



Department of Health

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June 17, 2022

TO: Healthcare Providers, Hospitals, Local Health Departments, Laboratories, Sexual Health Providers, Family Planning Providers, Emergency Rooms, Community Health Centers, College Health Centers, Community-Based Organizations, and Internal Medicine, Family Medicine, Pediatric, Adolescent Medicine, Dermatology, Infectious Disease, and Primary Care Providers

FROM: New York State Department of Health (NYSDOH) Bureaus of Communicable Disease Control (BCDC) and Healthcare Associated Infections (BHA), New York City Department of Health and Mental Hygiene (NYCDOHMH) Division of Disease Control

HEALTH ADVISORY: MONKEYPOX OUTBREAK, UNITED STATES

SUMMARY

- See attached Health Update from the Centers for Disease Control and Prevention (CDC): Monkeypox Virus Infection in the United States and Other Non-endemic Countries—2022, dated June 14, 2022.
- Monkeypox is a previously uncommon zoonotic viral disease rarely detected in the United States. Previous cases were typically associated with travel or exposure to an infected animal.
- As of June 16, 2022, there have been 72 confirmed monkeypox/orthopoxvirus cases in the US, and 2,166 reported worldwide since this outbreak started. There have been no reported deaths associated with the current outbreak.
- Twenty-one of these cases have been in residents of New York, with 19 of those in residents of New York City.
- Early data suggest that people who identify as gay, bisexual, and other men who have sex with men have made up a high proportion of cases. However, anyone who has been in close contact with someone who has monkeypox is at risk of infection.
- In the U.S., evidence of person-to-person disease transmission in multiple states and reports of clinical cases with some uncharacteristic features have raised concern that some cases are not being recognized and tested.
- Although all patients diagnosed with monkeypox in the U.S. to date have experienced a rash or enanthem, some cases have presented with some features uncharacteristic of classic monkeypox disease. These include:
 - Rash beginning in mucosal areas (e.g., genital, perianal, oral mucosa)
 - Lesions scattered or localized to a specific body site, rather than diffuse, and that may not involve the face or extremities
 - Lesions in different stages of progression on a specific anatomic site.
 - Classical prodromal symptoms not always occurring before the rash if they occur at all.

- Presentation with symptoms such as anorectal pain, tenesmus, and rectal bleeding.
- Presentation similar to some sexually transmitted infections (STI), such as syphilis, herpes, lymphogranuloma venereum (LGV), or other etiologies of proctitis.
- The diagnosis of an STI does not exclude monkeypox, as a concurrent infection may be present. Please refer to the CDC HAN for detailed considerations regarding concurrent evaluation for monkeypox and STI.
- Regardless of gender or sex of sex partner(s), providers should be alert for patients who have rash illnesses consistent with monkeypox, regardless of their travel history or specific risk factors for monkeypox.
- In people with epidemiologic risk factors, rashes initially considered characteristic of more common infections (e.g., varicella zoster, herpes, syphilis) should be carefully evaluated for concurrent characteristic monkeypox rash and considered for testing.
- Clinicians suspecting monkeypox infection should strictly adhere to infection prevention and control practices and immediately contact their local health department (LHD) to coordinate testing.
- Testing for monkeypox can be performed at NYSDOH Wadsworth Center and the NYC Public Health Laboratory. In this update, specimen collection for testing at Wadsworth has changed; specimens should be sent in viral transport media (VTM).

REPORTING

Healthcare providers must immediately report suspect cases of monkeypox to their local health department (LHD). Reporting should be to the county where the patient resides.

New York City residents suspected of monkeypox infection should be reported to the NYC Health Department Provider Access Line (PAL) at 866-692-3641. Outside of New York City, contact information is available at: https://www.health.ny.gov/contact/contact_information.

If you are unable to reach the LHD where the patient resides, please contact the NYSDOH Bureau of Communicable Disease Control at 518-473-4439 during business hours or 866-881-2809 evenings, weekends, and holidays.

TESTING

Testing for monkeypox is available at NYSDOH Wadsworth Center Biodefense Laboratory and the New York City Public Health Laboratory. **Specimen collection and submission must be coordinated with the local health department and/or NYSDOH. Within NYC, coordination must be done in consultation with the NYC Health Department.**

NYSDOH Wadsworth Center will accept specimens collected and transported in viral transport media (VTM) OR collected and transported dry. Specimens in VTM can be tested for orthopoxvirus, varicella zoster virus, and herpes simplex viruses I and II. Specimens collected dry can only be tested for orthopoxvirus. Testing for other viruses should be done locally.

The New York City Public Health Laboratory will only accept specimens collected and transported dry. They will only be tested for orthopoxvirus. Testing for other viruses should be done locally.

Specimen Collection

	<i>FOR SPECIMENS COLLECTED FROM NYS RESIDENTS AND TESTED AT THE NYSDOH WADSWORTH CENTER</i>	<i>FOR SPECIMENS COLLECTED FROM NYC RESIDENTS AND TESTED AT THE NYC PUBLIC HEALTH LABORATORY</i>
Specimen Types	Swab in viral transport media (VTM) or dry swab . Collect two samples from each of two lesions, for a total of 4 samples.	Dry swab ONLY . Collect two samples from each of two lesions, for a total of 4 samples.
Collection	<p>1. Identify two lesions per patient to sample, preferably from different locations on the body and/or with differencing appearances. (A total of four swabs should be collected).</p> <p>2. Collect the sample using the sterile swab, by scrubbing the base of the lesion vigorously enough to ensure that cells from the lesion are collected. Use separate sterile swabs (synthetic-Dacron, nylon, polyester, Rayon).</p> <p>3. Storage containers: Place each swab in tubes containing VTM. (can be tested for more viruses) OR place swabs in a dry sterile container (can only be tested for orthopoxvirus). See below for more information.</p>	<p>1. Identify two (2) lesions per patient to sample, preferably from different locations on the body and/or with differencing appearances. (A total of four swabs should be collected).</p> <p>2. Collect the sample using the sterile swab, by scrubbing the base of the lesion vigorously enough to ensure that cells from the lesion are collected.</p> <p>3. Storage containers: Place each swab (break off stick if necessary) in its own sterile container (i.e., conical tube or urine cup). (Reminder, do not add or store in viral or universal transport media.)</p> <p>For additional information on specimen collection refer to the Specimen collection, storage, and transport instructions section on the Instructions for Submission of Specimens for Monkeypox Testing to the New York City Public Health Laboratory guidance located here: https://www1.nyc.gov/assets/doh/downloads/pdf/labs/monkeypox-specimen-testing.pdf</p>
Submission information	<p>A Wadsworth Center Infectious Disease Request Form must accompany all samples; Remote Order Entry on the Health Commerce System is preferred.</p> <p>Label all tubes and swab holders with the patient's name, unique identifier, date of collection, source of specimen (vesicle/pustule) and name of person collecting the specimen.</p>	<p>A New York City Public Health Test Requisition (available upon request) must accompany each sample/collection site.</p> <p>Refer to Test ordering instructions on the NYC PHL guidance document at https://www1.nyc.gov/assets/doh/downloads/pdf/labs/monkeypox-specimen-testing.pdf.</p>

	Specimens should be stored and shipped refrigerated or frozen. Should not be shipped at ambient temperature.	Briefly, go to https://a816-phleorder.nyc.gov/PHLeOrder/ and perform the following 1. Sign in using credentials or register as a new user. 2. Fill out required information and add the following to the specified fields: a. Test: Clinical Poxvirus b. Specimen Container: Swab c. Specimen Source: Other d. Specimen Source Other: Skin or Lesion + site of lesion swabbed (e.g., Left arm) e. Fill in both collection date and collection time fields (required). 3. Communicate with your clinical laboratory that specimens are to be delivered to PHL and that an eOrder has been submitted.
Shipping Address	Dr. Christina Egan DAI 3021, Biodefense Laboratory, Wadsworth Center, NYS Dept. of Health 120 New Scotland Avenue Albany, NY 12208	Dr. Scott Hughes New York City Public Health Lab Biothreat Response Unit 455 1 st Avenue New York, NY 10016
Questions	Call the Wadsworth Center Biodefense Laboratory at 518-474-4177 (business hours) or the duty officer 866-881-2809 (after hours).	Call the NYC Biothreat Response Laboratory at 212-671-5834 (business hours) or Poison Control at 212-764-7667; ask for PHL duty officer (after hours). See also: https://www1.nyc.gov/assets/doh/downloads/pdf/labs/monkeypox-specimen-testing.pdf

Specimen Collection

To collect vesicular and pustular material:

1. Perform hand hygiene and don gloves, gown, face, and eye protection.
2. Sanitize the patient's skin with an alcohol wipe and allow skin to air dry (do not "wave" the site to facilitate drying).
3. For swabs in tubes containing VTM (NYS), label a swab holder and remove swab from the outer sheath. Collect cells from the lesion base by 1) vigorously swabbing or brushing lesion with two separate sterile synthetic swabs (Dacron, nylon, polyester, or Rayon); 2) Place each swab in a separate sterile tube containing VTM. Secure each tube with parafilm.
4. For the dry swabs (NYC and NYS) label a swab holder and remove swab from the outer sheath. Collect cells from the lesion base by 1) vigorously swabbing or brushing lesion with two separate sterile dry polyester, nylon, or Dacron swabs; 2) Break off end of applicator of each swab into a 1.5- or 2-mL screw-capped tube with O-ring or place each entire swab in a separate sterile container. Do not add or store in viral or universal transport media.

5. Repeat this process on different lesions.
 - a. For NYS there should be two specimens collected for each lesion: two sets of plastic tubes from each lesion for a total of 4 tubes.
 - b. For NYC there should be two swabs for each lesion
6. After specimen collection is completed all protective materials worn by the specimen collector (gloves, mask, gown, etc.) and all used sample collection materials (alcohol wipes, holders, etc.) must be placed in red biohazard bags and autoclaved or incinerated prior to disposal. Needles, blades, etc. used to open vesicles should be disposed of in an appropriate sharps container. **Thorough handwashing using soap** and water should be done immediately after specimen collection and following removal of personal protective equipment.
7. Other sample types such as serum and whole blood may also be requested.

Please note: Monkeypox virus can be cultivated in several cell culture types routinely used by the viral testing laboratory. Although laboratories should not attempt to isolate this virus, if you become aware that your laboratory has isolated monkeypox using cell culture, you should **immediately** contact the Wadsworth Center or the NYC PHL.

INFECTION CONTROL GUIDELINES

Standard Precautions should be applied for all patient care, including for patients with suspected monkeypox. If a patient seeking care is suspected to have monkeypox, infection prevention and control personnel should be notified immediately. Activities that could resuspend dried material from lesions, e.g., use of portable fans, dry dusting, sweeping, or vacuuming should be avoided.

A patient with suspected or confirmed monkeypox infection should be placed in a single-person room; special air handling is not required. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom. Transport and movement of the patient outside of the room should be limited to medically essential purposes. If the patient is transported outside of their room, they should use well-fitting source control (e.g., medical mask) and have any exposed skin lesions covered with a sheet, wound dressing, or gown. Intubation and extubation and any procedures likely to spread oral secretions should be performed in an airborne infection isolation room (AIIR).

PPE used by healthcare personnel who enter the patient's room should include gown, gloves, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), and a NIOSH-approved particulate respirator equipped with N95 filters or higher.

For more information on infection prevention and control of monkeypox, please visit the CDC website for this situation at <https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html> or the monkeypox main information page at <https://www.cdc.gov/poxvirus/monkeypox/index.html>.

PACKAGING AND TREATMENT OF MONKEYPOX MEDICAL WASTE

In June 2022, the U.S. Department of Transportation (USDOT) released additional guidance on the handling of regulated medical waste (RMW) from suspected or confirmed cases of monkeypox. The USDOT June 2022 guidance can be found at: <https://www.phmsa.dot.gov/transporting-infectious-substances/planning-guidance-handling-category-solid-waste>.

The current position of the USDOT is to hold untreated RMW generated from suspected cases of monkeypox and wait until testing confirms the diagnosis and identifies the clade. NYSDOH and the NYS Department of Environmental Conservation (NYSDEC) recommends that RMW from suspected cases be double bagged in red biohazardous waste bags and placed into a rigid container or box while in storage until testing confirms the diagnosis and identifies the clade.

USDOT has determined the following:

- If testing confirms the West African clade, waste needs to be packaged, transported and treated as RMW. The waste must be packaged in accordance with 49 CFR § 173.197, labelled as United Nations (UN) 3291, Regulated medical waste (Monkeypox waste), and treated by incineration or by autoclaving at 121°C/250°F for at least 30 minutes.
- If testing shows any clades except the West African clade, it needs to be packaged, transported, and treated as Category A waste. The waste must be packaged in accordance with 49 CFR § 173.196, labelled as United Nations (UN) 2814, Infectious substances, affecting humans (Monkeypox waste), and treated as Category A waste.

Additionally, waste generated in the home by a healthcare provider must be removed from the home by the provider. Other waste generated at home should be double-bagged before it enters the household waste stream.

This is an official **CDC HEALTH UPDATE**

Distributed via the CDC Health Alert Network
June 14, 2022, 5:00 PM ET
CDCHAN-00468

Updated Case-finding Guidance: Monkeypox Outbreak—United States, 2022

Summary

Since May 2022, monkeypox cases, which have historically been rare in the United States, have been identified in 18 states and territories among both persons returning from international travel and their close contacts domestically. Globally, more than 1,600 cases have been reported from more than 30 countries; the case count continues to rise daily. In the United States, evidence of person-to-person disease transmission in multiple states and reports of clinical cases with some uncharacteristic features have raised concern that some cases are not being recognized and tested.

This Health Alert Network (HAN) Health Update serves to alert clinicians to clinical presentations of monkeypox seen so far in the United States and to provide updated and expanded case definitions intended to encourage testing for monkeypox among persons presenting for care with relevant history, signs, and symptoms. In addition, this Health Update provides an update to a HAN Health Advisory that the Centers for Disease Control and Prevention (CDC) issued May 20, 2022 titled [Monkeypox Virus Infection in the United States and Other Non-endemic Countries—2022](#). In people with [epidemiologic risk factors](#), rashes initially considered characteristic of more common infections (e.g., varicella zoster, herpes, syphilis) should be carefully evaluated for concurrent characteristic monkeypox rash (see images and links to below) and considered for testing.

Background

The current identification of West African monkeypox cases in many countries that do not have endemic disease and involving patients with no direct travel history to an area with endemic monkeypox, suggests person-to-person community spread. The first case of monkeypox in the United States was diagnosed in a traveler who returned to Massachusetts from Canada on May 17, 2022. Since then, 65 cases have been identified in 18 states and territories and more than 1,600 have been identified in 35 countries and territories that do not have endemic disease. The case fatality rate of monkeypox associated with the West African clade of monkeypox virus is 1%, and possibly is higher in immunocompromised individuals; no deaths have been reported globally from the current outbreak. Any person, irrespective of gender identity or sexual orientation, can acquire and spread monkeypox. In this outbreak, however, many of the reported cases in the United States are among gay, bisexual, or other men who have sex with men (MSM). Close contact, sustained skin-to-skin contact including sexual contact, with a person with monkeypox or contact with contaminated fomites (e.g., shared linens) are the most significant risk factors associated with human-to-human transmission of *Monkeypox virus*.

Updated Case Definitions

- On June 1, 2022, CDC updated and expanded its monkeypox case definitions to ensure that anyone who is suspected of having monkeypox can be tested and appropriate steps to protect contacts can be taken.
- Revised categories of suspected, probable, and confirmed cases of monkeypox standardize case reporting through the [National Notifiable Diseases Surveillance System](#) (NNDSS). In addition, the “suspected” case definition encourages broader suspicion for monkeypox.

Clinical and laboratory classification	Criteria
Suspected	New characteristic rash* OR
	Meets one of the epidemiologic criteria and has high clinical suspicion† for monkeypox
Probable	No suspicion of other recent <i>Orthopoxvirus</i> exposure (e.g., <i>Vaccinia virus</i> in ACAM2000 vaccination) AND demonstration of the presence of <ul style="list-style-type: none"> • <i>Orthopoxvirus</i> DNA by polymerase chain reaction testing of a clinical specimen OR • <i>Orthopoxvirus</i> using immunohistochemical or electron microscopy testing methods OR • Demonstration of detectable levels of anti-orthopoxvirus IgM antibody during the period of 4–56 days after rash onset
	Demonstration of the presence of <i>Monkeypox virus</i> DNA by polymerase chain reaction testing or Next-Generation sequencing of a clinical specimen OR
	Isolation of <i>Monkeypox virus</i> in culture from a clinical specimen
Epidemiologic classification	
Within 21 days of illness onset:	Reports having contact with a person or persons with a similar appearing rash or with a person who has received a diagnosis of confirmed or probable monkeypox OR
	Had close or intimate in-person contact with persons in a social network experiencing monkeypox infections. This includes MSM who meet partners through an online website, digital application (“app”), or social event (e.g., a bar or party) OR
	Traveled, within 21 days of illness onset outside the United States to a country with confirmed cases of monkeypox or where <i>Monkeypox virus</i> 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.)
Exclusions	
A case might be excluded as a suspected, probable or confirmed case if:	An alternative diagnosis* can fully explain the illness OR
	A person 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 <i>Orthopoxvirus</i> or <i>Monkeypox virus</i> or antibodies to <i>Orthopoxvirus</i>

* The characteristic rash associated with monkeypox lesions involves 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. The rash can sometimes be confused with other diseases that are more commonly encountered in clinical practice (e.g., 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 *Monkeypox virus* testing, even if tests for other infectious agents are positive.

† Clinical suspicion may exist if lesions consistent with those from more common infections (e.g., syphilis, herpes, and varicella zoster) co-exist with lesions that may be characteristic of monkeypox.

Clinical presentations of confirmed cases to date

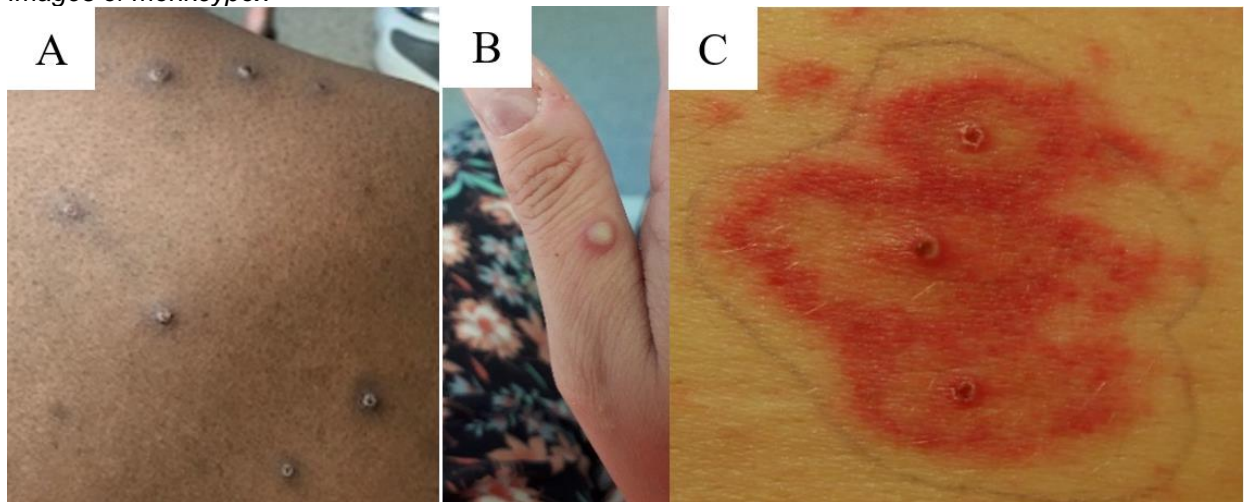
Descriptions of classic monkeypox disease describe a prodrome including fever, lymphadenopathy, headache, and muscle aches followed by development of a characteristic rash culminating in firm, deep-seated, well-circumscribed and sometimes umbilicated lesions. The rash usually starts on the face or in the oral cavity and progresses through several synchronized stages on each affected area and concentrates on the face and extremities, including lesions on the palms and soles.

Thus far in the U.S. outbreak, all patients diagnosed with monkeypox in the United States have experienced a rash or enanthem. Although the characteristic firm, deep-seated, well-circumscribed and sometimes umbilicated rash has been observed, the rash has often begun in mucosal areas (e.g., genital, perianal, oral mucosa) and in some patients, the lesions have been scattered or localized to a specific body site rather than diffuse and have not involved the face or extremities. In some instances, patients have presented with symptoms such as anorectal pain, tenesmus, and rectal bleeding which upon physical examination, have been found to be associated with visible perianal vesicular, pustular, or ulcerative skin lesions and proctitis. The lesions have sometimes been in different stages of progression on a specific anatomic site (e.g., vesicles and pustules existing side-by-side). In addition, prodromal symptoms including fever, malaise, headache, and lymphadenopathy have not always occurred before the rash if they have occurred at all.

The clinical presentation of monkeypox may be similar to some STIs, such as syphilis, herpes, lymphogranuloma venereum (LGV), or other etiologies of proctitis. Clinicians should perform a thorough skin and mucosal (e.g., anal, vaginal, oral) examination for the characteristic vesiculo-pustular rash of monkeypox; this allows for detection of lesions the patient may not have been previously aware of. The search for lesions consistent with monkeypox should be performed even if lesions consistent with those from more common infections (e.g., varicella zoster, syphilis, herpes) are observed; this is particularly important when evaluating patients who have epidemiologic risk factors for monkeypox. Specimens should be obtained from lesions (including those inside the mouth, anus, or vagina) and tested for monkeypox.

Any patient who meets the suspected case definition should be counseled to implement appropriate transmission precautions. Probable and confirmed case-patients should remain in isolation for the duration of their infectious period (i.e., until all lesions have resolved, the scabs have fallen off, and a fresh layer of intact skin has formed). Patients who do not require hospitalization but remain potentially infectious to others should isolate at home. This includes abstaining from contact with other persons and pets, and wearing appropriate personal protective equipment (e.g., clothing to cover lesions, face mask) to prevent further spread.

Images of monkeypox



Generalized monkeypox lesions are characteristically deep-seated, well-circumscribed, and often develop umbilication (A, B, C), Image A demonstrates both papulovesicular and pustular lesions in the same region of the body. Credits: Images A and B from NHS England High Consequence Infectious Diseases Network; image C from Reed KD, Melski JW, Graham MB et al. *The detection of monkeypox in humans in the Western Hemisphere*. Page 346. Copyright © 2004. Massachusetts Medical Society. Reprinted with permission. Please see lesion examples from [Nigeria](#) and [Italy](#).

Recommendations for Clinicians

- Patients with rashes initially considered characteristic of more common infections (e.g., varicella zoster or sexually transmitted infections) should be carefully evaluated for a characteristic monkeypox rash (see images and links), and submission of specimens of lesions should be considered, especially if the person has epidemiologic risk factors for monkeypox infection.
- Evaluate any individual presenting with perianal or genital ulcers, diffuse rash, or proctitis syndrome for STIs per the [2021 CDC STI Treatment Guidelines](#). Testing for STIs should be performed. The diagnosis of an STI does not exclude monkeypox as a concurrent infection may be present. The clinical presentation of monkeypox may be similar to some STIs, such as syphilis, herpes, lymphogranuloma venereum (LGV), or other etiologies of proctitis.

- Clinicians should perform a thorough skin and mucosal (e.g., anal, vaginal, oral) examination for the characteristic vesiculo-pustular rash of monkeypox; this allows for detection of lesions the patient may not have been previously aware of.
- If a patient does not respond to STI treatment as expected, the patient should return for follow-up evaluation and monkeypox testing should be considered.
- Please refer to the most recent CDC guidance for [specimen collection](#) to ensure proper collection of specimens.
 - In addition to dry swabs, CDC can now accept lesion swabs in viral transport media and lesion crusts (currently these two specimens **must be received by CDC within 7 days of collection**).
- Clinicians should use appropriate infection prevention measures when collecting specimens for monkeypox evaluation. Information on infection prevention and control in healthcare settings is provided on the [CDC website](#).
- Advise patients with prodromal symptoms (e.g., fever, malaise, headache) and one or more epidemiologic risk factors for monkeypox to self-quarantine. If a rash does not appear within 5 days, the illness is unlikely to be monkeypox and alternative etiologies should be sought.
- Clinicians should consult their state health department ([State Contacts](#)) if they suspect monkeypox.
 - All laboratory specimens should be sent through the state and territorial public health department, unless authorized to send them directly to CDC.

Recommendations for Health Departments

- Health departments should contact the CDC Monkeypox Call Center at poxvirus@cdc.gov to report probable or confirmed cases and receive a case ID and a case report form. This process allows test results from the Laboratory Response Network laboratories to be linked with case report forms.
- Health departments can obtain a PDF version of the [case report form data dictionary](#) to preview. Please do not attempt to fill out this PDF. Please contact the CDC Monkeypox Call Center at 770-488-7100 to receive access to the case report form.
 - Specimens that clinicians obtain from suspected patients should be tested for an *Orthopoxvirus* by the Laboratory Response Network laboratories; please refer to the most recent CDC guidance for [specimen collection](#) to ensure proper collection of specimens.
 - In addition to dry swabs, CDC can now accept lesion swabs in viral transport media and lesion crusts (currently these two specimens **must be received by CDC within 7 days of collection**).
- After diagnosing a patient with Orthopoxvirus, contact tracing can be initiated for identification of people who had [close contact](#) to the patient while the patient was symptomatic. Contacts should be monitored for 21 days after their last date of contact with the patient.
- Share this HAN Health Update with relevant healthcare provider networks, including STI clinics that may not always receive CDC HAN messages.

Recommendations for the Public

- CDC is closely monitoring worldwide case counts and working to understand the cause of the current cases. Based on limited information available at this time, overall risk to the U.S. public is currently low.
- People who may have symptoms of monkeypox, such as unknown rashes or lesions, should contact their healthcare provider for assessment. This includes anyone who:
 - Reports contact with a person who has a similar rash or received a diagnosis of confirmed or suspected monkeypox.
 - Had close or intimate in-person contact with individuals in a social network experiencing monkeypox infections, this includes MSM who meet partners through an online website, digital application (app), or social event (e.g., a bar or party).
 - Traveled to countries where monkeypox cases have been reported.

For More Information

- [Case Definitions for Use in the 2022 Monkeypox Response](#)
- [Information for Healthcare Professionals](#)
- [Clinical Recognition of Monkeypox](#)
- [Monitoring Persons Who Have Been Exposed](#)
- [Monkeypox Outbreak — Nine States, May 2022](#)
- [U.S. Monkeypox 2022: Situation Summary](#)
- [Monkeypox facts for people who are sexually active](#)
- Contact your state or local health department if you have any questions or suspect a patient may have monkeypox.

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention; highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##