

Forwarded by the Delaware Division of Public Health  
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The Delaware Division of Public Health (DPH) is forwarding this health update from the Centers for Disease Control and Prevention (CDC) providing updated information regarding clinical presentations of monkeypox.

## Summary

This Health Alert Network (HAN) Health Update serves to alert clinicians to clinical presentations of monkeypox seen so far in the United States and to **provide updated and expanded case definitions** intended to encourage testing for monkeypox among persons presenting for care with relevant history, signs, and symptoms. In addition, this Health Update **provides an update to a HAN Health Advisory** that the Centers for Disease Control and Prevention (CDC) **issued May 20, 2022**, titled Monkeypox Virus Infection in the United States and Other Non-endemic Countries—2022. In people with epidemiologic risk factors, rashes initially considered characteristic of more common infections (e.g., varicella zoster, herpes, syphilis) should be carefully evaluated for concurrent characteristic monkeypox rash (see images and links to below) and considered for testing.

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. 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.

## **Updated Case Definitions**

On June 1, 2022, CDC updated and expanded its monkeypox case definitions to ensure that anyone who is suspected of having monkeypox can be tested and appropriate steps to protect contacts can be taken.

Revised categories of suspected, probable, and confirmed cases of monkeypox standardize case reporting through the National Notifiable Diseases Surveillance System (NNDSS). In addition, the “suspected” case definition encourages broader suspicion for monkeypox.

For a Clinical and laboratory classification chart, go to <https://www.cdc.gov/poxvirus/monkeypox/clinicians/case-definition.html>.

## **Clinical presentations of confirmed cases to date**

Descriptions of classic monkeypox disease describe 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 usually starts 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 meets the suspected case definition 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.

For images of monkeypox lesions, visit <https://emergency.cdc.gov/han/2022/han00468.asp>.

## **Recommendations for Clinicians**

- 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.
- If a patient does not respond to STI treatment as expected, the patient should return for follow-up evaluation and monkeypox testing should be considered.
- Please refer to the most recent CDC guidance for specimen collection to ensure proper collection of specimens.
- In addition to dry swabs, CDC can now accept lesion swabs in viral transport media and lesion crusts (currently these two specimens must be received by CDC within 7 days of collection).
- Clinicians should use appropriate infection prevention measures when collecting specimens for monkeypox evaluation. Information on infection prevention and control in health care settings is provided on the CDC website.
- 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.
- Clinicians in Delaware who identify a patient with a suspected monkeypox rash should immediately contact DPH Office of Infectious Disease Epidemiology (OIDE), at 302-744-4990 (business hours) or 1-888-295-5156 (after hours) for testing coordination and additional consultation.

o DPH will coordinate testing with Delaware Public Health Laboratory (DPHL) and the CDC, if a patient meets the criteria for a suspected case <https://www.cdc.gov/poxvirus/monkeypox/clinicians/case-definition.html>

o Patients may be referred to public health clinics at the state service centers by OIDE, if the health care facility does not have the means to collect and store specimens.

o Health care facilities that require specimen collection kits can consult the DPHL supply email at [Labsupplies@delaware.gov](mailto:Labsupplies@delaware.gov).

### **Recommendations for the Public**

- CDC is closely monitoring worldwide case counts and working to understand the cause of the current cases. Based on limited information available at this time, overall risk to the U.S. public is currently low.
- People who may have symptoms of monkeypox, such as unknown rashes or lesions, should contact their health care provider for assessment. This includes anyone who:
- Reports contact with a person who has a similar rash or received a diagnosis of confirmed or suspected monkeypox.
- Had close or intimate in-person contact with individuals in a social network experiencing monkeypox infections, this includes MSM who meet partners through an online website, digital application (app), or social event (e.g., a bar or party).
- Traveled to countries where monkeypox cases have been reported.