



Alert for clinicians regarding increase in cases of monkeypox

KEY POINTS

- **Fifteen confirmed, and 51 suspected, cases of monkeypox have been detected in Europe and North America.**
- **Two cases have been detected in Australia; one in Victoria and one in New South Wales. There have been no detections in WA.**
- **Most cases have been in men who have sex with men (MSM).**
- **If you suspect monkeypox, clinicians are advised to immediately notify the Communicable Disease Control Directorate (☎ 9222 0255 or A/H: 9328 0553).**

What is the issue?

- Monkeypox is a rare zoonotic viral infection that usually occurs in West and Central Africa, with occasional cases being exported to other regions.
- There has been a recent increase in cases, primarily in Europe and North America with no travel links.
- To date, 15 confirmed cases of monkeypox have been reported in the UK, Canada, the United States and Portugal. Two cases have been reported in Australia, one in Victoria and one in New South Wales.
- Unusually, the majority of these cases have not travelled to the endemic African regions, indicating local community transmission, and have predominantly been among men who have sex with men (MSM).
- No cases of monkeypox has been detected in WA, to date.

Transmission of monkeypox

- Monkeypox is transmitted to humans through close contact with an infected person or animal, or with material contaminated with the virus, such as bedding.
- Person-to-person transmission is unusual and is mainly through direct contact with an infected person or via respiratory droplets. Monkeypox has not previously been described as a sexually transmitted infection, although it can be passed on by direct contact during sex.

Incubation and infectious period

- The incubation period is 10-14 days.
- People with monkey pox are infectious from the onset of the prodrome until the vesicles have dried and scabbed over.

Clinical presentation

- Monkeypox is usually a self-limited disease with the symptoms lasting from 2 to 4 weeks. Severe cases can occur. The initial symptoms (prodromal period) include fever, malaise, headache, and sometimes sore throat, cough, and lymphadenopathy.
- Following the prodrome, lesions develop and evolve on a given part of the body. The typical rash begins in oropharynx then spreads onto the face, trunk and extremities, including the palms and soles. The lesions progress through four stages: macular, papular, vesicular to pustular, before scabbing over and resolving. Unlike chickenpox where lesions in different stages can be present at a given time, all the lesions develop uniformly through the stages over 4-5 days. Lesions can be localised to a specific area of the body.

Management

- Clinicians are advised to look out for signs and symptoms consistent with monkeypox, particularly in returned travellers or persons with clinically compatible rash. A telemedicine consultation is advisable, where possible.
- If monkeypox is suspected, immediately notify the Communicable Disease Control Directorate (☎ 9222 0255 or A/H: 9328 0553) to discuss case management. Isolate the patient and ask the patient to wear a surgical mask while awaiting further advice.
- Monkeypox is usually a mild self-limiting illness, but in severe cases, antiviral therapy is used. Patients should be managed symptomatically and, if hospitalised, should be placed in negative pressure isolation and the Infection Prevention and Management Team notified.
- Post-exposure prophylaxis with vaccinia vaccination can be used as it is cross-protective.

Specimen Collection and Diagnosis

- Monkeypox virus PCR testing is the diagnostic test of choice for active infection and is available at PathWest QEII microbiology laboratory, Nedlands.
- Specimen collectors should use droplet precautions (surgical mask, protective eyewear, gown and gloves).
- After de-roofing a lesion, collect fluid and rub the base of the lesion using a dry swab; lesion tissue, crust or biopsy are also suitable for monkeypox PCR testing.
- Several lesions should be sampled using different swabs and sent in individual containers to the laboratory.
- Nasopharyngeal swabs are also suitable and should be collected. Other specimens can be considered after discussion with a Clinical Microbiologist.
- Samples should be sent to the laboratory as for other infectious material as soon as possible and be discussed with the Clinical Microbiologist prior to arrival. If there is a delay in specimen transport then refrigerate the specimen at 4°C.
- In addition to monkeypox PCR testing, consider other infective causes of vesicular rashes, such as herpes simplex virus and especially varicella.
- Lesion specimens and nasopharyngeal swabs can be processed in microbiology laboratories at Biosafety Level 2 by unvaccinated staff. Manipulation of the primary specimen should be performed in a Biosafety cabinet with appropriate PPE.
- Non-microbiology specimens e.g. blood samples from suspected and proven patients, can be handled using standard specimen precautions.
- Monkeypox serology is not available in WA.



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