Chief Medical Officer

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The Scottish Government
Riaghaltas na h-Alba

Dear Colleague

MONKEYPOX (MPX) CASES IN THE UK – INVESTIGATION AND ASSESSMENT OF INDIVIDUALS SUSPECTED TO HAVE MPX AND MANAGEMENT OF CONFIRMED CASES OF MPX

The aim of this letter is to support clinicians in primary and secondary care in the investigation and management of individuals suspected or confirmed to have MPX in the context of an evolving situation.

The information provided is correct as of 0800 on 20th May 2022. Further information will be available here, as the investigation develops.

To date there have been no confirmed cases of MPX in Scotland. However, this is a rapidly evolving situation with evidence of community transmission in England. NHS Boards therefore need to be prepared to identify, assess and manage any individuals with suspected monkeypox that may present to health services in their area.

On 18th May the UK Health Security Agency (UKHSA) reported 9 confirmed cases of Monkeypox in England (Monkeypox cases confirmed in England - latest updates). Unusually, most cases have not had links to foreign travel. Recent cases reported by UKHSA have been in individuals who identify as gay, bisexual or other men who have sex with men (GBMSM). This is consistent with international reports in recent days.

Monkeypox is a zoonotic viral infection caused by a double-stranded DNA virus belong to the Poxviridae family. Its main host is in wild mammals, including rodents and primates. There are two distinct viral clades; one found in the Congo basin of Central Africa, and the other in West Africa. The West African clade is considered less severe and appears to be the clade presenting in the cases in England.

Typically, monkeypox has an incubation period of 7 – 14 days, but it can be up to 21 days. The prodromal phase is characterised by symptoms such as fever, malaise, or

From the Chief Medical Officer
Professor Sir Gregor Smith

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Addresses

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headache. Following this, the rash of monkeypox appears, usually beginning on the face and then spreading more widely, including the palms and soles. Patients typically have marked lymphadenopathy. The lesions go through 4 stages; macules evolving to papules, vesicles and then pustules. They heal by crusting over and scabbing. Unlike chickenpox, the lesions are usually all at the same phase of development. The skin lesions resolve within 2-4 weeks.

The current cases in England have some atypical features. In some patients, there has been no documented prodrome and in several patients the rash started in the genital area before becoming more widespread. It is unclear whether these features will be seen more generally as further cases emerge.

Human-to-human transmission occurs through close physical contact by two main routes.

- Cutaneous lesions contain large amounts of virus that can infect others through breaks in the skin or mucosal membranes. Although monkeypox has not previously been described as a sexually transmitted infection, it can be passed on by direct contact during sex. In addition, infection can be acquired from virus within shed skin lesions that accumulate in clothes or bed linen.
- The virus is also found in the upper respiratory tract and can be transmitted by respiratory droplets during direct and prolonged face-to-face contact.

It can also be transmitted from mother to child, and from contact with an infected animal or through eating the meat of infected animals.

The symptoms of monkeypox are usually mild, particularly for infections with the West African clade, but they can progress to multi-organ involvement, with bronchopneumonia, encephalitis, and sepsis. The West African clade, the only clade detected so far in the cases reported in Europe, has been observed to have a case fatality rate of 3.6% in studies conducted in African countries. Mortality is higher among children, and immunocompromised individuals are especially at risk of severe disease. Most people recover within weeks. Although the course of the disease in the adult patients within England has been relatively mild, more data will need to be collected to provide an accurate estimate of disease severity within the UK.

Further information is available at Monkeypox cases confirmed in England – latest updates.

Case definition

As of the 19th May 2022 the case definition includes:

Possible case: A person with a febrile prodrome† compatible with monkeypox infection where there is known prior contact with a confirmed case in the 21 days before symptom onset

OR

A person with an illness where the clinician has a high suspicion of monkeypox (for example, this may include prodrome or atypical presentations with exposure histories deemed high risk by the clinician, or classical rash without risk factors)

Probable case: A person with a monkeypox compatible vesicular-pustular rash plus at least one of the following epidemiological criteria:

- Exposure to a confirmed or probable case in the 21 days before symptom onset
- History of travel to an area where monkeypox is endemic, or where there is a current outbreak in the 21 days before symptom onset (currently West and Central Africa, Spain, Portugal and USA)
- Gay, Bisexual and Men who have Sex with Men (GBMSM)

Confirmed case: A person with a laboratory confirmed monkeypox infection (monkeypox PCR positive)

† Febrile prodrome consists of fever ≥ 38°C, chills, headache, exhaustion, muscle aches (myalgia), joint pain (arthralgia), backache, & swollen lymph nodes (lymphadenopathy)

Assessment and Testing Arrangements

Anyone with suspected monkeypox requiring face to face clinical review should consider using their own private transport providing this will not result in exposure for previously unexposed individuals. Should a patient not have their own transport, or be too unwell to drive themselves, SAS should be informed of queried HCID as per usual HCID protocols. In an emergency situation, the 999 call handler should be informed that monkeypox is suspected.

Clinical diagnosis of monkeypox can be difficult, and it may be confused with other infections such as herpes simplex virus, chickenpox or syphillis. A definite diagnosis of monkeypox requires assessment by a health professional and specific testing in a specialist laboratory. It is important that a travel and sexual history is obtained in individuals who are suspected to have monkeypox.

In the UK, the Rare and Imported Pathogens Laboratory (RIPL) at the UK Health Security Agency (UKHSA) Porton Down is currently the designated diagnostic laboratory.

Clinicians should discuss individuals in whom monkeypox is suspected with their local Infectious Disease clinicians. The local ID clinician can discuss further ith the Imported Fever Service (IFS) (24 hours telephone service: 0844 778 8990) who can also advise on whether laboratory testing is indicated and what samples should be obtained.

Preferred sample in swab of vesicular lesions in viral transport medium.

Separate guidance on specimen handling and shipment requirements is being sent to laboratory networks.

Plans to introduce testing capacity in Scotland are being progressed, subject to appropriate validation requirements.

Infection Prevention and Control (IPC) – Management of a possible, probable or confirmed case

Possible, probable or confirmed patient cases who require to be seen by healthcare staff within a healthcare facility should be placed in a negative pressure room (or a single neutral

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pressure room where negative pressure room is unavailable) as per locally agreed HCID pathway wearing Level 3 enhanced HCID PPE outlined within Appendix 16 of the National Infection Prevention and Control Manual (NIPCM). **Levels of PPE for Healthcare workers when providing patient care**

**** Please note:** it is not necessary to wear surgical wellington boots, disposable boots covers or disposable fluid resistant hoods which are aligned with a HCID such a viral haemorrhagic fever (VHF) and high splash risk. Standard length aprons may be used on top of gown or coverall rather than full length aprons and standard gloves may be worn (2 pairs) rather than extended length gloves.

Decontamination of the room and any equipment within the room following discharge of the patient should be undertaken whilst wearing the PPE outlined above using:

- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); OR
- a general purpose neutral detergent in a solution of warm water followed by disinfection solution of 1,000ppm av.cl.1,000ppm available chlorine
  and as per standard terminal cleaning of an isolation room.

Vaccination

The smallpox vaccine (Imvanex) is the recommended vaccine for post-exposure prophylaxis against monkeypox in the UK. UKHSA guidance advises that if vaccination is to be used for post-exposure prophylaxis, the vaccine is most effective if given within four days of exposure to prevent onset of disease but can be given up to 14 days post-exposure to reduce severity of disease, if required.

There is a central UK stockpile of Imvanex®. Imvanex will only be supplied in response to authorisation by the National Incident Management Team; access is currently being prioritised to support the management of active cases.

Health risk state

Under the provisions of the Public Health etc. (Scotland) Act 2008 (“2008 Act”) (part 2 section 14), monkeypox should be regarded as a health risk state and reported as per the notification requirements of section 14 of the 2008 Act. Public Health etc. (Scotland) Act 2008 (legislation.gov.uk)

Therapeutics

Tecovirimat® is a medicine licensed within the US and European Union for the treatment of monkeypox. It has not yet been authorised by the Medicines and Healthcare products Regulatory Agency (MHRA). Acquisition of this drug by the UK is under active consideration.

Actions

Health boards must ensure that all front-line health care professionals, including primary care contractors, are aware of the updated case definition, have access to relevant national guidance and have a clear understanding of the management and investigation procedures for suspected cases of Monkeypox, including local pathways for assessment / testing.

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Actions on a possible or probable case:

- Test for monkeypox (using designated testing pathway)
- Undertake additional contemporaneous tests to rule out alternative diagnoses if clinically appropriate and if not done already
- **If admission of patient required for clinical reasons:** Manage patient in line with IPC measures outlined above)
    - OR
- **If patient not requiring admission for clinical reasons:** self-isolation at home pending test result (based on assessment by the clinician and following appropriate advice
    - OR
- **If patient not requiring admission for clinical reasons BUT self-isolation at home is not possible for social or medical reasons following clinician assessment:** Manage patient in line with IPC measures outlined above pending test result (prioritise probable cases)

Action on confirmed cases: Transfer to a designated centre for the care of high consequence infectious diseases (HCID unit) as per existing HCID protocols

Health boards should be preparing for identification and follow up of contacts, including arrangements for post exposure vaccination, if required.

Health Boards should ensure that all registered medical practitioners within their area are aware of the notification requirements for Monkeypox under part 2 section 14 - Health risk states: duties on registered medical practitioners of the 2008 Act. 7. Public Health etc. (Scotland) Act 2008 (legislation.gov.uk)

Yours sincerely

Gregor Smith

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Chief Medical Officer

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