No.F.1-22/Advisory/CDC/2024
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National Focal Point for International Health Regulations

15th August 2024

Subject: **Advisory on the Unprecedented Multi-country Mpox Outbreak in Non-Endemic Countries**

Recently, a rapid spread of new clade of Mpox cases has been observed in eastern DRC, neighboring countries that had not previously reported Mpox. Currently, this disease has been reported in all WHO regions including 122 countries with a total of 99,518 confirmed cases and 208 deaths till date. While in Pakistan, a total of 11 cases with 01 death has been reported since first cases detected in April, 2023. World Health Organization has declared Mpox as the Public Health Emergency of International Concern (PHEIC) on 14 August 2024. It is worthwhile to mention here that Mpox has previously been declared PHEIC in 2022 by WHO.

Objectives:

This advisory aims to provide global and country-wide situation of Mpox disease, to facilitate and provide directions for all the relevant stakeholders on prevention, early detection and response to Mpox.

Background:

Mpox is a rare viral zoonotic disease that is caused by infection with Mpox virus. Although natural reservoir of Mpox remains unknown however, African rodents and non-human primates (like monkeys) may harbor the virus and infect people. The patient develops a rash within 1 to 3 days after the appearance of fever, often beginning on the face then spreading to other parts of the body. Lesions progress through these stages before falling off: Macules→Papules→Vesicles→Pustules→Scabs. Other symptoms include headache, muscle aches, exhaustion and lymphadenopathy. The incubation period is usually 7−14 days but can range from 5−21 days. The illness typically lasts for 2−4 weeks.

There are two types of Mpox virus: **clade I** (Congo Basin) and **clade II** (West African). Clade I which is more associated with recent upsurge causes more severe illness and deaths. Some outbreaks have killed up to 10% of the people who get sick, although more recent outbreaks have had lower death rates. Clade I is endemic to Central Africa. Clade II is the type that is involved in

global outbreak since in 2022. Infections from clade II Mpox are less severe. More than 99.9% of people survive. Clade II is endemic to West Africa.

Transmission:

Transmission occurs via contact with infected animal, human, or materials contaminated with the virus. The virus enters the body through broken skin (even if not visible), respiratory tract, or the mucous membranes (eyes, nose, or mouth). Other human-to-human methods of transmission include direct or indirect contact with body fluids, lesion material or through contaminated clothing or linens.

Case Definitions:

Suspected Cases: Any person having skin rash/lesion (may include single or multiple oral, conjunctival, urethral, penile, vaginal, or ano-rectal lesions) with or without fever (>38.3°C), headache, lymphadenopathy, myalgia (muscle pain/body aches), back pain, profound weakness, any respiratory symptom and fatigue. Contact of probable/confirmed case developing febrile prodromal illness compatible with Mpox including Sexual and vertical transmission.

Probable case: A suspected case with an epidemiological link to confirmed cases or probable case during last 21 days.

Confirmed case: A person with laboratory confirmed MPXV infection by detection of unique sequences of viral DNA by real-time polymerase chain reaction (PCR) and/or sequencing.

Specimen Collection, transportation and Confirmation:

The recommended specimen type for laboratory confirmation of Mpox virus is skin lesion material, including swabs of lesion surface and/or exudate, roofs from more than one lesion, or lesion crusts. Lesions swabs, crusts and vesicular fluids should not be mixed in the same viral transport medium (VTM). The collected specimen should be transported to the designated laboratory with triple packaging maintaining cold chain accompanied by case summary. Moreover, the positive samples should be sent to virology lab-NIH for genomic sequencing.

Case Management:

Case management of a confirmed Mpox patient involves several steps to ensure proper treatment and prevent the spread of the virus including:

Isolation: The patient should be isolated in a single room with a private bathroom and provided with appropriate personal protective equipment (PPE) to prevent transmission of the virus to healthcare workers and other patients.

Symptomatic treatment: Treatment for Mpox is primarily supportive and symptomatic. Patients should be given antipyretics for fever, analgesics for pain relief, and fluids to maintain hydration. There is no specific antiviral treatment for Mpox, but some antiviral medications, such as cidofovir as advised by the physician, have shown efficacy in treating severe cases.

Infection prevention and control:

Strict infection prevention and control measures should be followed, including hand hygiene, environmental cleaning, and disinfection. Healthcare workers should wear appropriate PPE at all times when caring for the patient. However, close contacts of the patient should be identified, monitored for symptoms, and isolated if necessary. 6. Public health reporting: Confirmed cases of Mpox must be reported to local district and provincial health departments, who will provide guidance on additional measures to prevent the spread of the virus.

The situation has urged other countries to enhance surveillance and vigilance. NCOC- NIH is monitoring the situation and will keep the stakeholders updated. Please contact NIH for any further information / clarification. However, revised updated guidelines for Mpox are available at website (www.nih.org.k)

For any further assistance in this context, the Center for Disease Control (CDC-NIH) (051-9255237 and Fax No. 051-9255099) and Virology Department of Public Health Laboratories Division (051-9255082), NIH may be contacted.

The above 'advisorY' may please be circulated widely to all concerned.

(Dr. Mumtaz Ali Khan)
Chief-CDC/ Coordinator- NCOC
National Institute of Health

Distribution Overleaf

Distribution List:

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59. Medical Superintendent, IHITC, Islamabad
60. Officer In-charge, Provincial Disease Surveillance & Response Unit (PDSRU) at Provincial Health Directorates, Lahore, Hyderabad, Peshawar, Quetta, Gilgit and Muzaffarabad
61. All Deputy Commissioners with the request to direct all concerned departments at district level.

C.c:

1. Chief Secretary, Govt of Punjab, Sindh, KPK, Balochistan, GB and AJK.
2. Surgeon General Pakistan Army, GHQ Rawalpindi
3. Chief Commissioner, ICT Administration Islamabad
4. WHO Country Representative, Islamabad
5. SPS to Federal Minister of Health, M/o NHSR&C, Islamabad
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