXV genome copies per mL found in patient samples. Genome copies/mL of the two patients were averaged per sample type.

Figure 3

Isolation of MPXV IMBmuc1 on Vero E6 cells and serology results. VeroE6 cells were inoculated with sample material from a lanced pustule of Patient #1 following standard procedure. (A) typical plaque formation of MPXV IMBmuc 1 on Vero E6 two days post infection of the sample material. (B) Vero E6 mock infected. (C) Plaque morphology of vaccinia virus (VACV) Elstree (1), VACV WR (2), MPXV IMBmuc 1 (3; most similar to VACV Elstree), MPXV IMBdrc 2510 (4), on MA104 cells 3 dpi – size bar refers to (1-4). (D) Reactivity of VACV Elstree in immunofluorescence assay with sera from patient #1 at hospital

admission (1; non-reactive) and eleven days later (2; reactive, titre 80), sera of MVA unvaccinated (3; non-reactive) and MVA vaccinated (4; reactive) controls.

Figure 4

Maximum likelihood tree based on selection of full genome sequences of MPXV. The full tree was rooted at the separation between the Central and West African clades. German patient sequence marked with a green dot.