Risk Assessment Group

CONSULTATIVE SIGNAL ASSESSMENT
PRIMARY RISK ASSESSMENT
EVIDENCE BASED RISK ASSESSMENT
PUBLIC HEALTH EVENT ASSESSMENT

MONKEYPOX MULTI-COUNTRY OUTBREAK, MAY 2022

Date of the signal	Date of the PRA	Signal provider	Experts consulted	Method
07/05/2022: first case UK (imported) **17/05/2022: cases in second country**	**17/05/2022**	UK/ECDC/ Portugal	Leïla Belkhir (UCLouvain), Caroline Boulouffe (AViQ), Isabel Brosius (ITG), Wouter Dhaeze (AZG), Naïma Hammami (AZG), Niel Hens (UHasselt), Yves Lafort (Sciensano), Sanne Lenaerts (FOD), Tinne Lernout (Sciensano), Agnes Libois (CHU-St Pierre), Romain Mahieu (COCOM), Charlotte Martin (CHU-St Pierre), Christelle Meuris (ULiège), Javiera Rebolledo (Sciensano), Carole Schirvel (Chirec), Patrick Soentjens (ITG), Dominique Van Beckhoven (Sciensano), Marjan Van Esbroeck (ITG), Koen Vercauteren (ITG), Erika Vlieghe (UZ Antwerpen), Dirk Wildemeersch (AZG), Jean Cyr Yombi (UCLouvain).	**E-mail** consultation 17/05/2022 **Meeting** 20/05/2022 24/05/2022 31/05/2022
Date of update	**Closing date**			
20/05/2022 **24/05/2022** **31/05/2022**				

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Signal	Since 13 May 2022, cases of monkeypox have been reported in different countries worldwide, without travel link to endemic areas. Cases have mainly but not exclusively been identified amongst men who have sex with men (MSM).

UPDATE 31/05/2022

Epidemiological situation

On May 30, a total of 10 confirmed and 2 probable cases have been identified in Belgium. Other possible cases are pending a test result.
All cases are MSM, aged 28 to 43 years. The source of infection is travel to another country (and participation to events there) for 4 persons (1 in Portugal and 3 in Spain); a very-high-risk contact in the household for 1 person; participation to the Darklands event (4,500 participants, 20% Belgian) the first week of May for 6 cases and still under investigation for one.

Worldwide, 555 confirmed cases have been reported as of 31 May (Source: Our World in data). Most cases have been reported in EU/EEA countries, with the highest numbers in Spain and Portugal. Outside the EU, the highest number was reported by the UK. Cases were also reported by Argentina, Australia, Canada, Israel, Mexico, Switzerland, the United Arab Emirates and the US.

Risk evaluation

The **risk evaluation** for human to human transmission remains unchanged.

The Federal Agency for the Safety of the Food Chain (AFSCA-FAVV) estimates the risk of transmission from humans to animals as very low. As measure of precaution, cases and high-risk contacts are recommended to avoid contacts with any mammal pets, and in particular pet rodents.

In a preprint paper, modellers from the US conclude that, with no public health emergency interventions, the introduction of monkeypox infected individuals could lead to small national outbreaks of moderate duration; ultimately, the outbreaks would all subside. Contact tracing and isolation of symptomatic cases, or contact tracing, isolation of symptomatic cases and ring vaccination of the primary case contacts would substantially reduce the median size of outbreaks by 66.1—88.6% and median duration by 60.8–75.6%.

Recommendations

- The case definition of a possible case is extended to include also persons with exposure to a case and presenting with prodromal symptoms (before the rash):
  A person with an unexplained generalised or localised maculopapular or vesiculopustular rash with centrifugal spread, with lesions showing umbilication or scabbing, lymphadenopathy and one or more other MPX-compatible symptoms*
  OR one or more MPX-compatible symptoms in a high-risk contact person
  OR one or more MPX-compatible symptoms in a health care worker HCW who had contact with a MPX case (lesions or prolonged face-to-face contact), independent of appropriate PPE (low or high-risk contact).

- The preferred sample type for diagnosis remains a swab of the lesions, if present. Throat swabs and blood samples can be used if there are no lesions (yet). In case of anal or rectal lesions, an anal swab is also useful. The latter is also interesting for research purposes, but in absence of a clinical indication, an Informed Consent is needed to allow taking such a sample.
- Information to GPs has been sent through different channels, but it seems that mails and letters are often not read. Providing more information through webinars could be a useful complementary tool, if there is interest from GP associations. Such a webinar should focus on where to find useful information (Sciensano website) and the current recommendations: information to collect by phone for a suspected case, correct PPE if physical consultation, referral to an emergency ward of a hospital (if possible one from the list of referral centers) and follow-up of a case in isolation. GPs should still not take samples for diagnosis themselves. Webinars could also be useful for dermatologists.
- It could be useful to have a (printed) document with guidelines for cases (e.g. similar to the hygiene advice document for COVID-19 cases). In Flanders, this information is already available online: https://www.zorg-en-gezondheid.be/apenpokken-monkeypox.

SOURCES OF INFORMATION

1. https://ourworldindata.org/monkeypox

2. ECDC. Epidemiological updates. https://www.ecdc.europa.eu/en/news-events/epidemiological-update-monkeypox-multi-country-outbreak

3. D. Bisanzia & R. Reithinger. Keep Calm and Carry On: Projected Case Burden and Duration of the 2022 Monkeypox. Outbreak in Non-endemic Countries. https://doi.org/10.1101/2022.05.28.22275721