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***Updated guidance on Monkeypox testing, treatment and special populations including children & adolescents, pregnant and breastfeeding people and those with HIV; Update on Parechovirus***

**Thurston County Process for Suspect Monkeypox Cases:**

**Action Requested:**

- 1) Suspect and confirmed cases of monkeypox are immediately notifiable. Call Thurston County Public Health and Social Services when you have a patient with suspected monkeypox. Call 360-867-2500 between 8am-5pm Monday through Friday excluding holidays. After hours call 1-800-986-9050.
- 2) Collect specimens from three lesions. The recommended specimen type is material collected from the surface of a lesion or crust from a healing lesion. CDC recommends that three lesions per patient be swabbed. Swab the surface of the lesion vigorously to collect adequate DNA. It is not necessary to de-roof or lance the lesion before swabbing. For some individuals, the lesions may not be overtly visible (such as within the oral cavity or within the rectum), therefore clinicians should perform a thorough evaluation including a full body skin, oral, genital, and rectal examination to identify appropriate lesions for sampling.
- 3) Instruct suspect monkeypox case do the following until either they receive a negative test result or until lesions have completely healed and healthy skin has formed underneath if they test positive for monkeypox:
  - Isolate away from other people and from animals (mammals).
  - Restrict family, friends, or other visitors to those with an essential need to be in the home.
  - Wear well-fitting medical mask when in close contact with others at home.
  - Stay home except for getting health care.
  - Remain separate until the rash is gone, all scabs have fallen off, and the skin below is healed.
  - Not to share bedding, towels, dishes, or utensils.
  - Wash their own laundry and dishes.
  - Routinely clean and disinfect commonly touched surfaces and items.
  - Have somebody else take care of animals (mammals) like pets and livestock.
  - Avoid use of contact lenses to prevent inadvertent infection of the eye.
  - Avoid shaving rash-covered areas of the body as this can lead to spread of the virus
  - Not to use commercial travel (airplane, bus, taxi, shared car).
  - Not to kiss, hug, cuddle, sleep, or have sex with others.

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4) Specimen Shipping Conditions for Orthopox testing at PHL:

- Consult with Thurston County Public Health to get approval for testing at the Washington State Public Health Lab (PHL). Specimen **CANNOT** be tested at the PHL without approval of your local health jurisdiction.
- If transported within 24 hours of collection, package specimens from a single patient on refrigerated (2°C -8°C) gel packs.
- If you cannot guarantee specimens will be shipped and received at PHL within 24 hours, it is best to freeze specimens immediately. If transported after 24 hours of collection, freeze specimens, and ship on dry ice or at -70°C to -20°C.
- For more information on specimen collection for specimens sent to PHL, visit: Monkeypox Specimen Testing at PHL.
- At this time, no-cost testing can only be performed at the Washington State Public Health Laboratories (PHL).

Specimen submission through commercial laboratories.

- Notify Thurston County Public Health and Social Services of all suspect monkeypox cases – please provide name, address, phone number and demographic information, including race/ethnicity of the patient. Review specimen submission guidance specific to the commercial laboratory for testing.
- 5) Ship specimens and material suspected or confirmed to contain the West African clade of monkeypox virus as UN 3373 Biological Substance, Category B. The U.S. government does not consider the West African clade of monkeypox virus to meet the definition of Category A infectious substance under the Hazardous Materials Regulations (HMR).

**References:**

Centers for Disease Control HAN Alert [0471 – 07/28/2022](#)

[Update for Clinicians on Testing and Treatment for Monkeypox](#)

Washington State Department of Health Monkeypox <https://doh.wa.gov/public-health-healthcare-providers/notifiable-conditions/rare-disease-public-health-significance/monkeypox#FAQs>

Centers for Disease Control [Preparation and Collection of Specimens](#)

**Monkeypox Treatment: Using Tecovirimat (TPOXX)**

**Action Requested:**

- 1) Consider using Tecovirimat for individuals with monkeypox at high risk of severe disease including those who are immunocompromised, less than 8 years of age, pregnant or breastfeeding, have a history of atopic dermatitis or exfoliative skin condition, have complications from monkeypox infection or who have aberrant monkeypox infections.

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- 2) Contact Thurston County Public Health and Social Services if you have a patient who may benefit from Tecovirimat to facilitate obtaining the medication.
- 3) For urgent clinical situations after hours, providers may contact CDC's Emergency Operations Center (770-488-7100) to discuss the case with a clinician but pre-positioned TPOXX may be the fastest route to obtain the therapeutic. Treatment with TPOXX can begin upon receiving the medication and after obtaining informed consent. No pre-registration is required for clinicians or facilities to begin treatment. Forms requested under the EA-IND can all be returned to CDC after treatment begins.
- 4) Healthcare providers prescribing Tecovirimat should perform the following:
  - Obtain [informed consent](#) prior to treatment.
  - Conduct a baseline assessment and complete the [Patient Intake Form](#). If feasible, give the patient the [diary form](#) to complete at home and encourage the patient to return it directly to CDC. The top of the diary form provides the patient with instructions on how to return it to CDC.
  - Sign the [FDA Form 1572](#). One signed 1572 form per facility suffices for all (including future) TPOXX treatments administered under the EA-IND at the same facility.
  - Document progress during and after treatment on the [Clinical Outcome Form](#).
  - Report life-threatening or serious adverse events associated with TPOXX by completing a [PDF MedWatch Form \[226KB, 3 pages\]](#) and returning it to CDC via email ([regaffairs@cdc.gov](mailto:regaffairs@cdc.gov)) or uploading to [ShareFile](#) within 72 hours of awareness or sooner, if possible.
  - Comply with FDA requirements for IRB review described here: [Information for Healthcare Providers on Obtaining and Using TPOXX \(Tecovirimat\) for Treatment of Monkeypox | Monkeypox | Poxvirus | CDC](#).

**Background:**

Tecovirimat (also known as TPOXX or ST-246) is approved by the Food and Drug Administration (FDA) for treating human smallpox disease caused by Variola virus in adults and children. Its use for other Orthopoxvirus infections, including monkeypox, is not approved by the FDA. However, CDC has an expanded access Investigational New Drug application (EA-IND) to allow access to and use of TPOXX to treat monkeypox in adults and children of all ages.

**References:**

Centers for Disease Control HAN Alert [0471 – 07/28/2022 Update for Clinicians on Testing and Treatment for Monkeypox](#)

Centers for Disease Control [Obtaining and Using TPOXX \(Tecovirimat\)](#)

Centers for Disease Control [Treatment Information for Healthcare Professionals | Monkeypox | Poxvirus | CDC](#)

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## Recommendations and Information for Healthcare Providers

### Monkeypox in People with HIV

- 1) Persons with advanced and uncontrolled HIV might be at higher risk for severe or prolonged monkeypox disease. Therefore, prophylaxis (e.g., vaccination), medical treatment and close monitoring are a priority for this population. Compared with other persons with monkeypox, case reports among persons with inadequately treated HIV who have CD4 counts  $\leq 350$  per mm<sup>3</sup> reported higher rates of secondary bacterial infection, more prolonged illness (and thereby also longer period of infectiousness), as well as a higher likelihood of a confluent or partially confluent rash, rather than discrete lesions. In contrast, recent reports of patients with HIV infection and monkeypox who are on effective antiretroviral therapy (ART) have noted no deaths or evident excess hospitalizations to date. Providers should consider both viral suppression and CD4 count in weighing the risk of severe outcomes from monkeypox for any patient with HIV.
- 2) The rash of monkeypox can be confused with other rash illnesses that are considered in people with HIV, including herpes zoster (shingles), scabies, molluscum contagiosum, herpes, syphilis, chancroid, lymphogranuloma venereum, allergic skin rashes, and drug eruptions. Immunocompromised persons, including persons with advanced, untreated or inadequately suppressed HIV, may present with an atypical rash, including a disseminated rash that may make diagnosis more challenging.
- 3) [Prevention](#) of monkeypox and infection control practices in the [home](#) or [healthcare setting](#) are the same regardless of peoples' HIV status. [Post-exposure prophylaxis \(PEP\)](#) and antiviral [treatments](#), including [tecovirimat](#), are available for persons exposed to monkeypox or with *Monkeypox virus* infection. The safety and immunogenicity of JYNNEOS, a live, non-replicating viral vaccine, has been specifically established in people with HIV; however, immunogenicity among persons with HIV who have CD4 counts below 100 cells/mm<sup>3</sup> or who are not virologically suppressed remains unknown. ACAM2000, a replicating viral vaccine, should not be given to people with HIV (regardless of immune status). Antiviral treatments for monkeypox have [few](#) interactions with antiretroviral therapy. ART and opportunistic infection prophylaxis should be continued in all people with HIV who develop monkeypox.

#### **Background:**

In the current monkeypox outbreak, available international [summary surveillance data](#) in the CDC-issued [clinical considerations for people with HIV](#) indicate 30-51% HIV prevalence among persons with monkeypox for whom HIV status was known. It is currently unknown whether HIV infection affects a person's risk of acquiring *Monkeypox virus* infection and developing disease after exposure.

#### **References:**

Centers for Disease Control HAN Alert [0472 – 07/30/2022](#)  
[Update for Clinicians on Monkeypox in People with HIV, Children and Adolescents, and People who are Pregnant or Breastfeeding](#)

Centers for Disease Control [Clinical Considerations for Treatment and Prophylaxis of Monkeypox virus Infection in People with HIV | Monkeypox | Poxvirus | CDC](#)

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## Recommendations and Information for Healthcare Providers on Monkeypox in Children and Adolescents

- 1) Pediatric providers should be familiar with prevention, recognition, and testing considerations for monkeypox in children and adolescents. Monkeypox virus can spread to children through contact with infectious body fluids (e.g., lesion exudates and respiratory secretions) of people or animals or through contact with fomites, as may occur in households and other close contact settings.
- 2) Families should be counseled about preventing the spread of Monkeypox virus between children, caregivers, and household members in the home, including avoidance of contact with persons who have monkeypox, the body fluids of an infected person, and fomites (e.g., clothing, towels, bedding); wearing a well-fitting mask or respirator by the person with monkeypox and the contact (for children over 2 years of age) when interaction is unavoidable; and minimizing the number of caregivers for children with monkeypox. Particular attention should be made to keep children with monkeypox from scratching lesions or touching their eyes to prevent auto-inoculation and more severe illness. Caregivers should cover areas of broken skin with bandages to the extent possible and avoid direct skin-to-skin contact with the rash.
- 3) Children and adolescents who are close contacts of a person with monkeypox (e.g., household contact, other family member, caregiver, or friend) should be evaluated for illness and offered [post-exposure prophylaxis](#) with JYNNEOS or ACAM2000 (for children older than 12 months) or [treatment](#) when indicated. Monkeypox should be considered when children or adolescents present with [signs or symptoms](#) that could be consistent with the disease, especially if [epidemiologic criteria](#) are present. The rash of monkeypox can be confused with other rash illnesses that are commonly considered in children including varicella (chickenpox); hand, foot, and mouth disease; measles; scabies; molluscum contagiosum; herpes; allergic skin rashes and syphilis (including congenital syphilis); and drug eruptions.
- 4) Prophylactic therapeutics that can be administered include vaccination, Vaccinia immune globulin, and antiviral medication. For almost all children and adolescents, vaccination is the preventive treatment that should be administered. Immune globulin or antivirals may also be considered for infants under 6 months of age, given their immature immune systems and possible decreased responses to vaccination. [Tecovirimat](#) is currently being used as the first-line treatment for infection with *Monkeypox virus*, including [for children and adolescents](#) with severe disease or underlying medical conditions that may increase risk for severe disease and those with complications from monkeypox.

### **Background:**

Limited [pediatric](#) data on infection with the Congo Basin clade of *Monkeypox virus* suggest increased risk of severe disease in children younger than 8 years of age. Rare complications of monkeypox include abscess, airway obstruction due to severe lymphadenopathy, cellulitis, corneal scarring, encephalitis, keratitis, pneumonia, and sepsis. The West African clade of *Monkeypox virus* involved in the current outbreak typically causes less severe disease than the Congo Basin clade.

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**References:**

Centers for Disease Control HAN Alert [0472 – 07/30/2022](#)

[Update for Clinicians on Monkeypox in People with HIV, Children and Adolescents, and People who are Pregnant or Breastfeeding](#)

Centers for Disease Control [Clinical Considerations for Monkeypox in Children and Adolescents | Monkeypox | Poxvirus | CDC](#)

**Recommendations and Information for Healthcare Providers on Monkeypox in People who are Pregnant or Breastfeeding**

- 1) *Monkeypox virus* can be transmitted to the fetus during pregnancy and to the newborn by close contact during and after birth. There are few case reports of spontaneous pregnancy loss and stillbirth, preterm delivery, and neonatal monkeypox infection; the frequency and circumstances for these outcomes are unknown. Whether *Monkeypox virus* is present in breast milk is unknown; however, it may be transmitted through close contact during breastfeeding.
- 2) [Prevention](#) measures for monkeypox infection are similar for pregnant and non-pregnant people. Pre- or post-exposure prophylaxis should be offered to people who are pregnant or breastfeeding. When pre- or post-exposure prophylaxis by [vaccination](#) is chosen, JYNNEOS, a live, non-replicating viral vaccine, can be used. ACAM2000, a replicating viral vaccine, should not be used in people who are pregnant or breastfeeding.
- 3) During pregnancy, the cause of fever may be difficult to differentiate from other infections, such as intraamniotic infection (chorioamnionitis), until the monkeypox rash appears. Pregnant patients with rashes initially considered characteristic of dermatoses of pregnancy (e.g., polymorphic eruption of pregnancy) or of more common infections (e.g., varicella zoster or sexually transmitted infections) should be carefully evaluated for a monkeypox [rash](#), and [submission](#) of specimens of lesions for monkeypox diagnosis should be considered, especially if the person has any [epidemiologic risk factors](#) for monkeypox infection.
- 4) While most adults with *Monkeypox virus* infection experience self-limiting infection and recover within 2–4 weeks, pregnant and breastfeeding people should be prioritized for medical treatment, if needed, due to the probable increased risk of severe disease during pregnancy, risk of transmission to the fetus during pregnancy or to the newborn by close contact during and after birth, and risk of severe infection in newborns. Treatment for *Monkeypox virus* infection should be offered to people who are pregnant or breastfeeding. The risks and benefits of [treatment options](#) should be discussed with the patient.
- 5) Recommendations for [infection prevention and control](#) of monkeypox in healthcare settings are the same for pregnant and non-pregnant patients. Newborns born to people with monkeypox should be placed in isolation, and healthcare personnel should follow infection prevention and control recommendations. Patients with monkeypox should be counseled about measures to prevent risk of transmission of *Monkeypox virus* to their newborn from [close contact and breastfeeding](#).

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**Background:**

Data regarding *Monkeypox virus* infection during pregnancy are limited. It is unknown if pregnant people are more susceptible to acquiring *Monkeypox virus* infection or if illness is more severe during pregnancy. Other poxviruses cause more severe infection during pregnancy. *Monkeypox virus* can be transmitted to the fetus during pregnancy and to the newborn by close contact during and after birth. There are few case reports of spontaneous pregnancy loss and stillbirth, preterm delivery, and neonatal monkeypox infection; the frequency and circumstances for these outcomes are unknown. Whether *Monkeypox virus* is present in breast milk is unknown; however, it may be transmitted through close contact during breastfeeding.

**References:**

Centers for Disease Control HAN Alert [0472 – 07/30/2022](#)

[Update for Clinicians on Monkeypox in People with HIV, Children and Adolescents, and People who are Pregnant or Breastfeeding](#)

Centers for Disease Control [Clinical Considerations for Monkeypox in People Who are Pregnant or Breastfeeding | Monkeypox | Poxvirus | CDC](#)

## Communicable Disease Update on Parechovirus

**Requested Actions:**

- 1) Be aware that PeVs circulate in the summer and fall. In the absence of an identified pathogen, consider PeV infection in a neonate or infant presenting with fever, sepsis-like syndrome, or signs of neurologic involvement.
- 2) Become familiar with [specimen collection, storage, and shipping procedures](#). Testing for PeV is available at commercial clinical laboratories and SPHLs, and hospitals may use multiplex meningitis and encephalitis panels for CSF testing that include PeV. Testing and typing for PeV are also available at CDC when other options are unavailable; clinicians should still work with their state public health department to send specimens to CDC. Please contact [PicornaLab@cdc.gov](mailto:PicornaLab@cdc.gov) before submitting specimens. Accepted specimens include CSF, throat or nasopharyngeal swabs, blood, and stool.
- 3) Consider cohorting an infant hospitalized with detected PeV infection with other affected infant(s) to avoid healthcare-associated transmission in nurseries or neonatal intensive care units.
- 4) Use [Contact, Droplet, and Standard Precautions](#). In most clinical situations, alcohol-based hand sanitizer (ABHS) is preferred for cleaning hands with an alcohol content of at least 60%. However, soap and water is the preferred method after patient care involving diapering or toileting, before eating or feeding, and if hands are visibly soiled (e.g., dirt, blood, body fluids). Although non-enveloped viruses may be less susceptible to alcohol than enveloped viruses, ABHS offers benefits in skin tolerance, compliance, and overall effectiveness, especially when combined with glove use. See [Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings –Recommendations of the HICPAC](#) for more information.



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**Background:**

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory to inform clinicians and public health departments that parechovirus (PeV) is currently circulating in the United States. Since May 2022, CDC has received reports from healthcare providers in multiple states of PeV infections in neonates and young infants. Parechoviruses are a group of viruses known to cause a spectrum of disease in humans. Clinicians are encouraged to include PeV in the differential diagnoses of infants presenting with fever, sepsis-like syndrome, or neurologic illness (seizures, meningitis) without another known cause and to test for PeV in children with signs and symptoms compatible with PeV infection (see below). Commercial laboratory assays, multiplex platforms for meningitis and encephalitis, and testing through state public health laboratories (SPHLs) are available to test cerebrospinal fluid (CSF) for PeV to confirm a diagnosis. [CDC laboratory support](#) is also available for testing and typing patient specimens.

**References:**

Centers for Disease Control HAN Alert [0469 – 07/12/2022](#)  
[Recent Reports of Human Parechovirus \(PeV\) in the United States—2022](#)

TO REPORT A NOTIFIABLE CONDITION IN THURSTON COUNTY	
Voice mail for reporting <b>non-immediately reportable conditions (24 hours a day)</b>	Phone: 360-786-5470 Fax: 360-867-2601
<b>Day time immediately reportable conditions</b> – Call detailed information to the 24-hour Notifiable Condition Reporting Line at 360-786-5470. Messages are picked up hourly. If a call back can't wait call 360-867-2500 and ask staff to locate a Communicable Disease staff.	Phone: 360-786-5470
<b>After hours immediately and 24-hour reportable conditions or a public health emergency</b>	Call 1-800-986-9050
No one is available with Thurston County Public Health and condition is <b>immediately notifiable</b>	1-877-539-4344

Communicable Disease Updates are posted online at: <http://bit.ly/CDUpdatePHSS>

**THANK YOU FOR REPORTING**