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சுவசிரிபாய

**SUWASIRIPAYA**  
**සෞඛ්‍ය අමාත්‍යාංශය**  
**சுகாதார அமைச்சு**  
**Ministry of Health**

මගේ අංකය ) EPID/Monkeypox /2022  
எனது இல )  
My No. )

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உமது இல )  
Your No. : )

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திகதி ) 5.08.2022  
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 virus**

On July 23, the escalating global monkeypox outbreak was declared a Public Health Emergency of International Concern (PHEIC) by WHO. Accordingly, measures have to be taken to strengthen surveillance activities to identify, notify and manage any suspected cases of monkeypox virus promptly to prevent onward spread in the country.

**1. Surveillance case definitions and notification of cases**

The case definitions of suspected, probable, and confirmed cases of monkeypox 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 may be contacted for any clarifications and/or assistance.

## **2. Hospital admission**

Hospital admission of monkeypox 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, in the period beginning with the onset of the source case's first symptoms, and ending when all scabs have fallen off, has had one or more of the following exposures with a probable or confirmed case of monkeypox:

- face-to-face exposure (including health care workers without appropriate PPE)
- direct physical contact, including sexual contact
- sharing the contaminated materials such as clothing or bedding

### **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), but should remain close to home for the duration of surveillance. It may, however, be prudent to keep pre-school children away from daycare, nursery, or other group settings.

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 monkeypox.

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

### **4.1 Indication for testing**

Monkeypox 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 monkeypox 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 floccated 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 °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 monkeypox 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 monkeypox Real-time PCR

	Description
Request form (Annexure 2)	<p>A very brief history is mandatory for highlighting</p> <ol style="list-style-type: none"> <li>1. Clinical features: acute fever, rash, lymphadenopathy, conjunctivitis, headache, myalgia, arthralgia</li> <li>2. <u>Travel history to high-risk countries (West &amp; Central African countries)</u></li> <li>3. Day of illness that the sample was collected for monkeypox virus testing</li> <li>4. Any other investigations done for viral infections: Herpes simplex Virus, Varicella zoster virus, Enterovirus infection</li> </ol> <p>Fill in all the other fields in the request form very clearly.</p> <p>The container should be properly labelled</p>
Specimen type/ container and collection material	<p>Skin lesion material, including: Swabs of lesion exudate Lesion roofs Lesion crust Vesicular fluid</p> <p>Dacron or polyester flocked swabs with VTM or dry swab in the triple package</p>
Transport and short-term storage	<p>The specimen should be transported to the laboratory at <u>2 to 8°C</u> (refrigerate) as soon as possible (if the expected delay is &gt; 7 days, store, and transport at -20°C). Should be transported as a 'Triple package'</p>
Safety procedures for collection	<p>Appropriate PPE, using standard precautions and avoiding any procedures that could generate infectious aerosols.</p>

(Reference: WHO Laboratory testing for the monkeypox virus: Interim guidance. 23. May 2022)

## 5. Infection prevention and control of monkeypox in healthcare settings

- i. Standard precautions should be applied for all patient care for patients with suspected monkeypox.
- ii. If a patient seeking care is suspected to have monkeypox, an Infection Prevention and Control Nursing Officer (ICNO) should be notified immediately.
- iii. A patient with suspected or confirmed monkeypox infection should be placed in a separate area of the ward
- iv. Wear PPE including gloves, gown, a respirator (e.g., N95, FFP2), and eye protection when closely working with a confirmed monkeypox patient.

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



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Director General of Health Services

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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

The case definitions for use in this outbreak may be reviewed as additional information becomes available

### **Suspected case:**

A person of any age presenting since 01 January 2022 with an unexplained acute rash or one or more acute skin lesions

AND

one or more of the following signs or symptoms:

- Headache
- Acute onset of fever ( $>38.5^{\circ}\text{C}$ )
- Lymphadenopathy (swollen lymph nodes)
- Myalgia (muscle pain/body aches)
- Back pain
- Asthenia (profound weakness) 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 monkeypox infection is high due to either history and/or clinical presentation or possible exposure to a case, the identification of an alternate pathogen which causes rash illness should not preclude testing for MPXV, as coinfections have been identified.*

### **Probable case:**

A person meeting the case definition for a suspected case

AND

One or more of the following:

- has an epidemiological link [prolonged<sup>a</sup> face-to-face exposure in close proximity, including health workers without appropriate PPE (gloves, gown, eye protection and respirator)<sup>3</sup>; direct physical contact with skin or skin lesions, including sexual contact; or contact with contaminated materials such as clothing, bedding or utensils] to a probable or confirmed case of monkeypox in the 21 days before symptom onset
- has had multiple or anonymous sexual partners in the 21 days before symptom onset
- has detectable levels of anti-orthopoxvirus (OPXV) IgM antibody<sup>b</sup> (during the period of 4 to 56 days after rash onset); or a four-fold rise in IgG antibody titre based on acute (up to day 5-7) and convalescent (day 21 onwards) samples; in the absence of a recent smallpox/monkeypox vaccination or other known exposure to OPXV
- has a positive test result for orthopoxviral infection (e.g. OPXV-specific PCR without MPXV-specific PCR or sequencing)<sup>c</sup>

**Confirmed case:**

- Laboratory confirmed monkeypox virus by detection of unique sequences of viral DNA by real-time polymerase chain reaction (PCR)<sup>c</sup> and/or sequencing.

<sup>a</sup>Evidence is currently lacking as to the duration of exposure necessary for infection by the respiratory route, including how it relates to the severity of the index case's disease. Characterization of this parameter is one of the goals of the case investigation form described below.

<sup>b</sup>Serology can be used for retrospective case classification for a probable case in specific circumstances such as when diagnostic testing through PCR of skin lesion specimens has not been possible, or in the context of research with standardized data collection. The primary diagnostic test for monkeypox diagnosis is PCR of skin lesion material or other specimen such as an oral or nasopharyngeal swab as appropriate. Serology should not be used as a first line diagnostic test.

<sup>c</sup> PCR on a blood specimen may be unreliable and should also not be used alone as a first line diagnostic test. If blood PCR is negative and was the only test done, this is not sufficient to discard a case that otherwise meets the definition of a suspected for probable case. This applies regardless of whether the blood PCR was for OPXV or MPXV specific.



## Monkeypox Real time PCR Request Form

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

Name: .....	Age: .....	<b>Lab use only</b> Fitting to case definition Yes <input type="checkbox"/>  No <input type="checkbox"/>
Institution: .....	Gender: M/F	
Address: .....	Ward/ ICU:	
Pregnancy: Yes/ No, POA:.....		
Occupation: .....	BHT 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)

Travel history (Mandatory): **Yes /No** Date of arrival to Sri Lanka: .....

If yes which country:..... Date of exposure: .....

Exposure to confirmed/probable case: Yes/No

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) .....		