

Inoculation canker sores during genital transmission of mpox: A report of two cases

Ida Lenga Loumingou¹, Stéphanie Ntsame Ngoua², Ousmane Faye³, Raphaël Taty Taty⁴

¹Department of Dermatology, University of Brazzaville Medical Center, Brazzaville, Republic of the Congo, ²Department of Dermatology, University Hospital Center of Libreville, Gabon, ³Director of the Bamako Dermatology Hospital, University Hospital Center specialized in Dermatology in Mali, ⁴Infectious Disease Specialist in Pointe-Noire, Republic of Congo

Corresponding author: Ida Lenga Loumingou, MD, E-mail: idalengaloumingou@gmail.com

ABSTRACT

Mpox was recently classified as an emerging communicable disease. Ubiquitous, mpox is more common in sub-Saharan Africa. The morbidity and mortality caused by mpox are concerning, and its etiopathogenesis is debated. It is transmitted through direct contact. Cases of sexual transmission are increasingly being reported. Two adolescents, aged 20 and 22, were referred by the emergency department for a rash. Clinical examination revealed disseminated umbilicated papules and a chancre of the balanopreputial fold in one and a pubic fold in the other, with bilateral inguinal lymphadenopathy. Treponemal and chlamydial serologies were negative. There were no treponemes or hemophilus on direct examination after analysis of the chancroids' serosity; PCR performed on one papule was positive for mpox. The etiopathogenesis of mpox remains debated. The presence of a genital chancre is a strong argument for diagnosis.

Key word: MPOX; sexual contamination; chancre

INTRODUCTION

Mpox is a ubiquitous zoonosis transmitted by contact, declared a public health emergency of international concern on August 14, 2024 [1,2]. Central Africa is the most affected region [2]. During the disease, the symptomatology is dominated by cutaneous involvement. This localization helps guide the diagnosis [1]. In 2023, cases of sexual contamination of mpox were reported in West Africa [3,4] without specifying the mechanism. Herein, we report two transmissions of mpox with inoculation chancres.

Case 1

A twenty-year-old adolescent boy presented with a pubic chancre two days after sexual contact (Fig. 1). A disseminated papular rash with progressive onset appeared one week after the chancre. The papules were umbilicated and non-pruritic. The patient had a fever

of 38°C, without chills. He had inflammatory inguinal lymphadenopathy. Serological tests for syphilis, HIV, and chlamydia were negative. A sample of serum from the chancre revealed no bacteria. PCR performed on a papule was positive for mpox.

Case 2

This case involved a 22-year-old man who presented to the emergency department with disseminated papular lesions predominantly affecting the pelvic limbs and abdomen. These lesions had been progressing for one week. Clinical examination revealed a linear, oozing ulcerated lesion in the balano-preputial sulcus (Fig. 2). This painless chancre preceded the eruption by five days, and bilateral, tender, and firm lymphadenopathy was noted. Syphilis serology was negative. There were no treponemes or Donovan bodies on direct examination of the chancre. PCR of one papule was positive for mpox.

How to cite this article: Lenga Loumingou I, Ntsame Ngoua S, Faye O, Taty Taty R. Inoculation canker sores during genital transmission of mpox: A report of two cases. *Our Dermatol Online*. 2026;17(2):219-221.

Submission: 21.12.2025; **Acceptance:** 18.02.2026

DOI: 10.7241/ourd.20262.14



Figure 1: Penile chancre and amblicated pubic papules.



Figure 2: Chancre of the balano-preputial groove and amblicate papules on the thighs.

DISCUSSION

These were both patients with mpox with typical skin lesions preceded by chancres in the genital area several days after sexual contact. The notion of a sexually transmitted infection has been raised for mpox [4,5]. Mpox typically presents with an incubation period of twelve days on average, followed by an infectious syndrome and a maculopapular eruptive phase of fisticulopustules and diffuse crusts, followed by polyadenopathy [1]. The rash appears to predominate in the anogenital regions. Inoculation chancre is not classic [6]; its presence could mislead the diagnosis and suggest pathologies such as herpes, chancroid, or primary syphilis. The chancre in MPOX does not appear to have a typical characteristic. In both of our cases, it has irregular shapes, detached edges, and an oozing base. Harnessed

lymphadenopathy is present in both cases. These bilateral, inflammatory inguinal lymphadenopathies are firm and of variable size. Chancres should be systematically sought in other mucous membranes. It would be wise to routinely perform PCR for mpox on a chancre in endemic areas.

There is, therefore, a variability of clinical forms, ranging from simple forms to severe forms [7]. Diffuse skin forms are the most described [8], but mucosal locations, especially genital ones, represent a particular epidemiological and diagnostic interest [9,10].

CONCLUSION

The etiopathogenesis of mpox infection still raises questions. This pathology may be considered an STI for which an inoculation chancre should be systematically sought.

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

REFERENCES

1. Zinsou A, Clause O, Thonneau P. Cartographie des cas de Monkey en Afrique quemiologie et santé publique. 2023;71:101998.
2. Lemaille C, Halbrook M, Merritt S, Anta Y, Lunyanga L, Mukadi PK, et al. Assessing mpox knowledge and sexual behaviours within high-risk populations in the Democratic Republic of the Congo. medRxiv. 2025:2025.04.20.25326123.
3. Low N, Bachmann LH, Ogoina D, McDonald R, Ipekci AM, Quilter LAS, et al. Mpox virus and transmission through sexual contact: Defining the research agenda. PLoS Med. 2023;20:e1004163.
4. Yadav R, Chaudary AA, Srolavasva U. MPOX 2022 to 2025 update: A comprehension review on its compilations, transmission, diagnostics, treatment. Viruses. 2025;17:753.
5. Ebede SO, Orabueze IN, Maduakor UC, Nwafia IN, Ohanu ME. Recurrent Mpox: Divergent virulent clades and the urgent need for strategic measures including novel vaccine development to sustain global health security. BMC Infect Dis. 2025;25:536.
6. Zhu WF, Song SJ, Wei LW, Qiao JJ. Monkeypox presenting as a chancre-like rash: A case report. World J Clin Cases. 2023;11:6025-30.
7. Corona-Herrera JM, González-Torres JA, Bermúdez-Rodríguez SP, Méndez Flores S, Domínguez-Cherit JG. Monkeypox fulminante: une partie du spectre clinique du syndrome inflammatoire de reconstitution immunitaire ? Our Dermatol Online. 2023;14:393-5.
8. Sigha OB, Medi SC, Nkoro GA, Ndom MS, Mbenoun ML, Kamdem J, Essomba NE, Kouotou EAS. Défis dans la prise en

- charge du Monkeypox dans un pays en développement: cas du Cameroun. *Our Dermatol Online*. 2024;15(Supplément 1):24-9.
9. Nasaha TK, Nagesh M, Riyaz N, Fathima S. Mpox: A recent addition to the differential diagnosis of genital ulcer disease. *CosmoDerma*. 2025;5:68.
 10. Sasidharanpillai S. Monkeypox: An update. *J Skin Sex Transm Dis*. 2022;4:149.

Copyright by Ida Lenga Loumingou, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Source of Support: This article has no funding source.

Conflict of Interest: The authors have no conflict of interest to declare.