

Mpox (Monkeypox)

Disease Category: Zoonotic/Vaccine Preventable Disease

Timeframe to follow-up: Within the same day

Signs and Symptoms⁷

- Mpox disease is characterized by a relatively long incubation period, a prodrome, and rash.
- Prodrome: The prodrome is an early set of symptoms that may include:
 - Fever, malaise, headache, sore throat, cough, and many times swollen lymph nodes.
 - Lymphadenopathy is a characteristic of mpox where lymph nodes may swell in the neck (submandibular and cervical), armpits (axillary), or groin (inguinal) and can occur on both sides of the body or just one side.
 - **A person can be contagious during the prodrome period.*
- Rash: The rash typically follows 1-3 days after the prodrome, although can present without prodrome.
 - Lesions typically progress from papules, macules, vesicles, pustules, and then scabs.
 - **A person is contagious until all the scabs on the skin have fallen off and a fresh layer of intact skin has formed underneath.*

Incubation⁷⁻⁹

- 3-17 days (average, 5-13 days). CDC recommends that patients be monitored for up to 21 days after exposure.
- **A person is typically not contagious during this incubation period.*

<u>Case Classification</u>⁸	Clinical criteria: clinical compatible rash lesions or lymphadenopathy or fever 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 mpox OR • Had close or intimate in-person contact with individuals in a social network experiencing mpox 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 U.S. to a country with confirmed cases of mpox 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.) Suspect case: • Meets clinical criteria AND epidemiologic criteria AND no evidence of a negative test for either non-variola orthopoxvirus or monkeypox virus Probable case: • Detection of orthopoxvirus nucleic acid by molecular testing in a clinical specimen AND no laboratory evidence of infection with another non-variola orthopoxvirus; OR • Detection of presence of orthopoxvirus by immunohistochemistry in tissue; OR • Detection of orthopoxvirus by genomic sequencing in a clinical specimen; OR • Detection of anti-orthopoxvirus Immunoglobulin M (IgM) antibody using a validated assay on a serum sample drawn 4-56 days after rash onset, with no recent history (last 60 days) of vaccination Confirmed case: • Detection of monkeypox virus nucleic acid by molecular testing in a clinical specimen; OR • Detection of monkeypox virus by genomic sequencing in a clinical specimen.
Differential Diagnosis¹⁰	• Smallpox, chickenpox, shingles, measles, coxsackievirus, molluscum contagiosum, drug allergy, insect bites, scabies, rubella, syphilis, mononucleosis, impetigo, scarlet fever • For genital lesions: syphilis, herpes, chancroid. • Mpox can co-occur with other infections (co-infections).

<u>Treatment</u> ^{9,11-14}	Most patients with mpox will have self-limited disease. Patients should be counseled to not touch their eyes. There are no FDA-approved treatments specifically for mpox, but there are FDA-regulated medications that may help. Some available therapeutics - consult with CDC for treatment options: • Tecovirimat (TPOXX or ST-246) • Vaccinia immune globulin intravenous (VIGIV) • Brincidofovir (CMX001 or Tembexa) • Cidofovir *Cidofovir should not be used simultaneously with brincidofovir. Post-exposure prophylaxis (PEP) vaccine given ideally within 4 days of exposure with administration 4-14 days after exposure can provide protection against mpox.
<u>Duration</u> ¹³	Symptoms usually persist for 2-4 weeks, but in severe cases symptoms can last longer.
<u>Exposure</u> ^{9,15,16}	Anyone with an exposure to people or animals with mpox should monitor their health or be monitored for signs and symptoms consistent with mpox for 21 days after their last exposure. Post-exposure prophylaxis (PEP) may be recommended depending on exposure and individual risk factors. • Monitoring should include the person for all signs and symptoms of mpox, including a thorough skin and mouth (oral) exam in good lighting. Skin examination can be performed by the person in isolation, a caregiver, or a healthcare provider and should include examination of the genitals and anus for rash or lesions.
<u>Laboratory Testing</u>	Local Health Authority can arrange testing if an outbreak is suspected OR for contacts of cases: • Nevada State Public Health Laboratory testing resource can be found here. • Recommendations on testing and infection control can be found here
<u>Control of Contacts</u>	Contacts include individuals exposed to a case or a contaminated environment in a manner likely to cause transmission. Contacts may be identified through interviews, attendance lists, workplace rosters, passenger manifests, etc.
<u>Key areas of focus during investigation</u>	Key exposures include recent travel to endemic areas or areas where mpox outbreak is occurring. Symptoms and onset, contacts, vaccination status.
<u>Public Health Actions</u>	Reports of Mpox cases must be made to the Local Health Authority during the regular business hours of the health authority on the first working day following the identification of the case. Local Health Authority to notify Office of State Epidemiology (OSE) (dpbhepi@health.nv.gov) or call 775-400-0333 for individual cases or if outbreak suspected. For individual confirmed or probable cases: • Confirm diagnosis, if possible

	• Identify potential exposures • Identify potential outbreaks from common sources • Provide education about how to prevent transmission • Assess availability of treatments and pain management • Assess for vaccination eligibility for exposures • Identify any contacts and sites where case spent time while contagious. • Make appropriate recommendations to contacts • Prepare a case report and submit to the Chief Medical Officer (through OSE) within 7 days after completing the case investigation To the best of the local health authority's ability, each step of the investigation should be completed within one working day or in alignment with NAC 441A.
<u>Key Partner Agencies</u>	• Local Health Authorities • Nevada State Public Health Laboratory • Other states involved in outbreaks

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I. DISEASE REPORTING

A. Legal Reporting Requirements

A report to the health authority may be made by telephone; telecopy (in the form prescribed by the health authority); or any form of electronic communication identified by the health authority, following the specified format and procedure.⁽¹⁾

1. *Health Care Providers and Health Care Facilities*

Health providers and facilities must notify the health authority where provider is located within the first working day after identifying the case.¹⁻³

2. *Laboratories*

Laboratories must notify the health authority within the first working day after identifying the case.¹ If the lab is located outside of Nevada, notify the Nevada Chief Medical Officer through the Office of State Epidemiology (OSE) within the same timeframe.^{1,4}

3. *Local Health Authority (LHA)*

LHA's must notify the Office of State Epidemiology (OSE) within 7 days after completing the case investigation.⁵

II. THE DISEASE AND ITS EPIDEMIOLOGY

A. Background^{9,10}

Mpox (formerly known as monkeypox) is a viral zoonotic disease caused by the Monkeypox virus, which belongs to the same family of viruses responsible for smallpox. Historically, mpox has been endemic to Central and West Africa, though significant global spread occurred beginning in 2022. Risk is increased through close contact with infected individuals, animals, or contaminated materials. Illness typically lasts 2–4 weeks and may cause substantial morbidity, particularly in individuals with immunocompromising conditions.

B. Etiologic Agent^{9,10,17}

Mpox is caused by the Monkeypox virus, which includes two genetic clades: Clade I (Central African/Congo Basin) and Clade II (West African). Historically, Clade I is associated with more severe disease and greater transmissibility. Clade II includes subclades IIa and IIb, with IIb responsible for the 2022 global outbreak. Humans and monkeys are considered incidental hosts; the true natural reservoir is believed to be specific rodent species from Central Africa.

C. Description of Illness⁷

Mpox often begins with a prodrome of fever, chills, headache, muscle and back aches, lymphadenopathy, fatigue, and sometimes respiratory symptoms, though not all individuals experience a prodrome. A painful rash typically develops a few days after symptom onset, often involving mucosal areas such as the mouth, eyes, genitals, rectum, or throat. Lesions are firm, deep-seated, well-circumscribed, and may become umbilicated. Lesions may appear synchronously or asynchronously across the body and progress through macular, papular, vesicular, and pustular stages before crusting and healing. Rectal symptoms, including pain and bleeding, have been frequent in recent outbreaks. Illness generally lasts 2–4 weeks.

D. Disease Burden in Nevada

Nevada has reported 383 mpox cases since 2022, with most occurring between July 2022 and January 2023. Most cases in the state were identified in Clark County. Mpox is not considered endemic in Nevada.

See the [Nevada Office of State Epidemiology Communicable Disease Dashboard](#) for Nevada specific data on Mpox (Mpox Dashboard section).

E. Reservoirs^{10,15}

While first identified in macaques, the true natural reservoir remains unknown. Current evidence suggests that monkeys act as incidental hosts, similar to humans. Rodent species native to heavily forested areas of Central Africa are believed to be the most likely primary reservoirs.

F. Modes of Transmission^{10,18}

Mpox spreads through direct contact with infectious lesions or scabs, contact with bodily fluids, respiratory secretions during prolonged face-to-face exposure, and intimate physical contact. It can also spread through contaminated objects or fomites such as bedding, clothing, towels, or personal items. Transmission from infected animals can occur through bites, scratches, handling, or exposure during hunting or processing of wild animals in endemic regions. Pet transmission is possible but uncommon; individuals with mpox should avoid close contact with pets.

G. Incubation Period^{7,10}

The incubation period ranges from 3–17 days, with most individuals developing symptoms within 1–2 weeks. People are not believed to be contagious during this period. Monitoring of exposed individuals is recommended for up to 21 days.

H. Period of Communicability^{7,10}

Individuals may be contagious during the prodromal phase if it occurs, when symptoms such as fever, lymphadenopathy, and malaise begin. Contagiousness continues throughout the rash phase, during which lesions progress through macular, papular, vesicular, pustular, and scabbing stages. A person remains infectious until all scabs have fallen off and a new layer of intact skin has formed.

I. Testing¹⁹

Mpox is diagnosed using real-time polymerase chain reaction (PCR) tests. It is recommended that clinicians collect two swabs from each lesion in case additional testing such as clade-specific testing is needed. Specimens should be collected from acute lesions according to laboratory guidance. Providers should follow Nevada State Public Health Laboratory (NSPHL) testing requirements and consult the NSPHL webpage for submission instructions and specimen criteria.

J. Treatment¹¹⁻¹³

Treatment depends on severity and individual risk factors. Supportive care—such as pain control, hydration, and prevention of secondary infections—is essential. Post-exposure prophylaxis (PEP) vaccination depends on exposure risk.

Provide most current treatment guidelines from [Red Book](#) to the healthcare provider or refer case to physician for proper treatment for Mpox. Consultation with CDC may be needed for certain cases.

III. EPIDEMIOLOGIC CASE INVESTIGATION

The public health authority should begin investigating the case of Mpox, step by step, within the same day of notification or in alignment with [NAC 441A](#).

According to NRS 441A.160 (1), “A health authority who knows, suspects or is informed of the existence within the jurisdiction of the health authority of any communicable disease that poses a risk to the health of the public and is in an infectious state, at risk of developing into an infectious state or at risk of developing into a progressed state that endangers the health of the person with the communicable disease shall immediately investigate the matter and all circumstances connected with it, and shall take such measures for the prevention, suppression and control of the disease as are required by the regulations of the Board or a district board of health.”²⁰

A disease investigator from the public health authority will be assigned to investigate the case based on their availability and on the workload distribution among the entire disease investigation team.

A. Step 1: Review relevant information about the disease.

1. *Review scientific information in [Control of Communicable Diseases Manual](#), most recent edition.*
2. *Review Mpox most recent [case definition](#) (2022) CDC.*

B. Step 2: Begin investigating the case.

1. *Contact Reporting Source and/or Reported Case*

Upon receiving an initial case report, review lab test results and available clinical details and epidemiologic factors. Attempt to contact the provider to gather additional clinical information. Then attempt to contact the case (regardless of whether contact was made with the provider). Please make three attempts to contact the case (text and phone calls)

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on separate days, at different times of the day (morning, afternoon, late afternoon). Document all attempts to contact a reporting source and/or reported case in the “Encounters” tab of EpiTrax. Please use the questions in EpiTrax to gather accurate information about the case. Focus on the key data elements listed below. If PDF CMR is used, the completed PDF version should be attached to the CMR in EpiTrax in the “Notes” tab. The CMR should be completed within 7 days of completing the investigation of the case.⁵

C. Step 3: Identify potential sources of infection¹⁰

The investigation focuses on exposures occurring 3–17 days before symptom onset. Relevant exposures include direct skin-to-skin, skin-to-mucosal, or mouth-to-mucosal contact such as touching, hugging, kissing, or intimate/sexual contact. Investigators should also assess contact with contaminated materials like clothing, bedding, or surfaces disturbed during cleaning or laundry handling. Prolonged face-to-face respiratory exposure and potential inhalation of droplets or short-range aerosols should be considered. Additionally, possible respiratory or eye mucosal exposure to lesion material, including scabs or crusts, should be evaluated.

D. Step 4: Initiate control measures for case and/or for contacts (see Section IV – Section VI below).

E. Step 5: Provide Education and Prevention messaging to the case and/or contacts (see Section VIII below).

IV. CONTROL OF CASE^{13,16,21,22}

1. All symptomatic cases

Should be isolated either at home or another secure location and avoid contact with unaffected individuals until the rash has resolved, the scabs have fallen off, and a fresher layer of intact skin has formed. This often takes 2-4 weeks. During isolation cases should follow these recommendations:

- Friends, family or others without an essential need to be in home should not visit.
- Do not engage in sexual activity that involves direct physical contact.
- Do not share potentially contaminated items like bed linens, clothing, towels, washcloths, drinking glasses or eating utensils.
- Limit use of space and food shared with other household members.
- Routinely clean and disinfect commonly touched surfaces such as counters or light switches using an EPA-registered disinfectant such as List Q.
- Wear well-fitting medical mask when in close contact with others at home. If rash is present on hand, consider wearing gloves.
- Avoid use of contact lenses to avoid inadvertent infection of the eye.
- Avoid shaving rash-covered areas of the body as this can spread the virus.
- If possible, use a separate bathroom if there are others around the house.

- Avoid close contact with others including pets and other animals, specifically mammals as they can become infected with mpox. If possible, have friends or family members care for the healthy animal(s) until the owner has fully recovered.

2. *Management/Exclusions for Specific Groups or Settings*

Case in a Medical Facility with rash

- Standard and contact precautions. Additional personal protective equipment (PPE) recommended for use include eye protection and NIOSH approved N-95 mask or higher level respirator.
- Case should be placed in single-person room with dedicated bathroom, no special air handling required
- Keep door closed if safe to do so
- Limit transport and movement of case outside of room to medically essential purposes. If case needs to be transported, then use well-fitting medical mask and cover exposed skin lesions with sheet or gown.
- Perform intubation, extubation, and any procedures likely to spread oral secretions in an airborne infection isolation room (AIIR).
- Perform standard cleaning and disinfection procedures using an EPA-registered hospital grade disinfectant with an emerging viral pathogen claim (List Q).

Case in a Medical Facility - If symptoms of mpox are present, but there is no rash

- Place patients on empiric isolation precautions for mpox for 5 days after the development of any new symptom consistent with mpox, even if this 5-day period extends beyond the original 21-day monitoring period.
- If 5 days have passed without the development of any new symptom and a thorough skin and oral examination reveals no new rashes or lesions, discontinue isolation precautions.
- You may discontinue isolation precautions prior to 5 days if mpox has been ruled out.
- If a new symptom develops again at any point during the 21-day monitoring period, again place the patient on empiric isolation precautions for mpox; begin a new 5-day isolation period.

3. *Asymptomatic cases*²³

- There have been published reports of asymptomatic individuals transmitting mpox to a household contact.
- For these cases consultation should be done with OSE and CDC experts on additional isolation precautions and duration.
- It is advised for asymptomatic cases to follow general isolation recommendations for symptomatic cases to prevent transmission.

4. *Exclusion Notifications*

Cases should isolate until the rash has resolved, the scabs have fallen off, and a fresher layer of intact skin has formed. This often takes 2-4 weeks.

V. CONTROL OF CONTACTS^{13,16,21,22}

1. *Asymptomatic contacts*

- Contacts should be monitored, or should self-monitor daily for the onset of signs or symptoms for a period of 21 days from the last exposure.
- Contacts that remain asymptomatic can continue with routine daily activities and do not need to isolate.

2. *Symptomatic contacts*

- Advise to isolate immediately if symptoms consistent with mpox develops and undergo diagnostic testing.

3. *Exclusion Notifications*^{13,24}

To date there have been no confirmed reports of mpox transmission from medical products of human origin including blood transfusion, organ transplantation, or implantation, transplantation, infusion, or transfer of human cells, tissues, or cellular or tissue-based products. As a precaution, individuals with high or intermediate risk exposure should not donate blood, cells, tissue, breast milk, or semen while they are being monitored for symptoms.

VI. POST EXPOSURE PROPHYLAXIS (PEP) FOR CASES AND CONTACTS

Recommendation for PEP vaccination for cases and contacts depends on exposure risk, vaccination status, and any underlying comorbidities, and should be done in consultation with OSE and CDC if needed.

The table below lists exposure categories and settings¹³

Exposure category	Community	Health Care Setting
High	• Any sexual or intimate contact involving mucous membranes with an individual who has mpox • Contact between an exposed individual's broken skin or mucous membranes with either: • The skin lesions or bodily fluids from an individual with mpox • Materials that have contacted the skin lesions or bodily fluids of an individual with mpox	• Unprotected contact between an exposed HCP's broken skin or mucous membranes and either: • The skin lesions or bodily fluids from a patient with mpox OR • Soiled materials (e.g., linens, clothing) visibly contaminated with body fluids, dried lesion exudate, or crusts

Intermediate	▪ Being within 6 feet of a person with mpox who has laryngeal disease, cough, respiratory symptoms, or oral lesions for an extended period OR ▪ Contact between an exposed individual's intact skin with either: • The skin lesions or bodily fluids from a source patient with mpox • Materials that are visibly contaminated with body fluids or lesions, exudates, or crusts from a person with mpox without having been disinfected or laundered	▪ Unprotected contact between an exposed individual's intact skin or clothing and either: • The skin lesions or bodily fluids from an individual with mpox • Soiled materials visibly contaminated with body fluids, dried lesion exudate, or crusts OR ▪ Being inside the room of an individual with mpox without wearing all recommended PPE during either: • Medical procedures that may create aerosols from oral secretions • Activities that may resuspend dried exudates (e.g., shaking of soiled linens) OR ▪ Examining the oral cavity of a person with mpox with oral or laryngeal lesions while not wearing all recommended PPE
Uncertain to minimal	▪ Entry into the living space of a person with mpox (regardless of whether the person with mpox is present) and in the absence of any exposures above OR ▪ Contact between an exposed individual's intact skin or clothing and the intact skin or clothing of a person with mpox who has completely covered lesions (e.g., bandaged, covered with clothing)	▪ Unprotected contact with a person with mpox who has completely covered lesions (e.g., bandaged, covered with clothing) if there is no contact with their skin lesions, bodily fluids, or any materials (e.g., linens or clothing) visibly contaminated with body fluids, dried lesion exudate, or crusts
No identifiable risk	▪ No direct contact with the person with mpox, their potentially infectious contaminated materials, and only transient time spent within 6 feet of the person with mpox	▪ No direct contact with the patient with mpox or their contaminated materials or surfaces, and at most only transient time spent around the person with mpox

VII. PRE-EXPOSURE PROPHYLAXIS (PREP)¹³

Certain individuals can be at risk for increased mpox infection due to behavioral or occupational factors. Individuals who receive PrEP should be monitored after an exposure, but additional post-exposure prophylaxis is not indicated.

There are two vaccines available for PrEP and PEP.

- MVA vaccine (JYNNEOS in U.S.): made from highly attenuated, nonreplicating vaccinia virus with excellent safety profile, is administered in 2 doses 4 week apart.
- ACAM2000: replication-competent smallpox and mpox vaccine that can only be used in select patients and is associated with more adverse events than the MVA vaccine.

VIII. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL

Coordinate with senior epidemiology staff to determine if an outbreak is occurring. If so, notify local health authorities as appropriate.

A. Mpox and Pregnancy²⁵

- Mpox virus can be transmitted to the fetus during pregnancy or to the newborn by close contact during and after birth.
- Adverse pregnancy outcomes, including spontaneous pregnancy loss and stillbirth, have been reported in cases of confirmed mpox infection during pregnancy. Preterm delivery and neonatal mpox infection have also been reported.
- Breastfeeding may need to be delayed until criteria for discontinuing isolation have been met (i.e., all lesions have resolved, the scabs have fallen off, and a fresh layer of intact skin has formed).
- Vaccination prior to exposure and post-exposure prophylaxis should be offered when indicated.

B. Mpox in Children and Adolescents²⁶

- Exposure to household contact with mpox is the predominant route of exposure for children, while sexual contact is the predominant route of exposure for adolescents.
- Mpox should be considered when children or adolescents present with a rash that is consistent with the disease, especially if epidemiologic criteria are present.
- Young children, children with eczema and other skin conditions, and children with immuno-compromising conditions may be at increased risk of severe disease.
- Treatment should also be considered for children and adolescents who may be at high risk for severe disease:
 - Children under 1 year of age
 - Children and adolescents experiencing severe immunodeficiency or immunocompromise
 - Adolescents who are pregnant or breastfeeding
 - Children and adolescents with a condition affecting skin integrity

C. Ocular Manifestations of Mpox²⁷

- Potential complications include:
 - Corneal scarring and vision loss
 - Bacterial superinfection of corneal ulcerations
 - Periorbital and facial lesions in association with systemic symptoms
- Consider systemic antiviral therapy for all patients with severe mpox including ocular manifestations. Tecovirimat (TPOXX) is often given.
- Topical treatment options include Trifluridine-topical antiviral used for management of herpes-simplex keratitis, or topical lubricant or antibiotic in consultation with an ophthalmologist to prevent bacterial superinfection.

IX. PREVENTION

The investigator should reference the most recent disease specific public educational materials from the CDC. The [Nevada OSE website](#) also provides information about Mpox.

For the Public^{28,29}

- Vaccination is the most effective way to prevent mpox.
- Standard JYNNEOS regimen: two subcutaneous injections of 0.5 mL, administered 28 days (4 weeks) apart.
- Alternative JYNNEOS dose-sparing regimen: 0.1 mL intradermal injections, also administered 28 days (4 weeks) apart.
- Be safe during sex or at social gatherings
- Avoid people with rashes that look like mpox. Do not touch the rash or scabs and avoid kissing, hugging, sex or intimate activities and massage.
- Avoid contact with wild animals where mpox is endemic particularly in parts of Central or West Africa.
- Avoid contact with contaminated objects and materials such as bedding, towels, clothing of a person with mpox without right PPE
- Wash your hands often with soap and water or use an alcohol-based hand sanitizer with at least 60% alcohol.

Preventing Mpox transmission in the home of a mpox case²¹

- Wash hands with an alcohol-based hand rub or soap and water after touching rash material or clothing, linens, or environmental surfaces that may have had contact with rash material.
- Cover all skin rashes to the extent possible by wearing long sleeves or long pants.
- Consider gloves to cover rash on the hands when they're not in isolation, such as when they're receiving medical care.
- Use well-fitting source control (e.g., medical mask), if they can't avoid close contact with others, such as when receiving medical care.
- Other household members should wear a respirator or a well-fitting mask when in close contact (e.g., within 6 feet) with the person with monkeypox for more than a brief encounter.

- When possible, the person with monkeypox should change their own bandages and handle contaminated linens while wearing disposable gloves, followed by immediate handwashing after removing gloves.
 - Immediately launder any clothing that contacts the rash during bandage changes.
- As a last resort, if they need assistance with these activities, caregivers should avoid extensive contact and wear disposable medical gloves and a well-fitting mask or respirator at a minimum.
- Contain and dispose of contaminated waste, such as dressings, bandages, or disposable gloves.

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XI. ACKNOWLEDGEMENTS

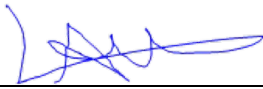
This document was developed based on the content and format of the disease investigation guidelines of several state and local health jurisdictions:

- Oregon Health Authority Investigative Guidelines
- Washington State Department of Health Reporting and Surveillance Guidelines

- Washoe County Health District Epidemiology and Communicable Disease Program Investigation of Communicable Disease Manual

The Nevada Office of State Epidemiology would like to acknowledge the work of these great partners.

XII. UPDATE LOG



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Chief Medical Officer

6/25/26

Chief Medical Officer Approval Date