NATIONAL AMBULANCE SERVICE
INFECTION PREVENTION & CONTROL GROUP (NASIPCG)
Monkeypox Guidance
POSITION STATEMENT – 10/06/2022
Please note this is a moving situation and further updates may be required.

Latest Update

As of 08/06/22 the UK Health Security Agency (UKHSA) has been notified of over 320 confirmed cases of monkeypox within the UK. The latest number of cases can be found here.

Background

Monkeypox is a rare zoonotic orthopoxvirus with similar symptoms and presentation to smallpox, but with a much lower mortality rate of approximately 1%. It is a hazard group 3 organism (ACDP/HSE), Primarily occurring in Central and West Africa, exported cases have been linked to travel in recent years.

New NHSEI working guidance on the management of Monkeypox cases can be found in the attached document.

Presentation

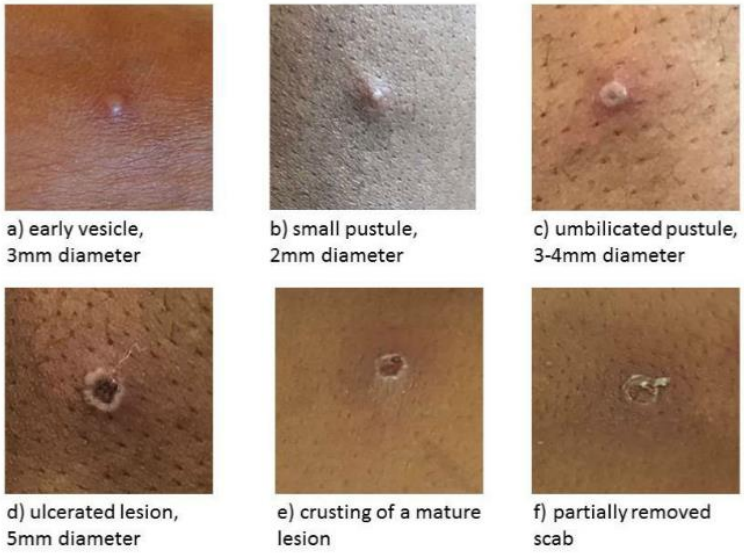
The symptoms of monkeypox begin 5-21 days after exposure, with an initial clinical presentation of:

- Fever.
- Headache.
- Muscle aches.
- Backache.
- Swollen lymph nodes.
- Chills.
- Exhaustion.

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:

- Areas of erythema and/or skin hyperpigmentation are often seen around discrete lesions.
- Lesions can vary in size and may be larger than those shown.
- Lesions of different appearances and stages may be seen at the same point in time.
- Detached scabs may be considerably smaller than the original lesion.

Figure 1 - Development of Monkeypox Rash



a) early vesicle, 3mm diameter

b) small pustule, 2mm diameter

c) umbilicated pustule, 3-4mm diameter

d) ulcerated lesion, 5mm diameter

e) crusting of a mature lesion

f) partially removed scab

In some of the new cases, the rash has presented on genitals and occurred before the fever prodrome.

The rash is sometimes confused with chickenpox. It starts as raised spots, which turn into small blisters filled with fluid. These blisters eventually form scabs which later fall off.

The symptoms usually resolve in 2 to 4 weeks.

Transmission

Monkeypox does not spread easily between people. It may occur when a person comes into close contact with an animal (rodents are believed to be the primary animal reservoir for transmission to humans but monkeypox is not found in UK rodents at present), human, or materials contaminated with the virus.

The virus enters the body through broken skin (even if not visible), the respiratory tract, or the mucous membranes (eyes, nose, or mouth). Person-to-person spread is uncommon, but may occur through:

- Contact with clothing or linen (such as bedding or towels) used by an infected person.
- Direct contact with monkeypox skin lesions or scabs.
- Coughing or sneezing of an individual with a monkeypox rash.

It is not a sexually transmitted disease but may be spread by close skin contact during sexual activity.

Infection Prevention and Control

Monkeypox is a hazard group 3 organism (ACDP/HSE). Other organisms in this category include Salmonella typhi, HIV, Hepatitis B and C, and Mycobacterium tuberculosis that are managed routinely in the community. High Consequence Infectious Disease is not a legal classification but is instead agreed by a UKHSA and NHS programme to enable a consistent approach to infections that meet agreed criteria. Frontline operational ambulances may transport these patients.

This proposal is to ensure a proportionate response to deliver on achievable strategic outcomes. These principles do not replace the need for local dynamic risk assessments which remain key.

Based on the level of exposure and risk assessment consideration of the hierarchy of controls will help determine the level of personal protective equipment (PPE) to use.

PPE Requirements for Possible/Probable and Confirmed Cases.

Minimum PPE required for:	PPE
Any individual presenting with an unexplained rash/symptoms suggesting possible MPX.	• A disposable, fluid-resistant apron • An FRSM (Type IIR)[1] • A visor/eye protection (if there is a risk of spraying/splashing), and • Single pair of disposable gloves
Any confirmed MPX, or probable case with respiratory symptoms and/or with severe disease and/or extensive vesicular lesions Or inpatient management of a case, which requires close clinical contact.	• A disposable, fluid-resistant gown (coveralls may be worn in some settings e.g. ambulance) • An FFP3 respirator (fit-tested and fit-checked) or equivalent e.g. powered air purifying respirator (PAPR)[1] • A full face visor[1] • Single pair of disposable gloves

1*Please note many FFP3 respirators are not fully fluid-resistant, therefore a full face visor is recommended.

If appropriate, the patient should be asked to wear a FRSM where respiratory symptoms and/or cough is present.

For ambulatory well possible, probable or confirmed cases with limited lesions, covering lesions and wearing a face covering/mask reduces the risk of onwards transmission.

Waste including PPE:

• Waste including PPE worn in the care episode for a possible/probable case; can be disposed of within the infectious waste stream. Waste may be quarantined whilst waiting for a case result to determine which waste stream to use.

• Waste including PPE worn in the care episode for a confirmed case; must be disposed of as Category A waste.

Linen:

All linen generated in the care of possible, probable, or confirmed MPX must be managed as infectious linen and bagged into a water soluble or soluble seam (alginate) bag then placed into a polythene bag or impermeable sack.

Decontamination

• Following convey of a possible case; carefully clean all equipment and vehicle environment with combined detergent/disinfectant wipe wipes and allow to air dry.

- For the convey of a highly probable (displaying extensive symptoms including weeping pustules and respiratory symptoms) or confirmed cases, vehicles must be initially cleaned using a detergent/disinfect wipe followed by a solution of 1,000ppm av.cl. (or alternative locally agreed cleaning product).

- PPE for cleaning should match the level of PPE for clinical patient care.

Furter information and guidance can be found on UKHSA and NHSE websites. If you have any questions please speak to your trust IPC lead.

Ref:
https://www.gov.uk/government/publications/principles-for-monkeypox-control-in-the-uk-4-nations-consensus-statement

C1636-national-ipc-manual-for-england-v2.pdf 8/6/22 Updated