Infection Prevention and Control Guidance for Healthcare Settings in Northern Ireland

Mpox: Management of possible, probable and confirmed cases

30 June 2023

Adopted from:

The principles for mpox control in the UK: 4 nations consensus statement

(published 30 May 2022)

NHS Scotland, Infection Prevention and Control advice for healthcare settings: Mpox: Management of possible, probable and confirmed cases

(Publication date: 6 June 2022)

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1. Purpose and Scope

This guidance has been produced in response to the ongoing mpox situation in Northern Ireland and aims to support those working in Healthcare settings. The guidance is based on the published Principles for mpox control in the UK four nations consensus statement from the UK Health Security Agency (UKHSA) and associated UKHSA guidance documents. This guidance also considers the advice which has been issued in Scotland, Infection Prevention and Control advice for healthcare settings: Mpox: Management of possible, probable and confirmed cases (Publication date: 6 June 2022) with permission from colleagues in NHS National Services, Scotland.

The guidance should be read in conjunction with the NI IPC Manual and links to the appropriate sections will be provided within this guidance. This guidance should be used by organisations and employers to support local implementation and risk assessment for the management of possible, probable and confirmed cases of Mpox. Given the rapidly evolving nature of this current situation, the content of this document will be subject to change.

2. Background

Since May 2022, cases of mpox have been reported in multiple countries that do not have endemic mpox virus in animal or human populations. Epidemiological investigations are ongoing; however reported cases thus far have no established travel links to an endemic area. This suggests significant community transmission in multiple non-endemic countries in recent weeks. In the UK, all reported cases have been identified as the West African clade through rapid molecular testing. Community transmission is occurring in the UK with multiple generations of spread. Illness appears to be generally mild, consistent with other information about the West African clade.

3. General Information

Mpox is a viral zoonotic disease that occurs primarily in Central and West Africa. There are 2 clades of mpox – a Central African clade with a reported mortality of 10% and a West African clade with a reported mortality of 1% from epidemiological cluster and outbreak reports from Africa.

Previously it was occasionally exported to other regions. Within the UK it was initially classified as a high consequence infectious disease (HCID) for NHS management, particularly to enable early identification and prevention of spread within the healthcare environment for imported cases and recognising the initial clinical diagnosis cannot determine the particular clade of mpox. Mpox is a hazard group 3 organism (ACDP/HSE). **On 10 June 2022, the Advisory Committee on Dangerous Pathogens (ACDP) met and considered whether these criteria apply currently to mpox in the context of the current outbreak. ACDP noted the data provided on the UK cases, which have not been severe, and also that a vaccine is available and being deployed. The committee recommended that the strain of West African clade mpox currently in community transmission within the UK should no longer be classified as an HCID**. Mpox usually presents with a classic viral prodrome of fever, headache, myalgia, lymphadenopathy with rash developing at around 5 days. Although the rash typically starts on the face, a number of cases recently have reported only single or multiple genital lesions, or have started in the genital area before spreading elsewhere. Adults born before 1970 who have had smallpox vaccination may have a degree of protection. Clinical diagnosis of mpox can be difficult, and it may be confused with other infections such as chicken pox, herpes simplex virus or syphilis. Unlike chickenpox, the lesions are usually all at the same phase of development. The skin lesions (pox) go through four phases, starting with (1) flat spots turning into (2) raised spots, then to (3) blisters and finally (4) healing by scabbing or crusting over and falling off.

Available data and expert opinion aligned with WHO suggests that:

- There is no evidence that individuals are infectious before the onset of prodromal illness.
- The highest risk period for onward infection is from onset of prodrome until lesions have scabbed and the scabs have fallen off.
- Spread is through fomites, droplet and close contact (which includes sexual contact).
- To date, there is little evidence regarding airborne transmission of the mpox virus.

4. Strategic aims

- To suppress the transmission of mpox in the community and aim for eradication (decreasing Rt below 1) by targeting public health measures to the highest risks for transmission.
- To protect against spread of infection in hospitals and healthcare settings and to healthcare workers assessing and managing patients.

- To enable safe functioning of NHS services, including those services which can diagnose and manage cases, in the context of community transmission of mpox.

5. Definition of possible, probable and confirmed cases (Mpox: case definitions - GOV.UK)

6. Patient management

In preparation, healthcare settings that may receive and care for probable, possible or confirmed MPX cases should ensure that staff are aware of what actions to take if a possible, probable or confirmed case presents and be familiar with all IPC controls required as per this guidance. For individuals with infection who are well, ambulatory, and have either prodrome or rash, the highest risk transmission routes are direct contact, droplet or fomite. Transmission seen so far in this outbreak is consistent with close direct contact. There is currently no evidence that individuals are infectious before the onset of the prodromal illness. For individuals with infection who have evidence of lower respiratory tract involvement or severe systemic illness requiring hospitalisation, the possibility of airborne transmission has not been excluded. The highest risk period for onwards infection is from the onset of the prodrome until the lesions have scabbed over and the scabs have fallen off. There is no available evidence on mpox in genital excretions and a precautionary approach for the use of condoms for 8 weeks after infection is recommended, (this will be updated as evidence emerges), in addition to abstaining from sex while symptomatic including during the prodromal phase and while lesions are present. The disease in healthy adults is primarily self-limiting and with a relatively low mortality. There is remaining uncertainty over potentially increased severity in children and in individuals who are highly immunocompromised or pregnant. Visitors to possible, probable or confirmed mpox inpatients should be restricted. If essential, for example carer/parents/guardians, individual advice should be sought from IPCT/HPT regarding the safest way to arrange a visit.

6.1 Patient placement

Possible, probable or confirmed mpox cases that require to be seen by healthcare staff within a healthcare facility should be placed in a negative pressure room (or a single neutral pressure room where negative pressure room is unavailable). All possible, probable or confirmed cases should be provided with a Fluid Resistant Surgical Mask (FRSM) to wear where this can be tolerated and does not compromise their clinical care e.g. when receiving oxygen therapy.

6.2 Personal Protective Equipment (PPE)

Risk assessment and consideration of the hierarchy of controls will help determine the level of personal protective equipment (PPE) to use. Deroofing procedures and throat swabs are not considered to be aerosol generating procedures (AGPs) but may cause droplets.

For possible/probable cases (Where symptoms are mild and there is no evidence of respiratory symptoms) the minimum PPE is:

- gloves
- fluid repellent surgical facemask (FRSM) (an FRSM should be replaced with an FFP3 respirator and eye protection if the case presents with a lower respiratory tract infection with a cough and / or changes on their chest x-ray indicating lower respiratory tract infection)
- apron
- eye protections is required if there is a risk of splash to the face and eyes (for example when taking diagnostic tests)

For confirmed cases requiring ongoing clinical management (for example inpatient care or repeated assessment of an individual who is clinically unwell or deteriorating), or for possible/probable cases where symptomology includes respiratory symptoms/widespread rash the minimum recommended PPE for healthcare workers is:

- fit-tested FFP3 respirator
- eye protection
- long sleeved, fluid repellent, disposable gown
- gloves

6.3 Waste

Waste management and decontamination practice should follow best practice and be based on all the available evidence on safe handling of all waste in accordance with country specific legislation and regulations. Please refer to the NI infection prevention and control manual. All waste generated in the care of possible, probable, or confirmed mpox cases should be managed as Category B waste in healthcare settings (clinical waste).

6.4 Linen

Contaminated clothing and linen are a potential source of transmission. Care must be taken not to shake the linen and prevent dispersal of skin scales. All linen generated during the care of a possible, probable, or confirmed case of mpox must be managed as infectious linen.

6.5 Decontamination

It remains important to reduce the risk of fomite transmission. The risk can be substantially reduced by following agreed cleaning methods based on standard cleaning and disinfection Please refer to the NI infection prevention and control manual