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Management of laboratory confirmed monkeypox infections

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Purpose

1. In light of the UKHSA principles paper, a risk stratified clinical approach has been developed to ensure that confirmed cases of monkeypox receive appropriate care, while also managing transmission risk. This approach is being further modified to take account of the derogation of the current specific monkeypox clade as a High Consequence Infectious Disease (HCID).

2. A UK wide clinical policy statement has also now been published guiding access to tecovirimat in individuals hospitalised due to monkeypox infection.

3. This document will be updated as further information becomes available.

Background

4. Monkeypox primarily occurs in Central and West Africa. Symptoms of monkeypox begin 5-21 days (average 6-16 days) after exposure with initial clinical presentation of fever, malaise, lymphadenopathy and headache. Within 1 to 5 days after the appearance of fever, a rash develops, often beginning on the face or genital area then spreading to other parts of the body. The rash changes and goes through different stages before finally forming a scab which later falls off. The illness is usually mild and most of those infected will recover within a few weeks without treatment. The mortality from monkeypox is low (≈1% in Africa) with pregnant women, children and immunocompromised hosts being at highest risk.

5. Admission to highly specialist ‘containment’ facilities within the (Airborne) High Consequence Infectious Diseases (HCID) Network would normally be mandated for all cases confirmed by UK Health Security Agency (UKHSA) specialised laboratories. This is no longer the case following the derogation of the *specific* current outbreak clade as an HCID.

6. First diagnosed in the UK in 2018, monkeypox had been a rare and sporadic imported infection. The NHS England HCID Network successfully managed all seven cases from 2018-21.

7. At present, there is a large outbreak of monkeypox in several European countries, including the UK, and further afield globally. While the UK's first case in May 2022 involved travel to Nigeria, all subsequent cases have none of the typical exposure risks and represent chains of transmission with the UK population. The majority of UK cases have so far been detected in men who have sex with men (MSM) in London.

8. The UK clinical and public health response to monkeypox was initially based on the HCID system. This was highly precautionary and designed for complete containment around single cases. It was also designed prior to the confirmed availability of vaccine and treatment. UKHSA has now confirmed that community transmission is occurring in the UK with multiple generations of spread. Illness appears to be generally mild. This is why the specific current outbreak clade has been derogated and is no longer being considered as an HCID.

Risk stratification

9. There is a need to balance the requirement to contain the spread of monkeypox in the community and within healthcare settings, while acknowledging that the NHS is adopting a more proportionate approach to admissions, based upon a patient-level assessment and stratification of risk.

10. The following groups of individuals have underlying risk factors for severe disease and may require hospitalisation. Cases involving the below MUST be discussed with your local infectious disease centre and can be discussed on the weekly clinical calls (see paragraph 22):

    - Immunocompromised individuals
    - Children (16 years or under)

11. Caution should be exercised in treating pregnant patients with tecovirimat for monkeypox infection. Please see the policy for guidance. Clinicians may wish to seek further discussion with the MDT in such situations.

12. Clinicians should assess patients and make a judgement as to whether they require admission. Where a clinician feels admission is needed, they should use their usual route for securing access to infectious disease advice and provision and to determine whether hospitalisation is needed.

13. Experience of treating over 60 inpatients in this outbreak clade has demonstrated that individuals have needed hospitalisation for:

    - Severe, refractory pain, commonly proctitis
    - Eye disease
    - Severe secondary bacterial infections or co-infection with STIs
    - Multiple lesions or those that require surgical intervention
    - Lesions associated with complications due to pain or swelling, e.g. constipation, urinary retention or inability to swallow
    - Rarely, encephalitis and pneumonitis

14. Any patient who has mild disease should self-isolate at home until recovery. This covers the majority of cases that we have seen during this outbreak. Their responsible clinician should advise the patient to get in contact with them if their condition deteriorates. Clinicians are actively encouraged to support recruitment of patients with laboratory confirmed monkeypox infection and with active skin or mucosal lesions, but who do not require hospital admission, to the *PLATINUM trial*.

Management of positive cases

15. Monkeypox cases NOT caused by the current outbreak clade MUST continue to be managed as HCIDs, as the associated morbidity and mortality may be greater. The responsible clinician should check for travel history, etc, to confirm the individual is infected by the specific outbreak clade. Any cases with a reported a travel history to countries where monkeypox is endemic in the 21 days before symptom onset should be discussed with local infection consultant (microbiology, virology or infectious diseases). Any case with a confirmed travel history should be treated as a HCID until the case has been sequenced the clade has been identified. The relevant local infection prevention and control team should be informed of any suspect cases

admitted. Where there is no local infection consultant available, the UKHSA Imported Fever Service may be contacted directly – enquiries process and contact information is available via https://www.gov.uk/guidance/imported-fever-service-ifs.

16. In response to a positive test result, clinicians should assess patients against the above risk stratification.

17. Patients requiring hospitalisation must, at a minimum, be treated in a respiratory isolation room by staff using the recommended PPE, although this does not necessarily need to be in an infectious disease unit. A respiratory isolation room is a ventilated single occupancy room with *en suite* bathroom. The ventilation options are a negative pressure room, or a positive pressure ventilated lobby (PPVL) patient room connected to an *en suite* bathroom with extract ventilation and with a positive pressure ventilated lobby.

18. Clinicians should use their usual route for securing access to infectious disease advice and provision if the patient requires inpatient care.

19. For ease, the following trusts in England form the Specialist Regional Infectious Disease network:

    - Alder Hey Children's NHS Foundation Trust (children*)
    - Barts Health NHS Trust (London) (adults and children)
    - Brighton and Sussex University Hospitals NHS Trust (adults)
    - Cambridge University Hospitals NHS Foundation Trust (adults)
    - Guy's & St Thomas' NHS Foundation Trust (adults* and children*)
    - Hull University Teaching Hospitals NHS Trust (adults)
    - Imperial College Healthcare NHS Trust, London (adults and children*)
    - Leeds Teaching Hospitals NHS Trust (adults)
    - Liverpool University Hospitals NHS Foundation Trust (adults*)
    - London North West University Healthcare NHS Trust (Northwick Park Hospital) (adults)
    - Manchester University NHS Foundation Trust (adults and children)
    - Nottingham University Hospitals NHS Trust (adults)
    - North Bristol NHS Trust (adults in conjunction with University Hospitals Bristol and Weston NHS Foundation Trust))

- Oxford University Hospitals NHS Foundation Trust (adults and children)
- Royal Devon and Exeter NHS Foundation Trust (adults)
- Royal Free London NHS Foundation Trust (adults*)
- Sheffield Children's NHS Foundation Trust (children)
- Sheffield Teaching Hospitals NHS Foundation Trust (adults*)
- South Tees Hospitals NHS Foundation Trust (adults)
- Southampton University Hospital NHS Foundation Trust (children)
- St George's University Hospitals NHS Foundation Trust, London (adults and children)
- The Newcastle upon Tyne Hospitals NHS Foundation Trust (adults* and children*)
- University College London Hospitals NHS Foundation Trust (adults)
- University Hospitals Birmingham NHS Foundation Trust (adults, children in-reach to Birmingham Women's & Children's Hospital NHS Foundation Trust)
- University Hospitals Bristol and Weston NHS Foundation Trust (adults in conjunction with North Bristol NHS Trust, children)
- University Hospitals of Leicester NHS Trust (adults)
- University Hospitals of North Midlands NHS Trust (Stoke) (adults)

20. Where required, infection specialists in Specialist Regional Infectious Disease Centres (SRIDCs) may obtain further advice from their nearest (airborne) HCID centre (indicated * in the above list).

21. UKHSA, with funding from DHSC, has secured a supply of the anti-viral, tecovirimat, and a UK wide clinical policy statement covering its use in individuals hospitalised due to a monkeypox infection has been published following approval from the Chief Medical Officer. To date, due to the complexity of treatment needs, the majority of the use of the drug has been in adults in SRIDCs. Stocks of the drug are therefore being held in these locations and can be couriered on an exceptional basis to other providers. Use of the drug in children under the age of 16 must be discussed on the national call (see paragraph 22).

22. For those trusts providing inpatient care to confirmed cases, there is currently a weekly national clinical call (1230 Thursdays) to:

- Discuss the management of complex cases that cannot be resolved locally or where access to broader advice is desirable, including a retrospective discussion of all patients where tecovirimat has been used.
- Agree what information should be disseminated about the management of cases, as experience evolves
- Support the management of cases where a child/children are involved

23. NHS organisations should email england.incident12@nhs.net with the details (initials, age, gender) of any case that they wish to discuss at the weekly clinical call, including all cases where tecovirimat has been used. A more urgent, next day call, can also be requested via this route.

24. The need for, and frequency of, regular clinical calls will be kept under review and may change.

25. All inpatient activity should be coded using the ICD10 code B04 so that a retrospective analysis of admissions can be undertaken.