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To:
Trust Chief Executives
HSC Trusts Medical Directors
HSC Trusts Directors of Nursing
Primary Care GPs
Community Pharmacists
Out of Hours GPs
Northern Ireland Ambulance Service
RQIA (for onward distributions to providers)

15th August 2024

Dear Colleagues,

EMERGING CLADE I MPOX OUTBREAK DECLARED AS PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN

The purpose of this letter is to share information about the emerging Clade I mpox outbreak in Central Africa after the World Health Organization's (WHO's) Director-General declared the outbreak a public health emergency of international concern on 14th August 2024.

I wanted to provide further detail on the implication of this and to make you aware of a recent UK Health Security Agency (UKHSA) briefing note and highlight how this affects management going forward. The UKHSA briefing note is attached for information.

I would be grateful if you could bring this letter to the attention of your clinical teams particularly ED and infectious diseases (adults and paediatrics), GUM, laboratory services, infection control, occupational health, and any other services which may come into contact with potential mpox cases in Northern Ireland.

Background and Epidemiology

There has been a rise in cases of mpox in the in the Democratic Republic of the Congo (DRC) and a growing number of countries in Africa. The WHO have determined that there is the potential of further spread across countries in Africa, and possibly outside the continent. At the time of writing a single case of Clade 1 mpox has been confirmed in Sweden, the firs outside Africa. The overall risk to the population of Northern Ireland is currently assessed as low.

Mpox virus (MPXV) can be divided into two broad virological groups (or 'Clades'): Clade I and Clade II. Clade I mpox virus is designated a 'high consequence infectious disease' (HCID) and has been reported to cause more severe mpox disease with a higher case fatality rate. Mpox cases diagnosed within the UK since 2022 have all been Clade II which is not an HCID. No cases of Clade I mpox have been identified in the UK to date.

Clinical features

Symptoms of mpox begin 5-21 days (average 6-16 days) after exposure with initial clinical presentation of:

- a febrile prodrome†
- Rash/unexplained lesions, including but not limited to: genital, ano-genital or oral lesion(s): for example, ulcers, nodules or
- Proctitis: for example anorectal pain, bleeding

†Febrile prodrome consists of fever ≥ 38°C, chills, headache, exhaustion, muscle aches (myalgia), joint pain (arthralgia), backache, and swollen lymph nodes (lymphadenopathy).

Source: Mpox (monkeypox): case definitions - GOV.UK (www.gov.uk) (accessed 15/08/24)

Implications for the health service in Northern Ireland

Travel history is key to the current case definition for risk assessing Clade I mpox cases. Clinicians should be alert to the possibility of mpox and, in particular Clade I mpox where there is a link to specific countries in the African region listed below:

Case definition for Clade I mpox disease (HCID)

The following patients should be managed as HCID cases:

- Confirmed mpox case where Clade I has been laboratory confirmed
- Confirmed or clinically suspected mpox case but Clade not yet known

  and

  - there is a travel history to the DRC or specified countries where there may be a risk of Clade I exposure

    or

  - a link to a suspected case from those countries (listed below*), within 21 days of symptom onset

    and/or

  - there is an epidemiological link to a case of Clade I mpox within 21 days of symptom onset.

*The countries **currently** on this list are those where Clade I cases have been reported, as well as countries bordering those with ongoing Clade I transmission. They include the DRC, Republic of Congo, Central African Republic, Burundi, Rwanda, Uganda, Kenya, Cameroon, Gabon, Angola, South Sudan, Tanzania, and Zambia.

This case definition and up to date country list is available here.

Given the rapid spread of Clade I in the African region and the likelihood this list of countries will change, please check the UKHSA mpox pages on the link above regularly for any updates to the countries included.

Cases meeting HCID definition

- Cases that meet the above case definitions should be treated as an HCID.
- All cases meeting the case definition where Clade I mpox is suspected should be discussed with an Infectious Diseases consultant. For adults (aged 16+ years) contact BHSCT switchboard and ask for ward 7A. For cases aged <16 years contact RBHSC switchboard and ask for Belvoir ward.

- Additionally, discuss any patient with suspected mpox and severe or disseminated disease with an Infectious Diseases consultant by contacting BHSCT switchboard, **even if no travel history is identified**. For adults (aged 16+ years) contact BHSCT switchboard and ask for ward 7A. For cases aged <16 years contact RBHSC switchboard and ask for Belvoir ward.
- For cases that meet the above case definitions clinical and infection prevention pathways necessary for HCID should be followed.

Cases not meeting HCID definition

- Confirmed or clinically suspected mpox cases where all of the following conditions apply can be managed using standard mpox precautions and do not require HCID precautions:
    - there is no history of travel to the DRC or specified countries within 21 days of symptom onset (check up to date country list)
    - there is no link to a suspected case from the DRC or specified countries within 21 days of symptom onset

Laboratories are requested to send **all** mpox positive samples tested locally to UKHSA's Rare and Imported Pathogens Laboratory (RIPL) for Clade differentiating tests regardless of whether Clade I is suspected.

Actions for primary and secondary care

- Be **alert** to the possibility of Clade I mpox in all patients with suspected mpox if there is a link to the specified countries those listed referenced in the case definition box above.
- **Isolate** patients meeting the case definition of Clade I mpox disease and contact the Infectious Diseases service (via BHSCT or RBHSC switchboard as described above) to discuss urgent testing, typing, and clinical management.
- Have a low threshold for suspecting mpox in patients with clinically compatible presentations with a travel history irrespective of sexual history.
- Discuss any patient with suspected mpox and severe or disseminated disease with the Infectious Disease service, even if no travel history is identified.

- Notify the Public Health Agency Health Protection Team on suspicion of all mpox cases.

Actions for laboratories

- Send all mpox positive samples tested locally to UKHSA's Rare and Imported Pathogens Laboratory (RIPL) for Clade differentiating tests, regardless of whether Clade I is suspected.

We expect further guidance is expected to be available soon e.g. for returning healthcare workers from the designated list of countries above*.

If you have any queries regarding the content of this letter please contact the Public Health Agency Health Protection Team on 0300 555 0119 or pha.dutyroom@hscni.net.

As more information becomes available and the epidemiological situation evolves, recommendations may change and we will communicate this with you. We recognise healthcare staff are incredibly busy at this time, and we are very grateful for your continued support.

Yours sincerely,

Dr Joanne McClean

Director of Public Health

Cc: Sharon Gallagher (Deputy Secretary, SPPG), Paul Cavanagh (Director of hospital service, SPPG), Teresa Magirr (AD specialist services, SPPG).