



WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health, Nutrition & Indigenous Medicine

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Monkey pox – the emerging epidemic Part II

This is the last of a series of 2 articles.

be seen.

Clinical signs and symptoms

Complications

The incubation period averages 12 days, ranging from 4 to 20 days.

In the prodrome or pre-eruptive stage (lasts 1-10 d), fever is commonly the first symptom (usually 38.5-40.5°C). The febrile illness is often accompanied by chills, drenching sweats, severe headache, backache, myalgia, malaise, anorexia, prostration, pharyngitis, shortness of breath, and cough (with or without sputum). Lymphadenopathy appears within 2-3 days after the fever.

Complications include pitted scars, deforming scars, secondary bacterial infection, bronchopneumonia, respiratory distress, keratitis, corneal ulceration, blindness, septicemia, and encephalitis.

In the exanthem (eruptive) stage, most persons develop a rash within 1-10 days after the onset of fever. The rash often starts on the face and then spreads to the rest of the body. The face, the trunk, the extremities, and the scalp are involved. Lesions appear in covered and uncovered areas. Lesions may be seen on the palms and the soles. Necrosis, petechiae, and ulceration may be features. Pain is unusual, and, if it occurs, it is often associated with a secondary bacterial infection. Pruritus may occur.



Vesicular rash on the dorsal aspect of the hand. Vesicopustules are seen; some have a central umbilication

The lesions persist for 2-4 weeks until all lesions have shed the crusts. Within a particular body region, lesions evolve synchronously over 14-21 days, similar to the development of lesions with smallpox. However, unlike smallpox, skin lesions may appear in crops. In contrast to smallpox, the lesions do not have a strong centrifugal distribution. Lesions progress from macules to papules to vesicles and pustules; umbilication, crusting, and desquamation follow. Most lesions are 3-15 mm in diameter. Encephalitis with immunoglobulin M found in the cerebrospinal fluid has been reported.



Umbilicated papule on the lower part of the leg. This smaller lesion still shows the typical umbilicated morphology

The most reliable clinical sign differentiating monkeypox from smallpox and chickenpox is enlarged lymph nodes, especially the submental, submandibular, cervical, and inguinal nodes. In patients who have been previously vaccinated against smallpox, a milder form of the disease occurs. In children, the lesions may appear as nonspecific, erythematous papules that are 1-5 mm in diameter and suggestive of arthropod bite reactions. Subtle umbilication may



Lymphadenopathy in monkeypox. Large nodes in the mandibular, cervical or inguinal region are commonly seen in monkeypox. The presence of

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significant lymphadenopathy helps differentiate monkeypox from smallpox and chickenpox.

Diagnosis From CDC

Probable Case

No suspicion of other recent Orthopoxvirus exposure (e.g., Vaccinia virus in ACAM2000 vaccination) AND demonstration of the presence of

Orthopoxvirus DNA by polymerase chain reaction of a clinical specimen OR

Orthopoxvirus using immunohistochemical or electron microscopy testing methods OR

Demonstration of detectable levels of anti-orthopoxvirus IgM antibody during the period of 4 to 56 days after rash onset

Confirmed Case

Demonstration of the presence of Monkeypox virus DNA by polymerase chain reaction testing or Next-Generation sequencing of a clinical specimen OR isolation of Monkeypox virus in culture from a clinical specimen

Epidemiologic Criteria

Within 21 days of illness onset:

Reports having contact with a person or people with a similar appearing rash or who received a diagnosis of confirmed or probable monkeypox OR

Had close or intimate in-person contact with individuals in a social network experiencing monkeypox activity, this includes men who have sex with men (MSM) who meet partners through an online website, digital application (“app”), or social event (e.g., a bar or party) OR

Traveled outside the US to a country with confirmed cases of monkeypox or where Monkeypox virus is endemic OR

Had contact with a dead or live wild animal or exotic pet that is an African endemic species or used a product derived from such animals (e.g., game meat, creams, lotions, powders, etc.)

Exclusion Criteria

A case may be excluded as a suspect, probable, or confirmed case if:

An alternative diagnosis* can fully explain the illness OR

An individual with symptoms consistent with monkeypox does not develop a rash within 5 days of illness onset OR

A case where high-quality specimens do not demonstrate the presence of Orthopoxvirus or Monkeypox virus or antibodies to orthopoxvirus

†Clinical suspicion may exist if presentation is consistent with illnesses confused with monkeypox (e.g., secondary syphilis, herpes, and varicella zoster).

*The characteristic rash associated with monkeypox lesions involve the following: deep-seated and well-circumscribed lesions, often with central umbilication; and lesion progression through specific sequential stages—macules, papules, vesicles, pustules, and scabs.; this can sometimes be confused with other diseases that are more commonly encountered in clinical practice (e.g., secondary syphilis, herpes, and varicella zoster). Historically, sporadic accounts of patients co-infected with Monkeypox virus and other infectious agents (e.g., varicella zoster, syphilis) have been reported, so patients with a characteristic rash should be considered for testing, even if other

tests are positive.

Categorization may change as the investigation continues (e.g., a patient may go from suspect to probable).

Prevention

Contact and respiratory isolation precautions should be exercised to prevent the spread of disease. Direct contact with skin lesions or fomites is considered infectious until the crust detaches from the last skin lesion. Patients and unexposed contacts should wear masks until respiratory symptoms resolve. Standard waste management practices and environmental infection control procedures must be adhered to. Human remains should be handled with care during autopsy and post mortem to prevent infection.

Health care workers and others who are asymptomatic and in contact with patients who are infected must closely monitor their symptoms and their temperature for 21 days after the last known contact.

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 14th- 20th May 2022 (20th Week)

RDHS	Dengue Fever		Dysentery		Encephaliti		Enteric Fever		Food Poi-		Leptospirosis		Typhus		Viral Hep-		Human		Chickenpox		Meningitis		Leishmania-		WRCD		
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**	
Colombo	25	3130	0	2	0	2	0	0	0	5	2	42	0	0	0	0	2	0	0	2	14	1	4	0	1	11	98
Gampaha	10	2406	0	4	0	0	0	0	6	12	1	40	0	0	1	4	0	1	3	14	2	9	0	7	6	69	
Kalutara	13	1302	0	4	0	1	0	1	0	6	6	124	0	2	0	1	0	2	0	25	0	12	1	1	3	100	
Kandy	86	863	1	8	0	0	0	0	0	4	6	38	4	15	0	5	0	0	2	25	2	4	1	5	8	96	
Matale	7	191	1	1	0	0	0	0	0	0	8	33	0	2	0	1	0	0	1	9	0	1	10	155	17	100	
NuwareEliya	4	73	3	12	0	0	0	0	0	0	0	20	0	8	0	0	0	0	0	10	0	1	0	0	14	100	
Galle	10	1194	1	4	0	0	0	0	0	0	5	158	0	8	0	2	0	0	1	27	0	9	0	0	10	100	
Hambantota	39	382	0	23	0	0	0	0	0	0	9	72	2	18	0	3	0	0	0	14	1	6	15	200	15	100	
Matara	35	425	1	7	0	0	0	0	0	0	18	84	0	5	0	1	0	0	0	14	0	5	5	121	24	100	
Jaftna	11	1622	2	16	0	2	2	40	0	19	0	18	5	369	0	4	0	4	2	59	2	6	0	0	58	88	
Kilinochchi	5	66	0	4	0	0	0	0	1	14	4	10	0	8	0	0	0	0	1	4	0	0	0	1	33	100	
Mannar	1	148	0	1	0	0	0	0	0	0	1	12	0	2	0	1	0	0	1	4	0	15	0	0	22	81	
Vavuniya	0	44	0	0	0	1	0	2	0	0	0	10	0	1	0	0	0	0	0	5	0	0	0	1	3	75	
Mullaitivu	1	31	0	3	0	0	0	2	0	3	1	18	0	4	0	0	0	0	0	4	0	0	0	1	25	100	
Batticaloa	65	665	0	41	0	5	0	0	0	17	7	22	0	0	0	1	0	0	0	6	0	18	0	1	33	100	
Ampara	0	63	0	6	0	1	0	0	1	8	4	41	0	1	0	1	0	0	2	29	1	9	0	11	9	100	
Trincomalee	21	757	2	22	0	0	0	1	0	2	1	14	0	3	0	4	0	0	0	13	0	3	0	0	18	91	
Kurunegala	35	1151	0	6	0	1	0	0	2	3	8	48	0	15	0	0	0	0	0	31	0	16	12	211	7	99	
Puttalam	34	960	0	2	0	0	0	0	0	0	2	9	0	3	0	0	0	0	0	5	0	11	0	4	13	92	
Anuradhapur	5	165	0	8	0	0	0	1	0	5	5	90	0	14	0	2	0	1	0	21	3	20	2	196	7	90	
Polonnaruwa	1	49	0	3	0	0	0	0	0	1	1	47	0	0	0	1	0	0	0	5	0	2	0	160	14	88	
Badulla	9	408	3	9	0	0	0	0	0	5	5	101	4	25	7	59	0	0	0	22	0	7	0	10	10	100	
Monaragala	10	144	0	5	0	0	0	4	0	2	6	148	0	11	0	22	0	0	1	29	1	17	2	66	6	100	
Ratnapura	72	930	0	21	0	5	0	2	2	18	51	330	1	9	0	11	0	0	3	35	1	18	0	91	10	95	
Kegalle	55	626	1	6	1	3	0	1	0	4	11	177	1	8	1	3	0	0	5	43	0	15	0	11	6	100	
Kalmune	40	410	0	20	0	0	0	0	0	4	0	8	0	1	0	0	0	0	6	24	0	13	0	0	27	100	
SRI LANKA	12	18205	15	238	1	21	2	54	12	132	16	1714	17	532	9	12	0	8	30	491	14	221	48	1254	15	94	

Source: Weekly Returns of Communicable Diseases (esurveillance.epid.gov.lk). T=Timeliness refers to returns received on or before 20th May, 2022. Total number of reporting units 361. Number of reporting units data provided for the current week: 329. C**=Completeness

Table 2: Vaccine-Preventable Diseases & AFP

14th – 20th May 2022 (20th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2022	Number of cases during same week in 2021	Total number of cases to date in 2022	Total number of cases to date in 2021	Difference between the number of cases to date in 2022 & 2021
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	00	00	00	00	33	20	65 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	00	00	00	00	00	00	00	00	02	02	00	18	41	- 56.0 %
Measles	00	00	00	00	00	00	00	00	00	00	00	11	08	37.5 %
Rubella	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	05	02	150 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	01	00	0 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	01	00	0 %
Tuberculosis	00	00	07	08	01	03	00	10	16	45	104	2614	2481	5.3 %

Key to Table 1 & 2

Provinces: W: Western, C: Central, S: Southern, N: North, E: East, NC: North Central, NW: North Western, U: Uva, Sab: Sabaragamuwa.
RDHS Divisions: CB: Colombo, GM: Gampaha, KL: Kalutara, KD: Kandy, ML: Matale, NE: Nuwara Eliya, GL: Galle, HB: Hambantota, MT: Matara, JF: Jaffna, KN: Killinochchi, MN: Mannar, VA: Vavuniya, MU: Mullaitivu, BT: Batticaloa, AM: Ampara, TR: Trincomalee, KM: Kalmunai, KR: Kurunegala, PU: Puttalam, AP: Anuradhapura, PO: Polonnaruwa, BD: Badulla, MO: Moneragala, RP: Ratnapura, KG: Kegalle.
Data Sources: Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS, Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis
CRS** =Congenital Rubella Syndrome
NA = Not Available

Number of Malaria Cases Up to End of May 2022,
02
 All are Imported!!!

Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to chepid@slt.net.lk. **Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

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