Washington DOH Health Alert: Monkeypox Recognition, Reporting, and Treatment Key Points:

On May 27, 2022, The Washington State Department of Health (DOH) reported the first case of confirmed orthopoxvirus presumed to be monkeypox in a Washington resident. As of July 21, 2022, we have identified 68 confirmed and probable cases in the state. (For the most up-to date case numbers, please visit the DOH Monkeypox Website: DOH Monkeypox page) •

Confirmed cases include Washington residents with no history of travel. Clinicians should suspect Monkeypox virus infection in any patient presenting with the characteristic monkeypox rash, regardless of the patient's travel or social history, gender, or sexual identity.

Background:

The identification of monkeypox cases in countries that do not have endemic disease and involving patients with no direct travel history to an area with endemic monkeypox, suggests person-to-person community spread. The case fatality rate of monkeypox associated with the West African clade of monkeypox virus is 1%, and possibly is higher in immunocompromised individuals. No deaths have been reported globally from the current outbreak. Any person, regardless of gender identity or sexual orientation, can acquire and spread monkeypox. In this outbreak, however, most of the reported cases in the United States are among gay, bisexual, or other men who have sex with men (MSM). The most significant risk factors associated with human-to-human transmission of Monkeypox virus, include close contact, including sexual or non-sexual sustained skin-to-skin contact with a person who has monkeypox, or contact with contaminated fomites (e.g., shared linens).

Clinical Guidance To enhance monkeypox surveillance, the Washington State Department of Health proposes the following case definitions (please note these definitions could change as more information becomes available

• Confirmed case: Demonstration of the presence of Monkeypox virus DNA by polymerase chain reaction testing or Next-Generation sequencing of a clinical specimen OR isolation of Monkeypox virus in culture from a clinical specimen.

- Probable case: No suspicion of other recent Orthopoxvirus exposure (e.g., Vaccinia virus in ACAM2000 vaccination) AND demonstration of the presence of.
    - Orthopoxvirus DNA by polymerase chain reaction of a clinical specimen OR
    - Orthopoxvirus using immunohistochemical or electron microscopy testing methods OR
    - Demonstration of detectable levels of anti-Orthopoxvirus IgM antibody during the period of 4 to 56 days after rash onset
- Suspect case: New characteristic rash* OR Meets one of the epidemiologic criteria and has a high clinical suspicion† for monkeypox
    - *Characteristic rash
        - The characteristic rash associated with 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.; this can sometimes be confused with other diseases that are more commonly encountered in clinical practice (e.g., secondary syphilis, herpes, and varicella zoster). Historically, sporadic

accounts of patients co-infected with Monkeypox virus and other infectious agents (e.g., varicella zoster, syphilis) have been reported, so patients with a characteristic rash should be considered for testing, even if other tests are positive.

- †Exclusion criteria
  - An alternative diagnosis can fully explain the illness OR
  - An individual with symptoms consistent with monkeypox does not develop a rash within 5 days of illness onset OR
  - A case where high-quality specimens do not demonstrate the presence of Orthopoxvirus or Monkeypox virus or antibodies to orthopoxvirus.

Monkeypox is a reportable condition in Washington State as a rare disease of public health significance.

- Healthcare providers must therefore rule out other diagnoses when evaluating patients with rash (such as herpes, syphilis, molluscum contagiosum, varicella zoster, etc.)
- Healthcare providers with cases highly suspected of monkeypox should contact their LHJ immediately. We ask that all LHJs work with providers in their jurisdiction in managing these cases.
- Please review the clinical findings (CDC Information for Providers) with the care team. If there is a high suspicion for monkeypox, please initiate testing and infection control.2
- At this time, no-cost testing can only be performed at the Washington State Public Health Laboratories (PHL). Some commercial labs also offer the testing at a fee.
- Testing at PHL and LabCorp consists of rtPCR to detect Orthopox virus, which, if detected, is assumed to be the Monkeypox virus in the context of the current outbreak. Specimens are then sent to CDC for confirmation. However, a positive Orthopoxvirus result is sufficient for diagnosis of monkeypox.
- Testing at the University of Washington Medical Center and Quest Diagnostics consists of rtPCR to detect the Monkeypox virus, a confirmatory test. Please consult with your local health jurisdiction for testing at PHL. See below for specimen collection, transportation, and submission guidance.

Infection Prevention and Control

- Patients presenting with suspected monkeypox should be placed as soon as possible in a single person exam room with the door shut if safe to do so. The patient should remain masked, as tolerated (as currently required for all persons in healthcare settings), and any exposed skin lesions should be covered with a sheet or gown.
- Healthcare personnel (HCP) evaluating patients with suspected monkeypox should wear the following personal protective equipment (PPE): gloves, gown, eye protection (goggles or face shield) and a National Institute for Occupational Safety and Health (NIOSH)-approved N95 or equivalent or higher-level respirator. HCP should don PPE before entering the patient's room and use it for all patient contact. HCP should remove and discard gloves, gown, and eye protection, and perform hand hygiene before leaving the patient's room. The N95 respirator should be removed, discarded, and replaced with a mask for source control after leaving the patient's room and closing the door.

- Any EPA-registered hospital-grade disinfectant should be used for cleaning and disinfecting environmental surfaces.
- Additional infection prevention and control recommendations for monkeypox in health care settings are available from the CDC.

Treatment Considerations

- Many individuals infected with the monkeypox virus have a mild, self-limiting disease course without specific therapy. However, antiviral treatment is available for patients at high risk of severe disease, and those aberrant infections involving accidental implantation in eyes, mouth, or other anatomic areas where Monkeypox virus infection might constitute a special hazard (e.g., the genitals or anus).
- Available Therapeutics:
    - Tecovirimat (also known as TPOXX, ST-246)
        - TPOXX is an antiviral medication that is approved by the United States Food and Drug Administration (FDA) [PDF – 24 pages] for the treatment of smallpox in adults and children.3
        - Data are not available on the effectiveness of tecovirimat in treating monkeypox infections in people, but studies using a variety of animal species have shown that tecovirimat is effective in treating disease caused by Orthopoxvirus.
        - Because tecovirimat use for monkeypox is under an EA-IND, certain documentation and return of information related to tecovirimat treatment are required to be completed by providers.
        - DOH is encouraging providers to proactively reach out to their local health jurisdiction to obtain EA-IND documentation if they anticipate that they will be providing this therapy.

      More information about Tecovirimat is available on CDC's website: https://www.cdc.gov/poxvirus/monkeypox/clinicians/treatment.html

Post Exposure Prophylaxis (PEP)

- CDC recommends that the vaccine be given within 4 days from the date of exposure to prevent onset of the disease.
- If given between 4–14 days after the date of exposure, vaccination may reduce the symptoms of disease, but may not prevent the disease.

Specimen Collection and Submission

- The U.S. government does not consider the West African clade of monkeypox virus meets the definition of Category A infectious substance under the Hazardous Materials Regulations (HMR).
- Therefore, specimens and material suspected or confirmed to contain the West African clade of monkeypox virus can be shipped as UN 3373 Biological Substance, Category B.
- Specimen collection instructions: o Acceptable specimens are swabs as well as scabs or serum. Also test for other causes of rashes such as syphilis, herpes, or chickenpox. Dual infections can occur (e.g., herpes and monkeypox).

    - Swabs from a discrete lesion, including a discrete oral or anal lesion; otherwise testing is not available for non-lesion swabbing of the oropharynx, nasopharynx, or rectum
    - Swabbed scabs or whole scabs if no fresh lesions are present
    - Serum (acute and convalescent) only if all lesions have resolved
- Specimen submission through the Washington State Public Health Laboratories (PHL):
    - Consult with your local health jurisdiction to get approval for testing at PHL.
    - Specimen Shipping Conditions for Orthopox testing at PHL
    - 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
- Specimen submission through commercial laboratories:
    - Notify your local health jurisdiction of all suspect monkeypox cases – please provide name, address, and demographic information, including race/ethnicity of the patient.
    - Review specimen submission guidance specific to the commercial laboratory for testing. Suspect and confirmed monkeypox cases are immediately notifiable.

Contact Thurston County Public Health and Social Services immediately if you suspect monkeypox:
Daytime Phone: (360) 867-2500 After Hours Phone: 1-800-986-9050