Management of Suspected MONKEYPOX – SOP v5 19/07/22

Monkeypox is a rare disease that is caused by infection with monkeypox. It may spread when a person comes into close contact with an infected animal (not detected in animals in the UK), human, or materials contaminated with the virus.

The virus enters the body through broken skin (even if not visible), the respiratory tract, or the mucous membranes (eyes, nose, or mouth). Person-to-person spread is uncommon, but may occur through:

- **contact with clothing or linens (such as bedding or towels) used by an infected person**
- **direct contact with monkeypox skin lesions or scabs**
- **coughing or sneezing of an individual with a monkeypox rash**

Monkeypox infection is usually a self-limiting illness and most people recover within several weeks. However, severe illness can occur in some individuals. The incubation period is between 5 and 21 days and the patient contagious until all the scabs have fallen off and there is intact skin underneath. Clinicians should be alert to possible cases.

NOTE: **Current guidance is that where possible, pregnant and severely immunosuppressed healthcare workers (as outlined in the Green Book) should not assess or clinically care for individuals with suspected or confirmed monkeypox.**

To prevent transmission of infection, implement the following control measures:

1. **Surgical face mask** required to be worn by the patient until in **isolation** (ideally in negative pressure) and where able when staff are in the room. For ED presentations, the isolation room for HCIDs is to be used. For direct admissions, contact the clinical commander.
2. **Follow high level isolation protocol 2** – all unnecessary equipment removed and door kept closed. Maintain a timed record of entry and a record of staff/patient contacts and submit to Infection Prevention and Control and Occupational Health as appropriate.
3. **Assess** the patient against the criteria for Monkeypox (**see over**)
4. **Droplet and Contact PPE as a minimum requirement:** *Gown; FFP3 mask or equiv; gloves; eye protection* to be worn by **all** persons entering the room where a patient is being isolated. This is advised from initial suspicion of a patient, through assessment until either confirmed or stepped down. Leave respiratory protection on until outside the room.
5. **Equipment:** Keep non-disposable equipment to a minimum. Where required equipment cannot be left in the room (e.g. portable xray), it must be disinfected with Tristel on exit in the lobby area.
6. **Cleaning:** decontaminate the room daily with Tristel, after any AGPs (ensure settle time completed prior to cleaning) and frequent touch points and the lobby at least twice daily. On discharge/transfer terminal clean with HPV or Double Tristel (clean once with Tristel – allow to dry and clean again with Tristel) and curtain change where applicable.
7. **Waste and laundry management:** Waste must be disposed of as infectious waste (orange bags) swan neck seal the bag in the room and store in the infectious waste store. Likewise, laundry is managed as infectious and contained in alginate bags. Caution to be taken not to disperse infectious particles by shaking bedding/clothing.

Case definition - updated 06/07/22 (UKHSA)

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).

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

Probable case

A person with an unexplained rash on any part of their body plus one or more classical symptom or symptoms of monkeypox infection¥ since 15 March 2022 and either:

- epidemiological link to a confirmed or probable case of monkeypox in the 21 days before symptom onset **or**
- 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)

¥Acute illness with fever (>38.5°C), intense headaches, myalgia, arthralgia, back pain, lymphadenopathy.

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

ACTIONS following assessment:

Contact the duty/on-call microbiologist if Monkeypox is still possible after assessment and notify the IPCTeam. The microbiologist will contact UKHSA and Imported Fever Service as appropriate for the next steps and sampling.

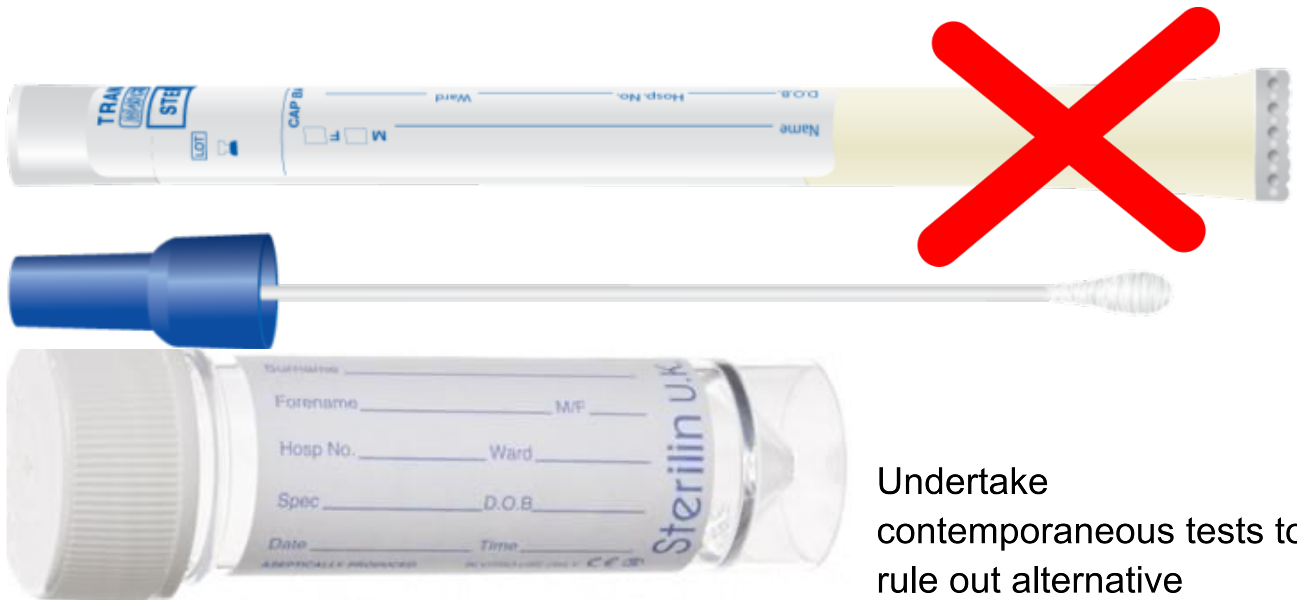
A definite diagnosis of monkeypox requires assessment by a health professional and specific testing in a specialist laboratory.

The **sample required** to diagnose Monkeypox is a **viral swab in viral transport medium** from an open sore or from the surface of a vesicle. If other wounds are present, ensure that the sample is definitely taken from an ulcer, vesicle, or crusted vesicle. Rub the swab over the lesion and place the swab in the viral transport medium. Label the tube with the patient details and mark with a “Danger of Infection” sticker.

SAMPLES SHOULD NOT BE PUT IN THE POD SYSTEM – THEY SHOULD BE HAND DELIVERED TO PATHOLOGY IN A RIGID CONTAINER.

CONTAINERS THAT SHOULD BE USED - (Viral transport media)

CONTAINERS THAT SHOULD NOT BE USED



Undertake contemporaneous tests to rule out alternative diagnoses if clinically appropriate and if not done already. The lab must be informed in advance of samples submitted from suspected or confirmed diagnosis of monkeypox, so that they can take the appropriate precautions to minimise risk to laboratory workers.

Monkeypox rash progression