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சுகாதார அமைச்சு
Ministry of Health

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Date)

Deputy Director General – NHSL

Deputy Director General – NH Kandy

Provincial Directors of Health Services

Regional Directors of Health Services

Directors and Superintendents of Teaching, Provincial General, District General, and Base hospitals

Heads/Directors of Health Institutions

Surveillance, notification, investigation, and laboratory testing of cases of (monkeypox) mpox virus

Mpox has been reported in the Democratic Republic of the Congo (DRC) for more than a decade, and the number of cases reported each year has increased steadily. Last year, reported cases increased significantly, and the number of cases reported so far this year has exceeded last year's total. On 14th August 2024, considering the upsurge of mpox in the Democratic Republic of the Congo (DRC) and a growing number of countries in Africa WHO Director-General declared a public health emergency of international concern (PHEIC) under the International Health Regulations (2005) (IHR).

Accordingly, measures must be taken to strengthen surveillance activities, to promptly identify, notify, and manage any suspected cases of mpox virus to prevent the introduction and onward spread in the country.

1. Surveillance case definitions and notification of cases

The case definitions of suspected, probable, and confirmed cases of mpox are attached to aid in the identification of cases (Annexure 1). Once a suspected case is identified, all healthcare institutions should report immediately to the Chief Epidemiologist, Epidemiology Unit through any of the numbers mentioned below:

Tel No: **011-2695112, 011-2681548**

Further, the Epidemiology Unit can be contacted for any clarifications and/or assistance.

2. Hospital admission

Hospital admission of mpox suspected/probable case should be decided by a clinician following a thorough evaluation of the patient.

3. Contacts and contact tracing

As soon as a suspected case is identified, contact tracing should be initiated by the public health authorities with the guidance of the Epidemiology Unit.

3.1 Definition of a contact

A contact is defined as a person who has been exposed to a person with suspected (clinically compatible), probable or confirmed mpox during the infectious period and who has one or more of the following exposures:

- direct skin-to-skin, skin-to-mucosal or mouth-to-mucosal physical contact (such as touching, hugging, kissing, intimate oral or other sexual contacts)
- contact with contaminated materials such as clothing or bedding, including material dislodged from bedding or surfaces during handling of laundry or cleaning of contaminated rooms
- prolonged face-to-face respiratory exposure in close proximity (inhalation of respiratory droplets and possibly short-range aerosols)
- respiratory (i.e., possible inhalation) or mucosal (e.g., eyes, nose, mouth) exposure to lesion material (e.g., scabs/crusts) from a person with mpox
- The above also apply for health workers potentially exposed in the absence of proper use of appropriate personal protective equipment (PPE).

3.2 Contact monitoring

Contacts should be monitored at least daily for the onset of signs/symptoms for a period of 21 days from the last contact with a patient or their contaminated materials during the infectious period. Signs/symptoms of concern include headache, fever, chills, sore throat, malaise, fatigue, rash, and lymphadenopathy. Contacts should monitor their temperatures twice daily. Asymptomatic contacts should not donate blood, cells, tissue, organs, breast milk, or semen while they are under symptom surveillance. Asymptomatic contacts can continue routine daily activities such as going to work and attending school (i.e., no quarantine is necessary). Although evidence on pre-symptomatic or asymptomatic transmission is still emerging and not conclusive, known contacts of confirmed or if not tested, clinically compatible, cases are

advised to avoid sexual contact with others during the 21-day monitoring period, irrespective of their symptoms.

A contact who develops initial signs/symptoms other than rash should be isolated and closely watched for signs of rash for the next seven days. If no rash develops, the contact can return to temperature monitoring for the remainder of the 21 days. If the contact develops a rash, they need to be isolated and evaluated as a suspected case, and a specimen should be collected for laboratory analysis to test for mpox.

4. Specimen collection, shipment, and storage for mpox Real-time PCR assay for the detection of mpox virus

4.1 Indication for testing

Mpox testing facilities are available at the Medical Research Institute. Any individual meeting the case definition for a suspected case should be offered testing. The decision to test should be based on both clinical and epidemiological factors, linked to an assessment of the likelihood of infection. It is recommended to consult the Department of Virology, Medical Research Institute **(011- 269 3532-34, 011-269 7280)** before sending samples to the Medical Research Institute.

4.2 Specimen collection, shipment, and storage safety procedures

All specimens collected for laboratory investigations should be regarded as potentially infectious and handled with caution. These should include wearing appropriate PPE, using rigorously applied standard precautions, and avoiding any procedures that could generate infectious aerosols.

4.3 Specimen to be collected

The recommended specimen type for laboratory confirmation of mpox is skin lesion material, including swabs of lesion surface and/or exudate, roofs from more than one lesion, or lesion crusts. Swab (Dacron or polyester flocked swabs with VTM or dry swab) the lesion vigorously, to ensure the adequate virus is collected. Both dry swabs and swabs placed in viral transport media (VTM) can be used. Swabs from the two lesions should be collected in one single tube, preferably from different locations on the body which differ in appearance.

Vesicular fluid can be sent in a VTM tube or as the sealed syringe used to collect the fluid. Lesions, crusts, and vesicular fluids should not be mixed in the same tube.

4.4 Specimen transport

The specimen should be transported to the laboratory at 2 to 8°C (refrigerate) as soon as possible (Should be transported in -20 ^{0}C or lower temperature if the delay is expected to be >7 days). The specimen should be transported as a 'Triple package.'

4.5 Specimen storage

Specimens collected for the mpox virus investigation should be refrigerated (2 to 8°C) within 24 hours after collection. If transport exceeds 7 days for the sample to be tested, specimens should be stored at -20°C or lower.

Triple pack all specimens in:

- Leakproof primary receptacle; multiple primary receptacles should be individually wrapped or separated
- Leakproof secondary receptacle, and
- Rigid outer packaging

If the specimen is a liquid, place absorbent material between the primary and secondary receptacle. Place a list of contents and paperwork between the secondary receptacle and outer packaging.

Label outer packaging with:

- Infectious substance
- Shipper and consignee identification (name, address, and telephone)
- Package orientation arrows

Brief Guideline for sample collection and transport for mpox Real-time PCR

	Description
Request form (Annexure 2)	A very brief history is mandatory for highlighting 1. Clinical features: acute fever, skin and mucosal rash, lymphadenopathy, conjunctivitis, headache, myalgia, arthralgia, anorectal pain/bleeding 2. Travel history to high-risk countries (West & Central African countries) 3. Day of illness that the sample was collected for mpox virus testing 4. Any other investigations done for viral infections: Herpes simplex Virus, Varicella zoster virus, Enterovirus infection Fill in all the other fields in the request form very clearly. The container should be properly labelled
Specimen type/ container and collection material	Skin/mucosal lesion material, including: Swabs of lesion exudate Lesion roofs Lesion crust Vesicular fluid Dacron or polyester flocked swabs with VTM or dry swab in the triple package. Alternatively, if skin/mucosal lesions are absent, but with strong epidemiological link, oropharyngeal swabs (Dacron or polyester flocked swabs with VTM) can be sent after discussing with the virology lab MRI.
Transport and short-term storage	The specimen should be transported to the laboratory at 2 to 8°C (refrigerate) as soon as possible (if the expected delay is > 7 days, store, and transport at -20°C). Should be transported as a 'Triple package'
Safety procedures for collection	Appropriate PPE, using standard precautions and avoiding any procedures that could generate infectious aerosols.

(Reference: WHO Laboratory testing for the mpox virus: Interim guidance. 10th May 2024)

5. Infection prevention and control of mpox in healthcare settings

i. Standard precautions should be applied for all patient care for patients with suspected mpox.

ii. If a patient seeking care is suspected to have mpox, an Infection Prevention and Control Nursing Officer (ICNO) should be notified immediately.

iii. A patient with suspected or confirmed mpox infection should be placed in a separate area of the ward

iv. Wear PPE including gloves, gown, face mask, and eye protection when closely working with a confirmed mpox patient.

Please bring the contents of this letter to the attention of relevant officers in your institution/ province/ district.

Dr. P.G. Mahipala
Secretary/ Ministry of Health

Dr. P. G. Mahipala
Secretary
Ministry of Health
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Cc:
Additional Secretary/Public Health Services
Additional Secretary/Medical Services
Director General of Health Services
DDG/PHS I
DDG/MS 1
DDG/MS II
DDG/Laboratory Services
Director/MRI
Director/National Blood Transfusion Service
Chief Epidemiologist

Annexure 1- Case Definitions

Suspected case:

i) A person who is a contact of a probable or confirmed mpox case in the 21 days before the onset of signs or symptoms, and who presents with any of the following: acute onset of fever (>38.5°C), headache, myalgia (muscle pain/body aches), back pain, profound weakness, or fatigue.

OR

ii) A person presenting with an unexplained acute skin rash, mucosal lesions or lymphadenopathy (swollen lymph nodes). The skin rash may include single or multiple lesions in the anogenital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Anorectal lesions can also manifest as anorectal inflammation (proctitis), pain and/or bleeding.

AND for which the following common causes of acute rash or skin lesions do not fully explain the clinical picture: varicella zoster, herpes zoster, measles, herpes simplex, bacterial skin infections, disseminated gonococcus infection, primary or secondary syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, molluscum contagiosum, allergic reaction (e.g., to plants); and any other locally relevant common causes of papular or vesicular rash.

N.B. *It is not necessary to obtain negative laboratory results for listed common causes of rash illness in order to classify a case as suspected. Further, if suspicion of mpox or MPXV (monkeypox virus) infection is high due to either history and/or clinical presentation or possible exposure to a case, the identification of an alternate pathogen that causes rash illness should not preclude testing for MPXV, as co-infections have been identified.*

Probable case:

A person presenting with an unexplained acute skin rash, mucosal lesions or lymphadenopathy (swollen lymph nodes). The skin rash may include single or multiple lesions in the anogenital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Anorectal lesions can also manifest as anorectal inflammation (proctitis), pain and/or bleeding.

AND One or more of the following:

- has an epidemiological link to a probable or confirmed case of mpox in the 21 days before symptom onset
- has had multiple and/or casual sexual partners in the 21 days before symptom onset
- has a positive test result for orthopoxviral infection (e.g., OPXV-specific PCR without MPXV-specific PCR or sequencing)

Confirmed case:

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

Annexure 2:

DEPARTMENT OF VIROLOGY, MEDICAL RESEARCH INSTITUTE, COLOMBO

MRI No:

Monkeypox Real time PCR Request Form

Mode of transport: In **triple package**, within 24 hours

Name: ..... Age: .....

Institution: ..... Gender: M/F

Address: ..... Ward/ ICU:

Pregnancy: Yes/ No, POA:.....

Occupation: ..... BHT No: .....

Lab use only
Fitting to case definition
Yes ☐
No ☐

Date of sample collection: .....

Sample type (circle): Lesion roof or crust/ vesicular fluid/ swabs of lesion / Nasopharyngeal & oropharyngeal swab
(Dacron or polyester flocked swabs/in plastic container)

Date of arrival to Sri Lanka: .....

Travel history (Mandatory): Yes /No

If yes which country:.....

Exposure to confirmed/probable case: Yes/No Date of exposure: .....

Co-morbid conditions: DM/ HIV or other STDs/ IHD/ HT /CKD/ malignancy/transplant

Temperature >38°C	Yes	No	**If lesion or rash "yes" distribution:**
Lesion or Rash	Yes	No	
Lymphadenopathy	Yes	No	
Myalgia	Yes	No	
Any other symptoms:			

Investigations: VZV/Herpes/ any STDS/Bacterial infections

Name of the Clinician/HO/SHO: .....

Contact telephone number.....

Note: the request may be rejected if this form is not filled properly & the specimen is not transported properly.

FOR LABORATORY USE ONLY

Date of sample receive: ..... In triple package: Yes/No Properly labeled: Y/N

Condition of the sample: Leaking/Not labeled/.....

Results: Positive / negative (date and time) .....