

Monkeypox

Signs and Symptoms	<ul style="list-style-type: none"> • Prodrome: does not always occur; if present, may be fever, chills, headache, muscle aches, backache, swollen lymph nodes, and exhaustion, cough or a sore throat. • Rash: follows 1 to 3+ days after prodromal symptoms, often starting on the face and then spreading to extremities. Isolated genital lesions (which can ulcerate) or rectal inflammation may also occur. Lesions progress over about 2 weeks: macule, papule, vesicle, pustule, scab 		
Incubation	Usually 7–14 days, range 5–21 days		
Case classification	<p>Clinical criteria: new rash, fever, other consistent symptoms</p> <p>Epi criteria: contact of a case or person with rash; man having regular in-person intimate close contact with men; travel to risk region; contact with exotic animal</p>		
	<table border="1"> <tr> <td>Confirmed: positive PCR OR Next-Generation sequencing OR positive culture for monkeypoxvirus</td> <td>Probable: No other <i>Orthopox</i> risk AND positive lab test for orthopoxvirus (PCR, EM, or IgM)</td> <td>Suspect: New characteristic rash OR meets epi criterion and high clinical suspicion for monkeypox</td> </tr> </table>	Confirmed: positive PCR OR Next-Generation sequencing OR positive culture for monkeypoxvirus	Probable: No other <i>Orthopox</i> risk AND positive lab test for orthopoxvirus (PCR, EM, or IgM)
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Differential diagnosis	Smallpox, chickenpox, shingles, measles, coxsackievirus, molluscum contagiosum, drug allergy, insect bites, scabies, rubella, syphilis, mononucleosis, impetigo, scarlet fever; for genital lesions: syphilis, herpes, chancroid; monkeypox can occur with another infection		
Treatment	Consider antiviral agents (investigational); post-exposure vaccine may prevent infection		
Duration	2-4 weeks or longer; contagious until scabs shed and healthy skin appears		
Exposure	Person-to-person; rarely contact with exotic animal		
Laboratory testing	<p>Local health jurisdiction (LHJ) and Communicable Disease Epidemiology (CDE) arrange testing for individual cases with CDC consult. CDC does confirmation or serology.</p> <ul style="list-style-type: none"> • Washington State Public Health Laboratories performs initial testing of swabs • Best specimens: <u>2 to 4 lesions swabbed</u> with synthetic swabs, place singly into dry screw-top vial; label each with: Name, date of birth, collection date, body site <p><i>Specimen shipping (Section 4):</i></p> <ul style="list-style-type: none"> • Refrigerate within an hour. Keep all specimens cold if shipping within 24 hours, otherwise freeze and ship frozen (except for serum). Include a BT form for each specimen: https://doh.wa.gov/sites/default/files/legacy/Documents/5230//302-018-BioterrorismSpecimen.pdf?uid=62942c8563327 Ship Category B. • Specimen Collection and Submission Instructions: https://doh.wa.gov/sites/default/files/2022-06/420%20416%20Monkeypox%20Specimen%20Testing.pdf?uid=6297e8f61c21e 		
Public health actions URGENT	<p>Immediately report suspected or confirmed cases to CDEpi (206-418-5500).</p> <ul style="list-style-type: none"> • Isolate potential case, obtain full clinical information, other test results, and if available digital photographs, and consult with CDEpi for testing • Identify close contacts; if case tests positive, interview contacts and conduct symptom monitoring for 21 days <p><i>Infection Control (home and healthcare settings):</i></p> <p>https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-home.html https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html</p>		

Monkeypox

1. DISEASE REPORTING

A. Purpose of Reporting and Surveillance

1. To understand the epidemiology of monkeypox in Washington State residents and to inform public health and healthcare organizations about conditions that have been diagnosed in residents.
2. To assist in the diagnosis and treatment of cases.
3. If applicable, to identify potentially exposed close contacts, healthcare workers, and laboratory personnel and to provide counseling.
4. To identify sources of transmission and to prevent further transmission.
5. To raise the index of suspicion of a possible bioterrorism event if no natural exposure source is identified.

B. Legal Reporting Requirements

1. Health care providers: **immediately notifiable to local health jurisdiction**
2. Health care facilities: **immediately notifiable to local health jurisdiction**
3. Laboratories: **immediately notifiable to local health jurisdiction**
4. Local health jurisdictions: **immediately notifiable to the Washington State Department of Health (DOH) Office of Communicable Disease Epidemiology (CDE) at 206-418-5500 or 877-539-4344.**

C. Local Health Jurisdiction Investigation Responsibilities

1. Begin follow up investigation immediately.
2. Report any case to CDE through the Washington Disease Reporting System (WDRS) as a Rare Disease of Public Health Significance, including entering the 'Rare disease of public health significance' in the Clinical and Laboratory tab.

2. THE DISEASE AND ITS EPIDEMIOLOGY

A. Etiologic Agent

Monkeypox virus, a DNA virus in the genus *Orthopox*. There are two clades: central African and west African. The west African clade causes milder illness. There can be various strains within a clade. Related viruses are variola virus (cause of smallpox), vaccinia virus (smallpox vaccine), and cowpox virus.

B. Description of Illness

The illness usually but not always begins with a prodrome including fever, chills, headache, muscle aches, backache, swollen lymph nodes, and exhaustion. There can be cough or a sore throat. Lymphadenopathy can occur, involving the neck, armpits, or groin, and be on one or both sides of the body. Either genital lesions (which can ulcerate) or rectal inflammation without external rash may occur without a febrile prodrome.

From 1 to 3 or more days after the prodrome (if present), a deep-seated well-circumscribed firm discrete rash develops. Lesions often but not always start on the face and then spread to other body areas, particularly the extremities. Lesions can be asynchronous, scattered or diffuse, limited to one body part (e.g., face, anogenital), or occur under a nail. For details see:

<https://www.cdc.gov/poxvirus/monkeypox/clinicians/clinical-recognition.html>

Rash lesions progress through stages, with lesions at a similar stage in one body area:

- Macule: spot with change in skin coloring
- Papule: raised (palpable) solid lesion
- Vesicle: circumscribed elevated lesion filled with clear fluid
- Pustule: circumscribed elevated lesion filled with opaque pus
- Scab: dry, dark

Vesicular or pustular lesions may ulcerate or umbilicate in the center and the surrounding skin may redden. Secondary bacterial infection can cause abscesses. Lesions are often painful, while scabs are itchy. Scabs may leave pitted scars or altered pigment.

The total duration of symptoms is 2–4 weeks. Case fatality rates during outbreaks in Africa have reached 10%, with higher risk for children.

Clinicians should consider other conditions causing rashes including: chickenpox, shingles, measles, coxsackievirus (hand foot mouth disease), scabies, drug allergy, insect bites, rubella, syphilis, molluscum contagiosum, mononucleosis, impetigo, scarlet fever, erythema toxicum, smallpox; for genital lesions: syphilis, herpes simplex virus infection, chancroid, varicella zoster. Note that multiple concurrent infections can occur (e.g., herpes and monkeypox).

For clinician FAQ see: <https://www.cdc.gov/poxvirus/monkeypox/clinicians/faq.html>

C. Monkeypox in Washington State

Prior to 2022 no cases had been detected. In May 2022 at least one case in Washington was identified during an international outbreak involving the west African strain. During the first month of the outbreak, cases were identified in Europe, North America (US data: [U.S. Monkeypox 2022: Situation Summary | Monkeypox | Poxvirus | CDC](#)), South America, the Middle East, and Australia. For a global update see:

https://www.who.int/health-topics/monkeypox#tab=tab_1

D. Reservoirs

Although first recognized in a research monkey colony, the reservoir for the virus in Central and West African countries is unknown. Several species of primates and rodents are known to be susceptible to infection with monkeypox virus. Person-to-person transmission occurs.

E. Modes of Transmission

Monkeypox is acquired by close contact with an infected animal or with an infected person. The virus is present in the rash, scabs and scab fragments, and, if there are oral lesions, in saliva. Contact with clothing or bedding contaminated with lesion fluid or

scabs can result in transmission. Virus occurs in the mouth and throat but droplet transmission alone is rarely implicated, so prolonged face-to-face contact is likely necessary for spread. Transmission during an air flight has not been documented. Transmission in a healthcare setting may have occurred through contaminated bedding: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7101111/pdf/19-1164.pdf>

Also see: <https://www.cdc.gov/poxvirus/monkeypox/transmission.html>

F. Incubation Period

The incubation period (time from infection to symptoms) for monkeypox is usually 7–14 days but can range from 5–21 days.

G. Period of Communicability

Communicable from onset of the first symptom until the last scab separates with healthy skin below. Scabs can retain infectious virus. Shed scabs and fabrics contaminated with scabs should be handled in a safe manner.

H. Treatment

Vaccination may be appropriate for post-exposure prophylaxis of close contacts (also see Section 7 for pre-exposure vaccination). Antiviral agents approved for treatment of smallpox can be considered to prevent severe disease or complications, particularly for persons at increased risk for severe disease. There may be an applicable Expanded Access Investigational New Drug Protocol. See:

<https://www.cdc.gov/poxvirus/monkeypox/treatment.html>

<https://www.cdc.gov/poxvirus/monkeypox/clinicians/treatment.html>

<https://www.cdc.gov/poxvirus/monkeypox/treatment.html>

Report vaccine adverse events to VAERS <https://vaers.hhs.gov/>

3. CASE DEFINITIONS

The situation is currently still evolving and case definitions may change in the future.

A. Case Definition (June 1, 2022)

Note that a person's categorization may change as the investigation continues (e.g., a person may go from Suspect to Probable).

Suspect case:

- New characteristic rash* OR
- Meets one of the epidemiologic criteria and has a high clinical suspicion for monkeypox; clinical suspicion may exist if presentation is consistent with illnesses confused with monkeypox (e.g., secondary syphilis, herpes, and varicella zoster)

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

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

B. Epidemiologic Criteria for Diagnosis

Within 21 days of illness onset:

- Reports having had contact with a person who had a similar-appearing rash or who received a diagnosis of confirmed or probable monkeypox OR
- Had close or intimate in-person contact with individuals in a social network experiencing monkeypox activity; this includes men who have sex with men (MSM) who meet partners through an online website, digital application (“app”), or social event (e.g., a bar or party) OR
- Traveled outside the US to a country with confirmed cases of monkeypox or where Monkeypox virus is endemic OR
- Had contact with a dead or live wild animal or exotic pet that is an African endemic species or used a product derived from such animals (e.g., game meat, creams, lotions, powders, etc.)

C. Exclusion Criteria

A case may be excluded as a suspect, probable, or confirmed monkeypox case if:

- An alternative diagnosis* can fully explain the illness OR
- An individual has symptoms consistent with monkeypox but 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*

* 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 another infectious agent (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.

See: <https://www.cdc.gov/poxvirus/monkeypox/clinicians/case-definition.html>

4. DIAGNOSIS AND LABORATORY SERVICES

A. Diagnosis

Testing for monkeypoxvirus is done at Washington State Public Health Laboratories (WAPHL). The decision is based on a good clinical history, a classic rash (typically on face/hands/legs), a clear exposure, and if possible negative results from clinical laboratories for other agents. Having a de-identified digital photograph of the rash to share is helpful. Preliminary testing is done at WAPHL, and specimens positive for *Orthopox* virus forwarded to CDC for confirmation.

B. Services Available at the Washington State Public Health Laboratories (WAPHL)

WAPHL can confirm *Orthopox* and rule out smallpox. Additional testing such as monkeypox confirmation, serology, microscopy, and culture is done at CDC.

Note that WAPHL require all clinical specimens have two patient identifiers, a name **and** a second identifier (e.g., date of birth) both on the specimen label and on the submission form. Due to laboratory accreditation standards, specimens will be rejected for testing if not properly identified.

For CDC information see:

<https://www.cdc.gov/poxvirus/monkeypox/clinicians/prep-collection-specimens.html>
and <https://www.cdc.gov/smallpox/lab-personnel/specimen-collection/specimen-collection-procedures.html>

C. Specimen Collection

Use appropriate person protective equipment when collecting specimens and obtain correct specimens. Obtain at least two swabs or scab specimens from separate lesions, preferably up to four. Refrigerate or freeze specimens within one hour of collection. Specimen arriving within 24 hours of collection can be shipped cold. Otherwise freeze all specimens (except serum). Ship serum cold and all other specimens frozen.

Ship Category B. For details of specimen collection including storage and shipping temperatures see: [Specimen collection guidance](#)

Label each specimen with two identifiers (e.g., name and date of birth), collection date, and the body site of the lesion (e.g., “palmer left hand second digit”). Each specimen should be packaged with its form in a separate bag. Multiple specimen bags can be combined in a secondary bag or container. For each specimen please enclose a completed WAPHL bioterrorism form available at:

<https://doh.wa.gov/sites/default/files/legacy/Documents/5230//302-018-BioterrorismSpecimen.pdf?uid=62942c8563327>

5. ROUTINE CASE INVESTIGATION

Routine case investigation: notify CDE immediately for suspected or confirmed case. Interview the case and others who may be able to provide pertinent information and review available medical records including digital photographs of a rash.

A. Evaluate the Diagnosis

Obtain detailed information regarding:

- Symptoms preceding the rash including the first symptom and the date it occurred. Did the person have a fever? (Date fever started? Highest temperature?) Did the person have: headache, muscle aches, backache, swollen lymph nodes, exhaustion, cough?
- Description of the rash? (Deep-seated and well-circumscribed? What stage/stages? Progression from macular and papular to vesicular and pustular? Lesions on a body part occur at the same stage? Painful or itchy?)
- Body part where the first lesion occurred
- Body parts now affected and which parts have the most lesions
- Underlying medical conditions, particularly any immunosuppression
- Any history of smallpox vaccination? If so, date and type?
- Contact Office of Communicable Disease Epidemiology (206-418-5500) for approval prior to submitting specimens. Provide a full clinical history (onset, symptoms, rash description, travel and other potential exposures), results of other tests for rash illnesses (e.g., syphilis, herpes), and if possible also submit de-identified digital photographs of the lesions.

Advise the provider to consider and test for alternative diagnosis such as syphilis, herpes, or chickenpox. While testing and evaluation are being conducted, the person should be in home isolation (see Section D below).

Advise use of appropriate personal protective equipment when evaluating the patient and obtaining specimens for monkeypox **and** for other potential causes (see: <https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html>). Note that dual infections can occur (e.g., herpes and monkeypox).

The person should be in home isolation until testing is done. If orthopoxvirus testing at WAPHL is positive, the person should continue home isolation through the end of their contagious period. If orthopoxvirus testing is negative, an alternative diagnosis should be pursued, and continued home isolation determined based on clinical suspicion or alternate diagnosis (e.g., varicella).

Since the end of isolation for monkeypox is based on clinical evaluation rather than a specific time period, persons with monkeypox should be evaluated prior to discontinuing isolation. Depending on local circumstances, persons with monkeypox could be evaluated in their homes by public health clinicians, at a public health clinic site, or by an infectious disease clinic provider at a local healthcare facility.

B. Identify Potential Sources of Infection

Ask about exposures 5-21 days before onset:

1. Travel particularly outside the United States including to a country with confirmed cases or with endemic monkeypox
 - a. Determine dates and locations of travel including: country, city, and any large gatherings or special events attended
 - b. Obtain air travel information: date, time, flight number, city of departure, city of arrival, seat number, if known names of those in adjacent seats
2. Man who regularly has close or intimate in-person contact with other men,

including men who meet partners through an online website, a digital application (“app”), or at a social event (e.g., a bar or party)

3. Contact with a known monkeypox case or with a person having a similar rash
4. Recently received or in contact with a person who received smallpox vaccination

C. Identify Potentially Exposed Persons

Have the person under investigation identify close contacts (including household members, sexual partners and contacts during travel or healthcare visits). If the person tests positive for non-smallpox *Orthopox* virus, conduct interviews with close contacts. Assess their degree of exposure and also their health status for risk of severe disease to determine whether prompt post-exposure prophylaxis (PEP) with vaccination is appropriate (see Section D below)

(<https://www.cdc.gov/poxvirus/monkeypox/clinicians/monitoring.html>):

1. High degree of exposure – monitor for 21 days, recommend PEP:
 - Unprotected contact between a person’s skin or mucous membranes and the skin, lesions, or bodily fluids from a patient (e.g., any sexual contact, inadvertent splashes of patient saliva to the eyes or oral cavity of a person, ungloved contact with patient), or contaminated materials (e.g., linens, clothing) OR
 - Being inside the patient’s room or within 6 feet of a patient during any procedures that may create aerosols from oral secretions, skin lesions, or resuspension of dried exudates (e.g., shaking of soiled linens), without wearing an N95 or equivalent respirator (or higher) and eye protection OR
 - Exposure that, at the discretion of public health authorities, was recategorized to this risk level (i.e., exposure that ordinarily would be considered a lower risk exposure, raised to this risk level because of unique circumstances)
2. Intermediate degree of exposure – monitor for 21 days, consider PEP:
 - Being within 6 feet for 3 hours or more of an unmasked patient without wearing, at a minimum, a surgical mask OR
 - Activities resulting in contact between sleeves and other parts of an individual’s clothing and the patient’s skin lesions or bodily fluids, or their soiled linens or dressings (e.g., turning, bathing, or assisting with transfer) while wearing gloves but not wearing a gown OR
 - Exposure that, at the discretion of public health authorities, was recategorized to this risk level because of unique circumstances (e.g., if the potential for an aerosol exposure is uncertain, public health authorities may choose to decrease risk level from high to intermediate)
3. Low/uncertain degree of exposure – monitor for 21 days:
 - Entered the patient room without wearing eye protection on one or more occasions, regardless of duration of exposure OR
 - During all entries in the patient care area or room (except for during any procedures listed above in the high-risk category), wore gown, gloves, eye protection, and at minimum, a surgical mask OR

- Being within 6 feet of an unmasked patient for less than 3 hours without wearing at minimum, a surgical mask OR
- Exposure that, at the discretion of public health authorities, was recategorized to this risk level based on unique circumstances (e.g., uncertainty about whether Monkeypox virus was present on a surface and/or whether a person touched that surface)

Exposed contacts who remain asymptomatic can continue routine daily activities (e.g., go to work, school, etc.) but should monitor for symptoms and check their temperature as detailed below. However, they should not donate blood, cells, tissue, breast milk, semen, or organs during the symptom monitoring period (21 days since last exposure).

Additionally, contacts with a high degree of exposure (based on the above framework) should not travel on commercial air flights during their monitoring period.

Contacts who are not healthcare workers should monitor for symptoms and check their temperature twice daily for 21 days from last exposure. If fever or rash develop they should self-isolate and contact the local health jurisdiction. If chills or swollen lymph nodes occur the contact should remain in self-isolation and monitor for fever and rash. If symptoms persist without fever or rash the person should consult with their clinician.

Contacts who are healthcare workers with unprotected (not using proper personal protective equipment) exposure to a case should undergo 21 days of active symptom monitoring with at least twice daily temperature checks. In addition the worker should be evaluated before each work shift regarding evidence of fever or rash.

D. Post-exposure Vaccine

Prompt post-exposure prophylaxis (PEP) with vaccine can reduce the chance of infection or severe illness. Consider PEP vaccination for asymptomatic persons who had direct contact with lesions, crusts, or bodily fluids or who had over 3 hours of unprotected respiratory exposure.

Non-replicating vaccine can be given to anybody unless allergic to any component of the vaccine. *Replicating vaccine* is contraindicated in individuals with immunodeficiency.

Due to risk of severe localized or systemic infection with replicating vaccine virus (progressive vaccinia) only the non-replicating vaccine should be given to a contact with weakened immune systems, including patients with leukemia, lymphoma, organ transplantation, generalized malignancy, HIV/AIDS, cellular or humoral immune deficiency, radiation therapy, or treatment with antimetabolites, alkylating agents, high-dose corticosteroids (>10 mg prednisone/day or equivalent for ≥ 2 weeks) or other immunomodulatory drugs. Persons with atopic dermatitis, eczema or other exfoliative skin conditions should also use a non-replicating vaccine.

See: <https://www.fda.gov/media/75792/download> and <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/smallpox-monkeypox.html>

Report vaccine adverse events to VAERS <https://vaers.hhs.gov/>

E. Infection Prevention Recommendations

Except for follow-up medical care, isolate the case at home until all scabs are dried and shed, and healthy skin has formed. Household members should limit contact with the

person. If interaction with household members is unavoidable, use of masks is recommended. In particular the case should avoid contact with anybody with a weakened immune system. The person should also avoid contact with wild or domestic mammals (see Section F below).

A person in isolation should take steps to prevent transmission. Follow strict hand hygiene, particularly after touching lesions or potentially contaminated fabric or items. Do not share dishes or utensils. Clean and disinfect contaminated surfaces with standard household disinfectants. Avoid shaking out dirty fabric and separately wash potentially contaminated clothing or bedding with detergent in hot water, and hot air dry. Shed scabs or bandages are potentially contagious. Put them in a plastic zip bag, add a small amount of bleach, seal, and discard.

For infection prevention at home see:

<https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-home.html>

For healthcare setting infection prevention see:

<https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html>

F. Zoonotic and Environmental Evaluation

1. Animal related issues

Infection has been documented in rodents and non-human primates, but all mammals should be considered susceptible to monkeypox. Symptoms in prairie dogs included cough, fever, conjunctivitis, lack of appetite, respiratory signs, and rash. Symptoms may vary with animal species.

There is plausible risk of transmission from an infected person to mammals. People with monkeypox should avoid direct contact with pets, including touching, snuggling, being kissed or licked, and sharing food or bedding. Pets should not sleep in the same room as the infected person. If possible, a household member should care for pets in the home. If a person with monkeypox must care for pets or other animals, they should wear a mask and wash their hands before and after interacting with a pet and avoid any direct contact. These steps should be taken for the duration of the isolation period.

Notify Office of CDEpi Zoonotic Disease (206-418-5500) for an animal exposed to a human case. Animals with exposure to monkeypox should be separated from all other animals (particularly wild rodents, either through an infestation in the home or through outdoor contact), monitored for symptoms and any symptoms reported to a veterinarian. Veterinarians examining animals with suspected monkeypox should implement infection control practices, including PPE (gown, gloves, eye protection or face shield, N95 mask).

Transmission to animals:

<https://www.cdc.gov/poxvirus/monkeypox/veterinarian/transmission.html>

Risk assessment: <https://www.gov.uk/government/publications/hairs-risk-assessment-monkeypox/qualitative-assessment-of-the-risk-to-the-uk-human-population-of-monkeypox-infection-in-a-canine-feline-mustelid-lagomorph-or-rodent-uk-pet#about-the-human-animal-infections-and-risk-surveillance-group>

Prairie dog outbreak: <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5227a5.htm> and https://wwwnc.cdc.gov/eid/article/13/9/07-0175_article

2. Environmental issues (also see Section 5D above)

Persons in isolation should do their own laundry and safely dispose of scabs and bandages. Standard household disinfectants should be used on contaminated surfaces.

See: <https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-home.html>

G. Resources

<https://www.cdc.gov/poxvirus/monkeypox/>

<https://www.cdc.gov/poxvirus/monkeypox/response/2022/index.html>

6. MANAGING SPECIAL SITUATIONS

A. Persons at risk

Persons with symptoms of monkeypox should contact their healthcare provider. Risks include (<https://www.cdc.gov/poxvirus/monkeypox/response/2022/index.html>):

1. Traveled to central or west African countries or to countries where monkeypox cases have been reported recently (see: https://www.who.int/health-topics/monkeypox#tab=tab_1), or other areas with confirmed cases of monkeypox during the month before their symptoms began OR
2. Had contact with a person with confirmed or suspected monkeypox OR
3. Is a man who regularly has close or intimate in-person contact with other men, including men who meet partners through an online website, digital application (“app”), or at a social event (e.g., a bar or party)

See the CDC info sheet: <https://www.cdc.gov/poxvirus/monkeypox/pdf/MonkeyPox-sexually-active-InfoSheet-508.pdf>

7. ROUTINE PREVENTION

A. Public Education:

Avoiding stigma is essential. Work with community partners to establish effective messaging. See:

<https://www.cdc.gov/poxvirus/monkeypox/reducing-stigma.html>

<https://www.cdc.gov/poxvirus/monkeypox/sexualhealth/index.html>

B. Immunization Recommendations:

Pre-exposure vaccination recommendations have been issued for persons at risk for occupational exposure to orthopoxviruses, including research laboratory personnel, clinical laboratory personnel performing diagnostic testing for orthopoxviruses, designated response team members, and health care personnel who administer ACAM2000 (Smallpox [Vaccinia] Vaccine, Live) or care for patients infected with orthopoxviruses. See:

https://www.cdc.gov/mmwr/volumes/71/wr/mm7122e1.htm?s_cid=mm7122e1_w and <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/smallpox-monkeypox.html>

ACKNOWLEDGEMENTS

This document is a revision of the Washington State Guidelines for Notifiable Condition Reporting and Surveillance published in 2002 which were originally based on the Control of Communicable Diseases Manual (CCDM), 17th Edition; James Chin, Ed. APHA 2000. We would like to acknowledge the Oregon Department of Human Services for developing the format and select content of this document.

UPDATES

June 2022: separated from Rare Disease guideline and expanded

June 10, 2022: more details provided about symptoms (Section 2B); for case definition positive IgM also requires no suspicion of other recent *Orthopox* exposure, exclusion criterion for negative tests requires high-quality specimens (Section 3); swab specimens suggested 2-4, shipping changed to Category B (Section 4); updated recommendations for isolation, contact monitoring, and completion of isolation (Section 5C); zoonoses information expanded (Section 5F), public education added (Section 7A)