



Health Alert Network Message 22-23: Update on Monkeypox Outbreak in the U.S.

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Update on Monkeypox Outbreak in U.S.

The Louisiana Department of Health (LDH) is issuing this health update in order to provide healthcare providers in Louisiana with the most recent information regarding clinical presentations of U.S. monkeypox cases to date.

Summary

Since May 2022, monkeypox cases, which have historically been rare in the United States, have been identified in 18 states and territories among both persons returning from international travel and their close contacts domestically. Globally, more than 1,600 cases have been reported from more than 30 countries; the case count continues to rise daily. In the United States, evidence of person-to-person disease transmission in multiple states and reports of clinical cases with some uncharacteristic features have raised concern that some cases are not being recognized and tested.

Background

The current identification of West African monkeypox cases in many 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 first case of monkeypox in the United States was diagnosed in a traveler who returned to Massachusetts from Canada on May 17, 2022. Since then, 65 cases have been identified in 18 states and territories and more than 1,600 have been identified in 35 countries and territories that do not have endemic disease. As of June 15, no cases have been identified in Louisiana.

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, irrespective of gender identity or sexual orientation, can acquire and spread monkeypox. In this outbreak, however, many of the reported cases in the United States are among gay, bisexual, or other men who have sex with men (MSM). Close contact, sustained skin-to-skin contact including sexual contact, with a person with monkeypox or contact with contaminated fomites (e.g., shared linens) are the most significant risk factors associated with human-to-human transmission of *Monkeypox virus*.

Clinical presentations of confirmed cases to date

Descriptions of classic monkeypox disease have traditionally described a prodrome including fever, lymphadenopathy, headache, and muscle aches followed by development of a characteristic rash culminating in firm, deep-seated, well-circumscribed and sometimes umbilicated lesions. The rash traditionally has started on the face or in the oral cavity and progresses through several synchronized stages on each affected area and concentrates on the face and extremities, including lesions on the palms and soles.

Thus far in the U.S. outbreak, all patients diagnosed with monkeypox in the United States have experienced a rash or enanthem. Although the characteristic firm, deep-seated, well-circumscribed and sometimes umbilicated rash has been observed, the rash has often begun in mucosal areas (e.g., genital, perianal, oral mucosa) and in some patients, the lesions have been scattered or localized to a specific body site rather than diffuse and have not involved the face or extremities. In some instances, patients have presented with symptoms such as anorectal pain, tenesmus, and rectal bleeding which upon physical examination, have been found to be associated with visible perianal vesicular, pustular, or ulcerative skin lesions and proctitis. The lesions have sometimes been in different stages of progression on a specific anatomic site (e.g., vesicles and pustules existing side-by-side). In addition, prodromal symptoms including fever, malaise, headache, and lymphadenopathy have not always occurred before the rash if they have occurred at all.

The clinical presentation of monkeypox may be similar to some STIs, such as syphilis, herpes, lymphogranuloma venereum (LGV), or other etiologies of proctitis. Clinicians should perform a thorough skin and mucosal (e.g., anal, vaginal, oral) examination for the characteristic vesiculo-pustular rash of monkeypox; this allows for detection of lesions the patient may not have been previously aware of. The search for lesions consistent with monkeypox should be performed even if lesions consistent with those from more common infections (e.g., varicella zoster, syphilis, herpes) are observed; this is particularly important when evaluating patients who have epidemiologic risk factors for monkeypox. Specimens should be obtained from lesions (including those inside the mouth, anus, or vagina) and tested for monkeypox.

Any patient who is suspected to be infected with monkeypox should be counseled to implement appropriate transmission precautions. Probable and confirmed case-patients should remain in isolation for the duration of their infectious period (i.e., until all lesions have resolved, the scabs have fallen off, and a fresh layer of intact skin has formed). Patients who do not require hospitalization but remain potentially infectious to others should isolate at home. This includes abstaining from contact with other persons and pets, and wearing appropriate personal protective equipment (e.g., clothing to cover lesions, face mask) to prevent further spread.

Images of monkeypox



Generalized monkeypox lesions are characteristically deep-seated, well-circumscribed, and often develop umbilication (A, B, C), Image A demonstrates both papulovesicular and pustular lesions in the same region of the body. Credits: Images A and B from NHS England High Consequence Infectious Diseases Network; image C from Reed KD, Melski JW, Graham MB et al. The detection of monkeypox in humans in the Western Hemisphere. Page 346. Copyright © Massachusetts Medical Society. Reprinted with permission. Please see lesion examples from Nigeria and Italy.

Recommendations for Clinicians

- **Louisiana healthcare providers should report all suspected cases of monkeypox to the Louisiana Department of Health’s (LDH) Infectious Disease Epidemiology (IDePi) 24/7 clinician hotline: 800-256-2748.**
- IDePi must approve all specimens prior to submission to the Louisiana State Public Health Laboratory (SPHL). Epidemiologists will provide detailed guidance regarding specimen submission upon approval. Two lesion swabs should be collected, one for testing at the Louisiana SPHL, the other will be forwarded to CDC for Monkeypox virus-specific testing. Specimens should be collected as follows:
 - Swab or brush the same lesion vigorously with two separate sterile dry swabs. Use a sterile nylon, polyester, or Dacron swab with a plastic, wood, or thin aluminum shaft. Do not use other types of swabs.
 - Place each swab in an individual sterile container. **DO NOT ADD ANY VIRAL OR UNIVERSAL TRANSPORT MEDIA, AND DO NOT PLACE SWABS IN THE SAME CONTAINER.**
 - Freeze (-20°C or lower) specimens within an hour after collection.
 - Clinicians should use appropriate infection prevention measures when collecting specimens for monkeypox evaluation. Information on infection prevention and control in healthcare settings is provided on the [CDC website](#).
- Patients with rashes initially considered characteristic of more common infections (e.g., varicella zoster or sexually transmitted infections) should be carefully evaluated for a characteristic monkeypox rash (see images and links), and submission of specimens of lesions should be considered, especially if the person has epidemiologic risk factors for monkeypox infection.
- Evaluate any individual presenting with perianal or genital ulcers, diffuse rash, or proctitis syndrome for STIs per the [2021 CDC STI Treatment Guidelines](#). Testing for STIs should be performed. The diagnosis of an STI does not exclude monkeypox as a concurrent infection may be present. The clinical presentation of monkeypox may be similar to some STIs, such as syphilis, herpes, lymphogranuloma venereum (LGV), or other etiologies of proctitis.
- Clinicians should perform a thorough skin and mucosal (e.g., anal, vaginal, oral) examination for the characteristic vesiculo-pustular rash of monkeypox; this allows for detection of lesions the patient may not have been previously aware of.
- Advise patients with prodromal symptoms (e.g., fever, malaise, headache) and one or more [epidemiologic risk factors](#) for monkeypox to self-quarantine. If a rash does not appear within 5 days, the illness is unlikely to be monkeypox and alternative etiologies should be sought.

For More Information

- [Information for Healthcare Professionals](#)
- [Clinical Recognition of Monkeypox](#)
- [Monitoring Persons Who Have Been Exposed](#)
- [U.S. Monkeypox 2022: Situation Summary](#)
- [Monkeypox facts for people who are sexually active](#)