seeking the ED due to a respiratory virus infection, and the source population would thus not include milder infections in the community [4]. We do not agree that including test-negative patients is very informative because it consists of a heterogenous group of patients with many different infections and diagnoses.

Second, the authors mentions that we had access to time-to-event data but used logistic regression for statistical modelling purposes. The cumulative incidence was included in the article to present the temporality of mortality among study participants. However, our main objective was not to model time to mortality, but rather to evaluate mortality as a binary outcome at 30 and 90 days after the ED visit. If using Cox regression, the adjusted hazard ratio (95% confidence interval [CI]) for 30-day mortality would be 2.21 (1.50–3.25) for Omicron versus influenza and 1.36 (.92–2.01) for Omicron versus RSV, that is, similar findings to those from the logistic regression models.

Third, the authors bring up a sentence in the discussion where it is mentioned that "*around 14 times more deaths occurred in the Omicron cohort compared to the influenza 2021/2022 cohort and the RSV 2021/2022 cohort*…." It is correct that these figures stem from dividing the number of deaths in the Omicron cohort with the number of deaths in the influenza and RSV cohorts, respectively. As mentioned in the article, this calculation assumes that all deaths were related to the respiratory infection and the length of the infection seasons were similar. The purpose of this calculation is to emphasize that during the 14-month study period, Omicron was both more prevalent and associated with more severe outcomes, a "double whammy," compared with influenza and RSV infections.

Finally, the authors point out that almost all cases of influenza in our study were influenza A (1082/1099), and thus we did not have sufficient power to compare patients infected with Omicron to patients infected with influenza B. This is mentioned as a limitation in the discussion, and we do agree with the authors that further investigations into this could provide important insights into the comparative severity of these respiratory viruses. It is important to emphasize that the severity of influenza epidemics varies widely [5] and continued assessments of the comparative severity of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infections and influenza and RSV infections are warranted as described in our article.

Notes

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Community Involvement in an Outbreak—One Year on for Mpox

To the Editor—We read with interest the article by Hazra and Cherabie [1], who conclude that the classification of mpox as a sexually transmitted infection would only worsen stigma faced by those affected. The authors provide examples of US initiatives to reduce stigma and emphasize educating communities on transmission dynamics and prevention methods. There is no mention of what affected communities think of mpox as an sexually transmitted infection, despite previous publications on this question [2], and no details on how to effectively involve communities in such discussions. Mpox-affected communities should be at the heart of this discourse. We call for a change in the global mpox response to be more community led, through the example of involving the community in a UK clinical treatment trial as a step toward this.

The UK mpox outbreak began in May 2022, with >3700 cases recorded, and has disproportionately affected gay, bisexual, and other men who have sex with men, who have been stigmatized as a result [3]. Between 38%–50% of those affected by mpox have also been with human immunodeficiency virus (HIV) [4]. The PLATINUM trial is a national UK trial to evaluate the safety and efficacy of tecovirimat in nonhospitalized patients with mpox. Early and rapid community

Table 1. Community Involvement Activities in the PLATINUM Trial

Activity	*Activity Description*	*Impact on Trial*
CAP	Includes persons recovered from mpox, sexual health workers who have treated mpox patients, gay and bisexual, and other men who have sex with men, and people with HIV; contributed to study protocol, participant information sheet, consent form, patient recruitment poster and flyer, participant questionnaire, press release, and website	Increased inclusivity and appropriateness of language used in patient-facing materials
Raising awareness	Presentation of trial at conferences by community members (eg, HIV Glasgow); interview with community podcast "What the Pox?"; hosting a stall at Manchester Pride festival 2023 to provide information about the trial to festival attendees	Identification of potential avenues for raising trial awareness that are outside routine trial recruitment strategies; increased community awareness about the trial
Training	Training provided to CAP members on trial background, planned future training on scientific publications	Increased community member understanding of the trial and research in general
	Community-delivered training in stigma and HIV history to trial team as a result of steering committee recommendation	Whole trial team invited to training; attendees gained greater understanding of the stigma faced by groups at risk of mpox and appropriate language and terminology to use when engaging with those communities
Community representation in steering committee	A CAP member is a member of the trial steering committee; training in stigma and HIV history was recommended by the community representative	Community voice present in trial governance
Communication with clinics	Advice from CAP on how to recruit potential participants in clinics across the country	Patient-centered and language-appropriate recruitment posters and flyers
Community organization engagement	Support from Terrence Higgins Trust, UK Community Advisory Board, Positively UK, NAM AIDSMAP, Prepster, and HIV i-Base; HIV i-Base, Positively UK, and the British HIV Association have included the trial on their websites	Increased community and healthcare worker awareness of the trial, including diverse high-risk community groups
Trial launch	CAP reviewed the press release, provided a statement within the release, and tweeted about the trial launch alongside supporting organizations; this, together with trial team and university tweets, potentially reached >1.4 million people, and the trial was covered by community media channel PinkNews	Improving awareness for potential participants beyond those normally reached by research organization engagement

Abbreviations: CAP, Community Advisory Panel; HIV, human immunodeficiency virus.

leadership led to community involvement in the PLATINUM trial (Table 1).

Early community involvement was enabled by trial leadership and funders prioritizing community engagement. Support was provided by community organizations and a rapidly established community advisory panel, including individuals previously treated for mpox and those with HIV. Examples of their impact included changing the trial protocol to include emergency contact numbers for participants and enhancing recruitment and communication. Despite these early initiatives, challenges remained. The extensive time for study approvals meant that the peak mpox case numbers had passed before the study started.

There have also been mounting feelings of discontent, reflecting the frustration in the community of gay, bisexual, and other men who have sex with men toward the national UK mpox response. In contrast to the United States, no single government representative for the mpox response was elected to tackle the outbreak, resulting in lack of coordination across intervention efforts. Instead, and consistent with the US response as noted by Hazra and Cherabie [1], sexual health clinics that were already stretched and underfunded have had to manage the outbreak response, such as vaccinations and referrals to trials like PLATINUM.

For years there have been calls for greater involvement of communities in our public health responses, with accessible guidance on how to do this in fields such as in HIV research [5], and yet coordinated community-centered responses are still lacking. The activities highlighted in the PLATINUM trial are a step toward correcting this. However, significant improvements need to be made to further support community engagement in response to outbreaks like mpox, such as standardizing the involvement of communities in studies and discussions such as the one outlined by Hazra and Cherabie [1], and nominating leaders of contact for outbreak responses. Greater meaningful, and continuous community engagement will ensure that future trials are as effective as possible and improvements in care and control are achieved.

Notes

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Community-Informed Approach Remains Critical to Our Mpox Response

To the Editor—We thank Cheyne et al [1] for their important insights into our viewpoint in which we argued that classification of mpox as a sexually transmitted infection (STI) should be a nuanced discussion and was presented as a counterpoint to a position statement published by Allan-Blitz et al [2, 3]. The purpose of these articles was to discuss the implications of categorizing mpox as an STI, highlight that mpox is not exclusively sexually transmitted, and illustrate concerns that such classification may perpetuate stigma among those impacted by mpox.

We wholeheartedly agree with Cheyne et al on the need for intentional community engagement and inclusion of critical stakeholders from the start of any study, intervention, or project directed at the very community being impacted. As clinicians working within community health centers in St. Louis and Chicago, respectively, we greatly value the input of patients and advocates in all of our work. It is encouraging to learn of the comprehensive efforts made by the Placebo-controlled randomised trial of tecovirimat in non-hospitalised Mpox patients (PLATINUM) trial in ensuring just that. Notably, the central argument of our viewpoint aligns with these sentiments. We must prioritize our efforts on destigmatizing this illness and empowering affected populations to protect themselves from mpox rather than spending our limited energy and resources on largely academic disease categorization. We still strongly believe that absolute classification of mpox as an STI would be shortsighted. While doing so may provide some protection for adolescents and direct funding from federal agencies, it would only amplify prejudices faced by marginalized communities while reinforcing outdated, overstretched STI funding silos. In the United States, far-right politicians have also weaponized the conflation of mpox as an STI to propagate false and dangerous claims against the LGBTQIA + community when infections were identified in animals and children [4]. As the Centers for Disease Control and Prevention has emphasized the need to decrease stigma around both mpox and STIs, we understand that to do so requires us to reframe our approach away from a disease-centric model and toward one that values overall sexual health, well-being, and pleasure.

As 2 queer infectious diseases physicians who have had countless patients, friends, and loved ones impacted by mpox, we feel a personal and professional responsibility in our work regarding this outbreak. Positioned at the front lines of sex-positive and patient-centered care, we were listening at community events, taking part in activism at conferences, and bringing screening and vaccination services directly to these venues. We also aimed to highlight that this outbreak did not occur in a vacuum and has affected global communities for decades. Our efforts to combat mpox must recognize and address all individuals affected by a disease beyond the LGBTQIA + populations largely impacted during this outbreak, both within our communities and globally. Without prioritizing global prevention and treatment efforts while decreasing the stigma associated with this disease, we are destined to see more outbreaks in the future.

Note

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