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Severe Mpox in people with advanced HIV disease complicated by disseminated tuberculosis: a report of three cases from Nigeria

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INTRODUCTION

Mpox in PLHIV(People Living with human immune deficiency virus) is associated with severe outcomes, particularly when co-infection with opportunistic pathogens, such as Mycobacterium tuberculosis (MTB), is present.

AIM

We describe three cases of severe mpox in PLHIV, each with CD4 counts under 200 cells/mm3 and laboratory-confirmed disseminated tuberculosis

METHOD

A retrospective review of three hospitalized patients with mpox and HIV(Human immune deficiency virus) who were also found to have disseminated tuberculosis. The clinical course, management, and outcomes were summarized.

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RESULTS & DISCUSSION

Case 1: A 44-year-old man with newly diagnosed HIV presented after 14 days of illness with disseminated necrotizing mpox and sepsis, along with severe immunosuppression (CD4 <200 cells/mm3). Urine LF-LAM(Lateral flow lipoarabinomanam) confirmed disseminated TB(Tuberculosis), and blood culture confirmed Staphylococcus aureus bacteremia. Despite oxygen supplementation and broad-spectrum antibiotics, he died within three days of admission, prior to starting anti-tuberculosis or ART(antiretroviral therapy)

Figure 1:A picture of case 1

RESULTS & DISCUSSION

Case 2: A 22-year-old woman with perinatally acquired HIV, virally suppressed on ART, presented after 8 days of illness with nodulopustular and severe genital mpox. Disseminated TB was confirmed via urine LF-LAM. She was started on anti-tuberculosis therapy, continued her ART, improved clinically, and was discharged after 10 days

Figure 2: A picture of case 2

Case 3: A 28-year-old woman with HIV who had stopped ART for over a year presented with two weeks of widespread nodulopustular lesions. Initially misdiagnosed as disseminated herpes, she was restarted on ART. She became unconscious and died shortly after starting ART, raising concern for unmasking IRIS(Immune reconstitution Inflammatory Syndrome

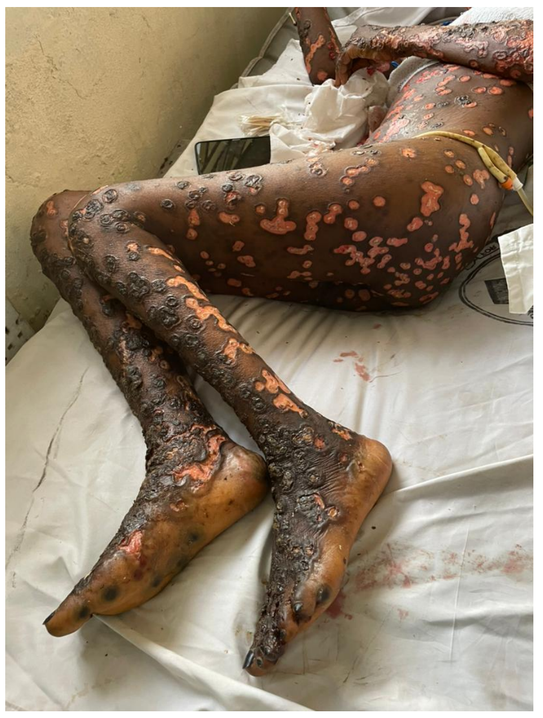

Figure 3: A picture of case 3

CONCLUSION

Mpox in PLHIV with severe immunosuppression is associated with high morbidity and mortality, especially when combined with disseminated TB and delayed ART initiation or reinitiation. Early recognition, integrated HIV/TB/mpox assessment, and careful timing of ART are crucial in high-burden settings to improve clinical outcomes

FUTURE WORK / REFERENCES

1.Onyeaghala C, Somiari A, Ichechiek U, Ogan J, Avundaa H, Ehiakhamen O, et al. Epidemiology, clinical presentation and outcome of human mpox in Rivers State, Nigeria during the 2022-23 outbreak: an observational retrospective study. Pan Afr Med J. 2025;50:5.

2. Ogoina D, Dalhat MM, Denue BA, Okowa M, Chika-Igwenyi NM, Yusuff HA, et al. Clinical characteristics and predictors of human mpox outcome during the 2022 outbreak in Nigeria: a cohort study. Lancet Infect Dis. 2023;23:1418–28.

3.Mitjà O, Alemany A, Marks M, Lezama Mora JI, Rodríguez-Aldama JC, Torres Silva MS, et al. Mpox in people with advanced HIV infection: a global case series. Lancet. 2023;401:939–49