COMMUNICABLE DISEASE UPDATE

COMMUNICABLE DISEASE CONTROL AND PREVENTION SECTION
THURSTON COUNTY PUBLIC HEALTH AND SOCIAL SERVICES DEPARTMENT
412 LILLY RD NE
OLYMPIA, WA, 98506-5132
DISEASE REPORTING: (360)786-5470

10/5/2022

** NOTICE: This health alert provides written guidance for health care professionals and others who may need to take action to prevent or control a notifiable condition. It is not intended to provide guidance for the general public.*

Acute Flaccid Myelitis in 2022, Severe Manifestations of Monkeypox among People who are Immunocompromised Due to HIV or Other Conditions and Washington State Department of Health Webinar "Pandemic to Endemic: Long-Term Recovery for Health Care Workers"

Acute Flaccid Myelitis in 2022

Requested Actions

In response to a possible increase in cases of acute flaccid myelitis (AFM), CDC recommends the following:

- THINK AFM: Clinicians should strongly consider AFM in patients with acute flaccid limb weakness, especially after respiratory illness or fever, and especially between August and November
- CONSIDER POLIO: Clinicians should consider polio in patients with sudden onset of limb weakness, especially in persons who are not vaccinated or under-vaccinated for polio and have traveled to areas with a higher risk of polio
  - HOSPITALIZE IMMEDIATELY: Patients with AFM can progress rapidly to respiratory failure. Clinicians should monitor respiratory status of patients and order MRI of the spine and brain with the highest Tesla scanner available. The clinical signs and symptoms of AFM overlap with other neurologic conditions. Therefore, it is critical to consult with specialists in neurology and infectious diseases for appropriate diagnosis and management.
  - LABORATORY TESTING: Clinicians should collect specimens from patients with possible AFM or polio as early as possible in the course of illness (preferably on the day of onset of limb weakness).
    - The following specimens should be collected: **CSF; serum; stool; and a nasopharyngeal (NP) or oropharyngeal (OP) swab**

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- Note, it is critical to obtain **two stool samples** collected at least 24 hours apart, both collected as early in illness as possible and ideally within 14 days of illness onset (poliovirus is most likely to be detected in stool)
- Coordinate with Thurston County Public Health and Social Services and The Washington State Public Health Laboratories to send specimens to CDC for AFM/polio testing. Please call Thurston County Public Health and Social Services at (360) 867 – 2500 Monday-Friday 8-5pm or 1-800-986-9050 after hours to coordinate specimen transport. Additional instructions regarding specimen collection and shipping can be found at: https://www.cdc.gov/acute-flaccid-myelitis/hcp/specimen-collection.html

- CASE REPORTING: Clinicians should report possible cases of AFM (acute onset of flaccid limb weakness AND MRI showing a spinal cord lesion in at least some gray matter, excluding persons with gray matter lesions in the spinal cord resulting from physician diagnosed malignancy, vascular disease, or anatomic abnormalities) or polio to Thurston County Public Health and Social Services using the patient summary form (https://www.cdc.gov/acute-flaccid-myelitis/hcp/data-collection.html). Copies of the spinal cord and brain MRI reports, images, and the neurology consult note should be provided along with the patient summary form. Patients with gray matter lesions in the spinal cord resulting from physician -diagnosed malignancy, vascular disease, or anatomic abnormalities do not need to be reported. Please fax reports to Thurston County Public Health and Social Services at 360-867-2601.
  - Reports from possible cases of AFM will be submitted to CDC as part of surveillance to help track AFM, understand the spectrum of the disease, detect outbreaks, and inform research.
  - Case classification status (i.e., confirmed, probable, suspect, not a case) is for surveillance purposes and based on consistent and specific criteria to ensure cases being tracked are similar.
  - **Clinicians should not wait for CDC's surveillance case classification to diagnose and manage their patients.**

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Background

Since the end of August 2022, CDC sentinel surveillance sites for respiratory pathogens have been reporting increases in enterovirus D-68 (EV-D68) respiratory disease. EV-D68 is also the main enterovirus responsible for cases of acute flaccid myelitis (AFM) during years when we see increases in AFM cases. AFM is a rare outcome of EV-D68 infection and is a serious neurologic condition that affects mostly children. It typically presents with sudden limb weakness that can lead to permanent paralysis. Traditionally, increases in EV-D68 respiratory disease have preceded cases of AFM by about 2 weeks. Therefore, increased vigilance for AFM is important. Clinicians should strongly consider the diagnosis of AFM in patients with acute onset of flaccid weakness, especially during August–November, to ensure prompt hospitalization and referral to specialty care. Recent respiratory illness or fever and the presence of neck or back pain or any neurologic symptom should heighten suspicion of AFM. Clinicians should also report possible cases of AFM to Thurston County Public Health and Social Services as soon as they suspect AFM. Case reporting will help states and the CDC monitor AFM and better understand factors associated with this illness.

With the identification of a paralytic polio case in an unvaccinated person in New York in July 2022, healthcare providers should also consider polio in the differential diagnosis of patients with sudden onset of limb weakness, as polio and AFM are clinically similar. Clinicians should obtain stool samples from all patients with suspected AFM to rule out poliovirus infection, especially if the patient is under-vaccinated and has had recent international travel to places where poliovirus is circulating.

From January 1, 2022, through September 6, 2022, CDC has received 35 reports of suspected acute flaccid myelitis (AFM) in persons from 17 U.S. states; 13 have been classified as confirmed cases of AFM, 2 as probable, 6 as not cases, 1 as suspect, and 13 are awaiting information or classification.

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References:

Acute Flaccid Myelitis

- AFM: https://www.cdc.gov/acute-flaccid-myelitis/index.html
- AFM physician consult and support portal: https://wearesrna.org/living-with-myelitis/resources/afm-physician-support-portal/
- For clinicians and health departments: https://www.cdc.gov/acute-flaccid-myelitis/hcp/clinicians-health-departments.html
- Resources and references for AFM: https://www.cdc.gov/acute-flaccid-myelitis/hcp/references-resources.html
- The standardized case definition for AFM surveillance is available at: https://www.cdc.gov/acute-flaccid-myelitis/hcp/case-definitions.html

Polio

- Poliomyelitis: For Healthcare Providers: https://www.cdc.gov/polio/what-is-polio/hcp.html
- Polio Fact sheet: Polio Fact Sheet-8-17-22-508 (cdc.gov)
- Polio vaccine ACIP recommendation: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/polio.html
- Resources and references for polio: https://www.cdc.gov/polio/what-is-polio/resources-refs.html

Severe Manifestations of Monkeypox among People who are Immunocompromised Due to HIV or Other Conditions

Requested Actions:

- Upon initial presentation of signs and symptoms consistent with monkeypox, in addition to monkeypox, test all sexually active adults and adolescents for HIV (including acute infection) and other sexually transmitted infections (such as syphilis, herpes, gonorrhea, and chlamydia), and assess for other immunocompromising conditions.
- Be familiar with severe manifestations of monkeypox and risk factors for severe disease.

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- Contact local and state health departments early when there is concern for progression to severe manifestations or severe manifestations are present for guidance on management and securing necessary resources for treatment.
- Consider treating immunocompromised people diagnosed with monkeypox with tecovirimat early in the course of disease and consider a prolonged course of tecovirimat for those with more refractory and severe monkeypox infection. In certain clinical situations, modifications to the dose, frequency, and duration may be necessary depending on the individual's clinical condition, disease progression, therapeutic response, and clinical judgment in consultation with CDC and FDA as appropriate. To request Tecovirimat please call Thurston County Public Health and Social Services at (360) 867 – 2500 Monday-Friday 8-5pm or 1-800-986-9050 after hours. To request clinical consultation regarding dosing adjustments, contact the CDC EOC at (770) 488-7100 or send an email to eocevent482@cdc.gov.
- Where available, healthcare providers should encourage people with monkeypox to be assessed for enrollment in the ACTG STOMP trial evaluating the efficacy of tecovirimat.
- Have a low threshold to use multiple medical countermeasures, including tecovirimat, cidofovir or brincidofovir, and VIGIV in immunocompromised people who present with severe manifestations of monkeypox or are at high risk of progression to severe manifestations.
- Optimize immune function among immunocompromised people with suspected or confirmed monkeypox, specifically by ensuring those with HIV are on effective antiretroviral therapy.
- Discuss HIV pre-exposure prophylaxis (PrEP) with those who are HIV-negative and at risk for HIV.
- Consider consultation with CDC Monkeypox Response Clinical Escalations Team (email eocevent482@cdc.gov or healthcare providers may contact the CDC EOC at (770) 488-7100), and multidisciplinary consultation with specialists such as infectious disease, ophthalmology, dermatology, urology, or critical care medicine.

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Background

Since May 2022, more than 25,000 monkeypox cases have been identified in the United States. During the current outbreak in the United States, 38 percent of people diagnosed with monkeypox were coinfected with HIV[1], and most reported cases of monkeypox with severe manifestations have been among people living with untreated HIV.

Some patients with monkeypox in the United States have experienced prolonged hospitalizations or substantial morbidity; deaths have occurred. As the monkeypox outbreak has progressed, an increasing proportion of cases have been identified among Black and Hispanic/Latino people. Black and Hispanic/Latino people are disproportionately affected by HIV.

Severe manifestations of monkeypox can occur in both immunocompetent and immunocompromised people; however, most people diagnosed with monkeypox have had mild-to-moderate clinical courses. Of the people with severe manifestations of monkeypox for whom CDC has been consulted, the majority have had HIV with CD4 counts <200 cells/ml, indicating substantial immunosuppression. Healthcare providers should recognize underlying risk factors for severe disease, optimize immune function, and when appropriate, initiate medical countermeasures (such as tecovirimat and vaccinia immunoglobulin) early to prevent or mitigate severe disease.

During the current outbreak, CDC has received reports of people with monkeypox who have severe manifestations of disease, including but not limited to

- Atypical or persistent rash with coalescing or necrotic lesions, or both, some which have required extensive surgical debridement or amputation of an affected extremity.
- Lesions on a significant proportion of the total body surface area, which may be associated with edema and secondary bacterial or fungal infections among other complications.
- Lesions in sensitive areas (including mucosal surfaces such as, oropharynx, urethra, rectum, vagina) resulting in severe pain that interferes with activities of daily living.
- Bowel lesions that are exudative or cause significant tissue edema, leading to obstruction.
- Severe lymphadenopathy that can be necrotizing or obstructing (such as in airways).
- Lesions leading to stricture and scar formation resulting in significant morbidity such as urethral and bowel strictures, phimosis, and facial scarring.

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- Involvement of multiple organ systems and associated comorbidities, including:
  - Oropharyngeal lesions inhibiting oral intake
  - Pulmonary involvement with nodular lesions
  - Neurologic conditions including encephalitis and transverse myelitis
  - Cardiac complications including myocarditis and pericardial disease
  - Ocular conditions including severe conjunctivitis and sight-threatening corneal ulcerations
  - Urologic involvement including urethritis and penile necrosis

Healthcare providers should be aware of risk factors for severe manifestations of monkeypox and should conduct HIV testing for people with confirmed or suspected monkeypox**.** In prior monkeypox outbreaks in Nigeria, co-infection with HIV was associated with worse clinical outcomes, including severe manifestations of monkeypox, hospitalization, and death.[2] Providers should also consider other immunocompromising conditions* and medications that may increase risk of severe manifestation of monkeypox.

In immunocompromised people, monkeypox treatment should include optimizing immune function by limiting the use of immunosuppressive medications if not otherwise clinically indicated, and, for those with HIV, providing antiretroviral therapy. In addition, there are medical countermeasures that may have a role in treating severe illness, including oral and intravenous tecovirimat (TPOXX), cidofovir or brincidofovir, and vaccinia immune globulin intravenous (VIGIV), although there are no data on effectiveness in treating human monkeypox with these medical countermeasures. Decisions on whether and when to use these medical countermeasures must be made individually for each person and can depend on a variety of clinical and other parameters.

Healthcare providers of people with monkeypox who are at risk for or who have severe manifestations of disease should reach out to their local public health jurisdictions or CDC for guidance about appropriate treatment. People with severe manifestations of monkeypox may benefit from multidisciplinary consultation with specialists such as infectious disease, ophthalmology, dermatology, urology, or critical care medicine. CDC offers a clinical consultation service (email eocevent482@cdc.govor healthcare providers may contact the

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CDC Emergency Operations Center [EOC] at (770) 488-7100) and can provide additional guidance to clinicians with patient management questions. Clinicians seeking treatments should work with their local or state public health jurisdictions and CDC to access appropriate treatments as soon as potential need becomes apparent.

Worsening, non-healing, recurrent, and new skin lesions while receiving antiviral treatment have been observed among immunocompromised people with severe manifestations of monkeypox. Clinicians are encouraged to obtain repeat lesion swabs to assess for persistent monkeypox DNA. In such people, clinicians may consider continuing tecovirimat beyond 14 days, until there is clinical improvement (no more than 90 days).[3] In certain clinical situations, modifications to the dose, frequency, and duration may be necessary depending on the individual patient's clinical condition, disease progression, therapeutic response, and/or clinical judgement in consultation with CDC and U.S. Food and Drug Administration (FDA) as appropriate. To request clinical consultation regarding dosing adjustments, contact the CDC EOC at (770) 488-7100 or send an email to eocevent482@cdc.gov.

Currently, CDC is conducting surveillance to monitor for the development of resistance to tecovirimat primarily from specimens that were sent to CDC for monkeypox confirmatory testing; however, resistance testing results are not CLIA-waived (approved) for use in clinical decision making. For the purposes of public health surveillance, CDC encourages clinicians to submit specimens for further monkeypox virus characterization through genetic sequencing to identify mutations that could potentially result in resistance to antiviral therapy. At this time, after evaluating more than 600 samples, there have been no specimens with mutations associated with tecovirimat resistance; however, it is not clear how many of those samples were collected from people with disease progression while on tecovirimat.

***** Severe immunocompromise due to leukemia, lymphoma, generalized malignancy, solid organ transplantation, therapy with alkylating agents, antimetabolites, radiation, tumor necrosis factor inhibitors, or high-dose corticosteroids, being a recipient of a hematopoietic stem cell transplant <24 months post-transplant or ≥24 months but with graft-versus-host disease or disease relapse, or having autoimmune disease with immunodeficiency as a clinical component

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- HIV and Sexually Transmitted Infections Among Persons with Monkeypox—Eight U.S. Jurisdictions, May 17–July 22, 2022. MMWR Morb Mort Wkly Rep 2022; 71(36):1141 – 1147. https://www.cdc.gov/mmwr/volumes/71/wr/mm7136a1.htm
- Outbreak of Human Monkeypox in Nigeria in 2017–18: A Clinical and Epidemiological Report – The Lancet Infectious Diseases. https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(19)30294-4/fulltext
- Centers for Disease Control and Prevention. Expanded Access IND Protocol: Use of Tecovirimat (TPOXX) for Treatment of Human Non-Variola Orthopoxvirus Infections in Adults and Children (IND 116,039/Protocol #6402). https://www.cdc.gov/poxvirus/monkeypox/clinicians/obtaining-tecovirimat.html

Additional Resources

- Monkeypox clinical management: https://www.cdc.gov/poxvirus/monkeypox/clinicians/clinical-guidance.html
- Patient's guide to tecovirimat (TPOXX): https://www.cdc.gov/poxvirus/monkeypox/if-sick/treatment.html
- Considerations for people living with HIV: https://www.cdc.gov/poxvirus/monkeypox/clinicians/people-with-HIV.html
- Monkeypox (MPV) Provider FAQs and Resources - Washington State Department of Health: https://doh.wa.gov/you-and-your-family/illness-and-disease-z/monkeypox/provider-faq-and-resources

Washington State Department of Health Webinar "Pandemic to Endemic: Long-Term Recovery for Health Care Workers"

Webinar presented as part of the Power of Providers Initiative by Kira Mauseth, Ph.D. Co-Lead of the Washington State Department of Health Behavioral Health Strike Team addressing the mental health impact of the COVID-19 on health care workers.

Friday October 21, 2022 12:00 PM – 1:00 PM
Register at: https://register.gotowebinar.com/register/7443763415337545740

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TO REPORT A NOTIFIABLE CONDITION IN THURSTON COUNTY	
Voice mail for reporting **non-immediately reportable conditions (24 hours a day)**	Phone: 360-786-5470 Fax: 360-867-2601
Day time immediately reportable conditions – Call detailed information to the 24-hour Notifiable Condition Reporting Line at 360-786-5470. Messages are picked up hourly. If a call back can't wait call 360-867-2500 and ask staff to locate a Communicable Disease staff.	Phone: 360-786-5470
After hours immediately and 24-hour reportable conditions or a public health emergency	Call 1-800-986-9050
No one is available with Thurston County Public Health and condition is **immediately notifiable**	1-877-539-4344

Communicable Disease Updates are posted online at: http://bit.ly/CDUpdatePHSS

THANK YOU FOR REPORTING