Clade I Mpox Virus (MPXV): a guide for Primary Care

NHS Somerset

Background and Clinical Presentation

Mpox virus (MPXV) is from the same family as smallpox and causes a rash illness that can range from mild and localised to severe and disseminated. There are two distinct clades: Clade I and Clade II. Clade I MPXV is considered more severe and is classified as a high consequence infectious disease (HCID). It has recently expanded its geographical range beyond its historical Central African countries

Symptoms of mpox typically appear 5 to 21 days after exposure, beginning with fever, malaise, lymphadenopathy, and headache. A rash develops within 1 to 5 days after fever onset, often starting on the face or genital area before spreading. The rash progresses through different stages before forming scabs that eventually fall off. Treatment is primarily supportive

Case definition - is this a high consequence infectious disease (HCID)?

Confirmed Clade I MPXV

Patients with laboratory-confirmed Clade I MPXV infection

Suspected Cases with Travel History

Travel history to DRC or specified countries, with a risk of Mpox exposure within 21 days of symptom onset

Contact

Contact with a confirmed Mpox case within 21 days of symptom onset

Epidemiological Link

Close or intimate in person contact/epidemiological link to a Mpox case within 21 days of symptom onset

For an up to date list of countries of risk, please see Operational mpox HCID (Clade I) case definition - GOV.UK (www.gov.uk)

Cases with laboratory-confirmed Clade II MPXV infection are not considered HCID

Management of Possible Cases

1 Identification

Does the patient have clinical signs of being a possible or probable case?

- Febrile prodrome (fever>38, chills, headache, exhaustion, myalgia, arthralgia and lymphadenopathy)
- Suspicion of Mpox (e.g. new characteristic rash, unexplained lesions, ulcers)

If a potential case is identified, contact UKHSA **without delay** to agree next steps - They will provide guidance on assessment and management.

Do not test for Mpox in community settings

2 Isolation and PPE

Isolate suspected cases (single room, closed door).

Where a face-to-face assessment is required, clinical staff should don gloves, apron, a well-fitting fluid resistant surgical mask (and visor/goggles where possible), ensuring there is **no direct patient contact**, and assessment is undertaken at a distance **greater than 1 metre**.

If there is a need to provide immediate clinical care **(direct contact/<1m)** clinical staff should wear face fit tested FFP3 masks, eye protection, long sleeved splash resistant gowns and gloves, similar to that used in acute care settings.

For further information please see National Infection Prevention & Control Manual (NIPCM)

3 UKHSA/Local Infection Control Team Notification

Clinicians treating patients with suspected mpox who may meet the operational case definition of an HCID (as outlined above) should promptly contact UKHSA for guidance on diagnostic testing, appropriate arrangements for transfer into secondary care and immediate precautions in the setting

UKHSA - Health Protection Team:

0300 303 8162 - choose option 2

swhpt@ukhsa.gov.uk

https://www.gov.uk/health-protection-team

NHS Somerset IPC Team:

somicb.infectionpreventioncontrolteam@nhs.net

Actions for Primary Care

Consider Clade I MPXV as a differential diagnosis for any patients meeting the operational case definition as outlined above. **If a suspected case presents, contact UKHSA without delay**

Maintain adequate stocks of appropriate PPE (including fit tested FFP3 masks) and train staff in its use for suspected Clade I MPXV cases

Establish clinical pathways for triage, isolation and management of suspected Clade I MPXV cases, including liaison with UKHSA and the local IPC team

▼ Additional Resources

UKHSA Public Health Messaging for NHS Service Providers

NHS response to outbreak of Clade 1 Mpox

Case definitions and countries of risk

National Infection Prevention & Control Manual

Addendum on HCID PPE