

only the herpes simplex virus, *Chlamydia trachomatis*, and *Neisseria gonorrhoea* were tested for in tissue samples. Given the condomless penetrative and receptive anal intercourse by this patient, at least serological tests for syphilis and HIV should be conducted.

Finally, the positive PCR results for monkeypox virus in anorectal and oropharyngeal swabs were sufficient to make a diagnosis of mpox in this case. I consider that it is not necessary to conduct histopathological examination for this patient. Although histopathological examination can also determine the disease, it is traumatic and time consuming.

I declare no competing interests.

Ya Bin Zhou

chouyabin@163.com

Department of Dermatology, Beijing Children's Hospital, Capital Medical University, National Center for Children's Health, Beijing 100045, China

- 1 Müller M, Ingold-Heppner B, Stocker H, Heppner FL, Dittmayer C, Laue M. Electron microscopy images of monkeypox virus infection in 24-year-old man. *Lancet* 2022; **400**: 1618.
- 2 Tarín-Vicente EJ, Alemany A, Agud-Díos M, et al. Clinical presentation and virological assessment of confirmed human monkeypox virus cases in Spain: a prospective observational cohort study. *Lancet* 2022; **400**: 661–69.
- 3 Nörz D, Brehm TT, Tang HT, et al. Clinical characteristics and comparison of longitudinal qPCR results from different specimen types in a cohort of ambulatory and hospitalized patients infected with monkeypox virus. *J Clin Virol* 2022; **155**: 105254.
- 4 Jezek Z, Szczepirowski M, Paluku KM, Mutombo M. Human monkeypox: clinical features of 282 patients. *J Infect Dis* 1987; **156**: 293–98.

Authors' reply

We appreciate the comments of Ya Bin Zhou on our Clinical Picture¹ and agree that the diagnosis of monkeypox virus infection is indeed best achieved by detection of the virus in skin lesions.^{2,3}

In fact, in our patient, monkeypox virus DNA was detected by quantitative PCR in swabs taken from the oropharynx, rectum, and skin lesions. Since our Clinical Picture obviously did not focus on the diagnostic strategy or

virus transmission of the case, we felt that the result of the skin swabs was not relevant. The main intention of our short contribution was to show the ultrastructural presentation of an mpox infection of the colon, which is distinct from the presentation in the skin and that, to our knowledge, has not been shown previously.

Proctitis and severe anal pain are now known to be frequently observed symptoms of mpox in the affected population, but they differ from symptoms previously described for the disease in the medical literature.³ At the time of admission to hospital, the severe anal pain of our patient required anorectoscopy and subsequent tissue extraction from anal ulcerating lesions was essential to exclude other differential diagnoses including neoplasms. Although we fully agree with Zhou that it is of utmost importance to investigate patients with mpox for other sexually transmitted diseases, the patient in our case was an HIV-pre-exposure prophylaxis user who had been tested for HIV and syphilis with negative results directly before admission to, and right after discharge from, hospital.

We declare no competing interests.

Markus Müller, Barbara Ingold-Heppner, Hartmut Stocker, Frank L Heppner, Carsten Dittmayer, *Michael Laue
lauem@rki.de

Clinic for Infectious Diseases, St Joseph Krankenhaus, Berlin, Germany (MM, HS); Institute of Pathology, DRK Kliniken Berlin, Berlin, Germany (BI-H); Department of Neuropathology, Charité—Universitätsmedizin Berlin, Berlin, Germany (FLH, CD); Cluster of Excellence, NeuroCure, Berlin, Germany (FLH); German Center for Neurodegenerative Diseases, Berlin, Germany (FLH); National Consultant Laboratory for Diagnostic Electron Microscopy of Pathogens, Centre for Biological Threats and Special Pathogens, Robert Koch Institute, Berlin 13353, Germany (ML)

- 1 Müller M, Ingold-Heppner B, Stocker H, Heppner FL, Dittmayer C, Laue M. Electron microscopy images of monkeypox virus infection in 24-year-old man. *Lancet* 2022; **400**: 1618.
- 2 Tarín-Vicente EJ, Alemany A, Agud-Díos M, et al. Clinical presentation and virological assessment of confirmed human monkeypox virus cases in Spain: a prospective observational cohort study. *Lancet* 2022; **400**: 661–9.

- 3 WHO. Monkeypox fact sheet. 2022. <https://www.who.int/news-room/fact-sheets/detail/monkeypox> (accessed Jan 13, 2023).

Helicobacter pylori eradication and aspirin: a puzzle yet to be solved

We read with great interest the Article by Chris Hawkey and colleagues¹ on the *Helicobacter* Eradication Aspirin Trial (HEAT). The authors should be commended for performing such a complex trial. Although the trial was conceived to evaluate the role of *Helicobacter pylori* eradication in older patients (aged ≥ 60 years) prescribed aspirin, the study was not planned to verify eradication. A breath retest was randomly performed in only 10% of patients, reporting *H pylori* eradication in 146 (90.7%) of 161 patients receiving active eradication therapy. Such high eradication is usually achieved only with quadruple therapies lasting 10 days or longer, but not with 7-day triple therapies.^{2,3} Furthermore, *H pylori* eradication was unexpectedly observed in 41 (24.0%) of 171 patients in the placebo group. Although exposure to clarithromycin, which occurred in 13 (32%) of the 41 control patients with a negative repeat breath test, might theoretically support these results,⁴ there is no clear explanation for the remaining cases. These findings suggest that it would have been worthwhile to assess eradication in a new larger random sample in both groups.

During the first 2.5 years of follow-up, prescriptions for aspirin decreased progressively in both study groups, while prescriptions for proton pump inhibitors increased in both groups. Even if analyses were adjusted for time-varying prescribed medications, this trend might have had consequences on the second part of follow-up with regard to the primary outcome, and a type two error cannot be excluded.