

May 20, 2022

Georgia Department of Public Health Reminds Clinicians to be Prepared to Identify, Isolate and Inform Due to Recent Monkeypox Cases

Summary

- The Massachusetts Department of Public Health and the Centers for Disease Control and Prevention (CDC) are investigating a confirmed case of monkeypox in the United States.
- Cases of monkeypox have previously been identified in travelers from, or residents of, West African or Central African countries where monkeypox is considered to be endemic. Since May 14, 2022, clusters of monkeypox cases have been reported in several countries that don't normally have monkeypox. Georgia is issuing this Health Advisory to remind clinicians in Georgia to be vigilant to Identify, Isolate and Inform.
- Suspicion for monkeypox should be heightened if the rash occurs in people who 1) traveled to countries with recently confirmed cases of monkeypox, 2) report having had contact with a person or people who have a similar appearing rash or received a diagnosis of confirmed or suspected monkeypox, or 3) is a man who regularly has close or intimate in-person contact with other men. Lesions may be disseminated or located on the genital or perianal area alone. Some patients may present with proctitis, and their illness could be clinically confused with a sexually transmitted infection (STI) like syphilis or herpes, or with varicella zoster virus infection.
- Providers can review Georgia's Travel Clinical Assistant to identify areas where monkeypox outbreaks have occurred, <https://dph.georgia.gov/TravelClinicalAssistant>
- Clinicians who suspect monkeypox should immediately **call 866-PUB-HLTH (1-866-782-4584)** and request to speak with a medical epidemiologist for consultation.

Background

Since May 14, 2022, clusters of monkeypox cases, have been reported in several countries that don't normally have monkeypox. Although previous cases outside of Africa have been associated with travel from Nigeria, most of the recent cases do not have direct travel-associated exposure risks. The United Kingdom Health Security Agency (UKHSA) was the first to announce on May 7, 2022, identification of a recent U.K. case that occurred in a traveler returning from Nigeria. On May 14, 2022, UKHSA announced an unrelated cluster of monkeypox cases in two people living in the same household who have no history of recent travel. On May 16, 2022, UKHSA announced a third temporally clustered group of cases involving four people who self-identify as gay, bisexual, or men who have sex with men (MSM), none of whom have links to the three previously diagnosed patients. Some evidence suggests that cases among MSM may be epidemiologically linked; the patients in this cluster were identified at sexual health clinics. This is an evolving investigation and public health authorities hope to learn more about routes of exposure in the coming days.

[Monkeypox](#) is a zoonotic infection endemic to several Central and West African countries. The wild animal reservoir is unknown. Before May 2022, cases outside of Africa were reported either among people with recent travel to Nigeria or contact with a person with a confirmed monkeypox virus infection. However, in May 2022, nine patients were confirmed with monkeypox in England; six were among persons without a history of travel to Africa and the source of these infections is unknown.

Monkeypox disease symptoms always involve the characteristic rash, regardless of whether there is disseminated rash. Historically, the rash has been preceded by a prodrome including fever, lymphadenopathy, and often other non-specific symptoms such as malaise, headache, and muscle aches. In the most recent reported cases, prodromal symptoms may not have always occurred; some

recent cases have begun with characteristic, monkeypox-like lesions in the genital and perianal region, in the absence of subjective fever and other prodromal symptoms. For this reason, cases may be confused with more commonly seen infections (e.g., syphilis, chancroid, herpes, and varicella zoster). The average incubation period for symptom onset is 5–13 days.

The typical monkeypox lesions involve the following: deep-seated and well-circumscribed lesions, often with central umbilication; and lesion progression through specific sequential stages— macules, papules, vesicles, pustules, and scabs. Synchronized progression occurs on specific anatomic sites with lesions in each stage of development for at least 1–2 days. The scabs eventually fall off. Lesions can occur on the palms and soles, and when generalized, the rash is very similar to that of smallpox including a centrifugal distribution. Monkeypox can occur concurrently with other rash illnesses, including varicella-zoster virus and herpes simplex virus infections. Case fatality for monkeypox is reported to range between 1 and 11%. Confirmatory laboratory diagnostic testing for monkeypox is performed using real-time polymerase chain reaction assay on lesion-derived specimens.

A person is considered infectious from the onset of symptoms and is presumed to remain infectious until lesions have crusted, those crusts have separated, and a fresh layer of healthy skin has formed underneath. Human-to-human transmission occurs through large respiratory droplets and by direct contact with body fluids or lesion material. Respiratory droplets generally cannot travel more than a few feet, so prolonged face-to-face contact is required. Indirect contact with lesion material through fomites has also been documented. Animal-to-human transmission may occur through a bite or scratch, preparation of wild game, and direct or indirect contact with body fluids or lesion material.

There is no specific treatment for monkeypox virus infection, although antivirals developed for use in patients with smallpox may prove beneficial. Persons with direct contact (e.g., exposure to the skin, crusts, bodily fluids, or other materials) or indirect contact (e.g., presence within a six-foot radius in the absence of an N95 or filtering respirator for ≥ 3 hours) with a patient with monkeypox should be monitored by health departments; depending on their level of risk, some persons may be candidates for post-exposure prophylaxis with smallpox vaccine under an Investigational New Drug protocol after consultation with public health authorities.

Recommendations for Clinicians

- The risk of monkeypox in Georgia is still very low, but, if clinicians identify patients with a rash that could be consistent with monkeypox (see above for additional details about disease presentation), especially those with a recent travel history to a country where monkeypox has been reported, monkeypox should be considered as a possible diagnosis.
- Information on infection prevention and control in healthcare settings is provided on the CDC website: [Infection Control: Hospital | Monkeypox | Poxvirus | CDC.](#)
- Clinicians in Georgia should call 866-PUB-HLTH (1-866-782-4584) and request to speak to a medical epidemiologist for consultation.
- Once testing is approved by a medical epidemiologist, shipping instructions to the public health lab and paperwork will be provided, the specimen guidance below should be followed:
 - Molecular Testing:
 - More than one lesion should be sampled, preferably from different locations on the body and/or from lesions with differing appearances.
 - The following specimen types will be accepted:
 - Vesicle fluid, skin, crust, “roof”
 - Dry or wet swab of lesion (dry swab is preferred)
 - Touch prep (slide) of lesion
 - Fresh biopsy of pustule or vesicle (no formalin)
 - Swab each lesion separately with a sterile nylon, polyester, or Dacron swab with plastic or thin aluminum shaft. Do not use other types of swabs. Place in an

- individual collection tube (i.e., one tube per lesion sampled). Write site of collection on each specimen.
 - Refrigerate (2-8°C) or freeze (-20°C or lower) specimens within an hour after collection.
- Serology Testing:
 - Serum, minimum of 0.5 mL; 1 mL preferred
 - Use blood collection tubes containing a clot activator and/or gel for serum separation. Separate and aliquot serum prior to storage and transport. Refrigerate (2-8 °C) or freeze (-20 °C or lower) specimens within an hour after collection.
- In addition to infection control protocols linked above to be used while a patient is in a health care facility, patients being tested for monkeypox who are well enough to be discharged home, should isolate from others until results are returned. If approved for testing, a person will also be issued an isolation order, details of this isolation order can be discussed at the time of clinical assessment based on the patient's individual situation.
 - Persons who are under suspicion of monkeypox should not take public or shared transportation while test results are pending (ex. Public transportation, Uber, Lyft, or other rideshare programs).

For More Information

- CDC Monkeypox Website (including information on signs, symptoms, and infection control): <https://www.cdc.gov/poxvirus/monkeypox/index.html>
- The National Emerging Special Pathogens Training and Education Center (NETEC) has the following information available about Monkeypox.
 - For EMS: <https://netec.org/2022/05/19/ems-response-to-the-current-outbreak-of-monkeypox/>
 - For healthcare: <https://netec.org/2022/05/19/outbreak-update-monkeypox-outbreak-in-the-us/>