

June 10, 2022

Summary

The Centers for Disease Control and Prevention (CDC) is tracking several cases of monkeypox that have been reported in countries where monkeypox is not endemic. As of June 9, 45 confirmed cases of orthopox/monkeypox in the United States, but no cases have been identified in Indiana.

Clinicians should be alert to patients presenting with a new characteristic rash or if the patient meets one of the [epidemiologic criteria](#) and there is a high clinical suspicion for monkeypox. The rash associated with monkeypox can be confused including herpes, syphilis, and varicella. Patients co-infected with monkeypox virus and other infectious agents (e.g., varicella zoster, herpes, syphilis) have been reported. Clinicians should have monkeypox on their differential diagnosis when presented with a sexually transmitted infection (STI)-associated or STI-like rash, even if it is localized and not (yet) diffuse. Please refer to [CDC's Case Definitions for use in the 2022 Monkeypox Response](#).

Cases of monkeypox described in the current outbreak have some atypical features. The rash may start in the genital and perianal areas, the rash may not always disseminate to other parts of the body, and typical prodromal symptoms may be mild or absent. These features of the newest monkeypox cases can easily be confused with STI. It is important to comprehensively evaluate patients presenting with genital or perianal ulcers for STIs. However, co-infections with monkeypox and STIs have been reported and the presence of an STI does not rule out monkeypox.

Patients with a new characteristic rash or who meet one or more of the [epidemiologic criteria](#) and in which there is a high suspicion should be tested for monkeypox. If a case of monkeypox is suspected, clinicians are urged to contact the Indiana Department of Health (IDOH) Epidemiology Resource Center at 317-233-7125 during normal business hours (Monday-Friday, 8:15 a.m. - 4:45 p.m. Eastern) or 317-233-1325 after hours for consultation and testing.

About Monkeypox

After an exposure to monkeypox, there is an incubation period that lasts on average 7-14 days but can range from 5-21 days. Individuals will often experience an onset of initial symptoms (e.g., fever, malaise, headache, lymphadenopathy, etc.), which mark the beginning of the prodromal period.

A rash develops shortly after the prodrome, usually within 1-3 days but sometimes longer. The rash often begins on the face then spreads to other parts of the body. Lesions typically begin to develop simultaneously and evolve together on any given part of the body, but there have been reports of rashes developing asynchronously. The evolution of lesions progresses through four stages — macular, papular, vesicular, and pustular — before scabbing over and resolving. Lesions are well circumscribed, deep seated, and often develop umbilication (resembles a dot on the top of the lesion). An individual is contagious until all the scabs have fallen off, which can last anywhere from 2-4 weeks after rash onset. Individuals with a rash that looks like monkeypox should talk to their healthcare provider, even if they do not think they had contact with someone who has monkeypox.

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).

Monkeypox Case Criteria

- **Suspect Case:** New characteristic rash OR meets one of the epidemiologic criteria and has a high clinical suspicion for monkeypox
- **Probable Case:** No suspicion of other recent *Orthopoxvirus* exposure AND demonstration of the presence of *Orthopoxvirus* DNA

Epidemiologic Criteria

Monkeypox spreads between people primarily through direct contact with infectious sores, scabs, or body fluids. It can also spread by respiratory secretions during prolonged, face-to-face contact. People who may be at higher risk might include, but are not limited to, those who within 21 days of illness onset:

- Had contact with someone who had a rash that looks like monkeypox or someone who was diagnosed with confirmed or probable monkeypox
- Had skin-to-skin contact with someone in a social network experiencing monkeypox activity;
- Traveled outside the United States to a country with confirmed cases of monkeypox or where monkeypox activity has been ongoing
- Had contact with a dead or live wild animal or exotic pet that exists only in Africa or used a product derived from such animals (e.g., game meat, creams, lotions, powders, etc.)

Please view CDC's [Monkeypox Case Definition](#) for the most up-to-date case criteria.

Recommendations for Monkeypox Specimen Collection and Testing

Personnel who collect specimens for monkeypox testing should use personal protective equipment (PPE) in accordance with [CDC's recommendations for healthcare settings](#).

Monkeypox testing should include collecting swabs from more than one lesion, preferably from different locations on the body and/or from lesions with differing appearances. Dry synthetic swabs must be used for collection and placed into 1.5- or 2-mL sterile, screw-capped tube with O-ring or 15-mL sterile, screw-capped tube. Specimens should be stored at refrigerated temperatures after collection. Please contact IDOH for more detailed information regarding specimen collection and to arrange transportation to IDOH Laboratory.

Necessary sample collection and transport supplies:

- Synthetic swab (i.e. rayon, polyester or Dacron) with plastic shaft. Calcium alginate or charcoal-impregnated swabs should not be used, nor should wood shaft swabs.
- Sterile, screw-capped tube (preferably with o-ring) – 10-mL to 15-mL tube will generally fit the entire swab. 1.5- or 2-mL tubes can be used but the swab shaft will need to be cut/broken off after collection since only the swab tip and a small amount of swab shaft will fit in the tube.
- Biohazard specimen bag with absorbent material, preferably with outer pocket for test requisition form (i.e., LimsNet coversheet).
- Cold packs (need to be frozen prior to shipment)
- Insulated shipping box (cardboard outer box with Styrofoam inner box). Box will need to be labeled appropriately as Category B Infectious Substance

Recommendations for Treatment

There are no specific treatments available for monkeypox infection. However, resources are available to help control monkeypox outbreaks. These include: smallpox vaccine, cidofovir, ST-246, and vaccinia immune globulin (VIG). You can find information on each [here](#).

Recommendations for Post-Exposure Prophylaxis

Post-exposure prophylaxis (PEP) with smallpox vaccine can be utilized for individuals exposed to monkeypox. CDC



recommends that the vaccine be given within 4 days from the date of exposure to prevent onset of the disease. If given between 4–14 days after the date of exposure, vaccination may reduce the symptoms of disease, but may not prevent the disease. While there are contraindications to administration of smallpox vaccine, the risks from monkeypox disease are greater than the risks from the smallpox or monkeypox vaccine. For more information, please review CDC [guidance](#).

Resources

- [Monkeypox Clinical Recognition](#)
- [FAQ for Providers](#)
- [Reducing Stigma in Communication and Community Engagement](#)
- [Monkeypox: Get the facts Infographic](#)
- [Social Gatherings, Safer Sex, and Monkeypox Infographic](#)

For More Information

Please direct questions the IDOH Epidemiology Resource Center at 317-233-7125 during normal business hours (Monday-Friday, 8:15 a.m. - 4:45 p.m. Eastern) or 317-233-1325 after hours.

