Birmingham Women's and Children's NHS Foundation Trust

Infection prevention and control guidance for the assessment and treatment of patients presenting with possible, probable or confirmed monkeypox

Version	2
Approved by	Infection Prevention and Control Team
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Target audience	BCH site staff

1. Updates to version 2

Section 9 Diagnostic testing: Updated to provide more information on diagnostic testing

Section 10 Further information: Telephone number for the new Monkeypox Clinical Advice Line added

2. Case Definitions

Confirmed case
A person with a laboratory confirmed monkeypox infection (monkeypox PCR positive) since 15.03.2022

Probable case
A person with an unexplained rash on any part of their body plus one or more classical symptoms of monkeypox infection (see Clinical Features below) since 15th March 2022 and:
Has an epidemiological link to a confirmed or probable case of monkeypox in the 21 days before symptom onset **OR**
Has a travel history to West or Central Africa in the 21 days before symptom onset OR
Is a gay, bisexual or other man who has sex with men (GBMSM)

Possible case
A person with a febrile prodrome (see Clinical Features below) 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).

Asymptomatic contact
A person who is asymptomatic, but has had contact with a confirmed or probable case in the past 21 days

3. Clinical Features of Monkeypox

Causative organism	Monkeypox virus
Routes of transmission	The virus can enter the body through: • Broken skin (even if the break is not visible); • The respiratory tract; or • Intact mucous membranes (eyes, nose, or mouth). Person-to-person spread but may occur through: • Direct contact with monkeypox skin lesions or scabs • Inhalation, especially if an infected individual is coughing or sneezing

	• Contact with an environment contaminated by an infected person
Incubation period	5-21 days (average 6-21 days)
Period of infectivity	From onset of fever until all scabs have fallen off
Clinical features	Initial clinical presentation is with fever, malaise, lymphadenopathy, myalgia, arthralgia and headache (often intense). Rash develops 1-5 days after the appearance of fever. Usually begins on the face or genital area, then spreading to other parts of the body. Most cases recover within a few weeks without treatment.

4. Infection Prevention and Control Precautions for Patients that are a Definite or Probable Case, or a Contact of a Case

- Inform the IPCT (out of hours the on-call Consultant Microbiologist) as soon as a case of monkeypox is suspected, or a contact of a case of monkeypox is identified
- Isolate in a single room, or cohort isolation, with respiratory and contact precautions. For inpatient care the single room should be en suite. In other settings (e.g. ED, Triage) where the patient needs to use a communal toilet, the toilet must be quarantined until it has been deep-cleaned (see below)
- Where possible patients should not be cared for on wards with a large number of immunocompromised patients
- Pregnant staff should not work with possible, probable or confirmed cases
- Staff entering the room must wear PPE as follows:
    - Disposable gown
    - Disposable gloves
    - FFP3 respirator
    - Eye protection (single use if possible)
- All single use PPE must be removed and disposed of (see section on Waste Disposal below) on leaving the room. Sessional use of PPE (as used during the COVID-19 pandemic) is not permitted
- Where possible the patient should wear a surgical face mask, unless they are alone in a single room
- Regular hand hygiene must be practised

5. Management of Contacts

- The smallpox vaccine (Imvanex) is the recommended vaccine for post-exposure prophylaxis against monkeypox in the UK. The vaccine is most effective if given within four days of exposure but it can be given up to 14 days post-exposure if required
- Staff who have been in contact with a case without wearing appropriate PPE will be asked to isolate, and will be excluded from work, for 21 days.

6. Visitors

- Visiting (if permitted) is ordinarily limited to a single parent/carer/visitor who is required to stay with the patient at all times. PPE will be offered to the visitor

7. Daily and Terminal Cleaning

- PPE as described above must be worn for both daily and terminal cleaning
- Potentially contaminated clothing and linens should be collected and bagged before the room is cleaned. These clothing or linen items should not be shaken or handled in a manner that may disperse infectious particles. Items of potentially infected clothing or linen should be placed in a water soluble (alginate) bag, sealed or tied and placed inside an impermeable bag for transport to the laundry facility. Alternatively, the IPCT may advise that linen and clothing should be disposed of as clinical waste, rather than being laundered; this would be especially the case for patients with a rash.
- After contaminated clothing and linens have been removed, the rooms can be cleaned and disinfected using Chlorclean as per standard cleaning of an isolation room.
- Clean from the highest, towards the lowest, points in the room.
- Terminal infectious clean of vacated rooms to include changing curtains, and careful assessment of the mattress. If the protective cover is damaged or soiled it must be replaced, and the old cover disposed of as clinical waste. If the mattress itself is soiled, it must be immediately condemned. It must be double wrapped, sealed and sent for incineration.
- An IPCN or Senior Nurse must sign off cleaning as satisfactory before the cubicle is reused.

8. Waste Disposal

- Any waste generated from a known or high risk monkeypox patient must be dealt with as Category A waste.

9. Diagnostic testing

- Swabs from skin lesions in viral transport medium are the mainstay of diagnosis.
- If the patient has fever or widespread rash, sore throat or other systemic symptoms, collect also an EDTA blood sample and a throat swab in viral transport medium. Urine samples may also be sent in a universal container, but will only be tested if deemed necessary for clinical management
- For high risk contacts of a confirmed case who have developed systemic symptoms but do not have a rash or lesions for sampling, you should take a throat swab in viral transport media. Note that even if the throat swab is negative, the individual must continue with monitoring and isolation as instructed, and should be reassessed and sampled if further symptoms develop
- Deliver all samples (marked as Biohazard) by hand to the laboratories. Do not send any samples via the air tube system

10. Further advice

Clinical queries about monkeypox, especially about patients who are seriously unwell, should be referred to the Monkeypox Clinical Advice Line on 0344 225 0602 (operational 24/7).

Where Monkeypox is suspected, the Imported Fever Service (IFS) should be contacted on 0844 7788990 to discuss sample testing. Normally this will be done by the Consultant Microbiologist.

The following information is required before calling the IFS:

- Patient identifiers
- Full travel history including dates and locations of travel, activities & exposures
- Vaccination/prophylaxis history
- Clinical details and past history

There the IFFS advises to send samples for testing by the Rare and Imported Pathogens Laboratory (RIPL) a referral form P1 SPATHW039-04.qxp (publishing.service.gov.uk) will need to be completed.

Once completed, the sample and referral form should be sent by courier (arranged by the BWC NHSFT laboratory) to:

Imported fever service
c/o Rare and imported pathogens laboratory (RIPL)
Public Health England
Manor Farm Road
Porton Down
Wiltshire
SP4 0JG