



Public Health
England

Protecting and improving the nation's health

Monkeypox: information for primary care

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For queries relating to this document, please contact [your local HPT](#). Information is also available on the PHE monkeypox webpage <https://www.gov.uk/guidance/monkeypox>



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Background

Monkeypox is a rare infectious disease caused by the monkeypox virus (genus orthopox). Monkeypox virus is related to, but distinct from, the viruses that cause smallpox (variola virus) and cowpox. Following the global eradication of smallpox in 1977, monkeypox has become the dominant cause of orthopox outbreaks in humans, primarily in countries in West and Central Africa. Outbreaks in these African countries typically occur in remote, forested regions.

In 2018 in Africa, monkeypox cases have been reported from Cameroon, the Central African Republic, the Democratic Republic of Congo, Liberia and Nigeria.

In September 2018, **two cases of monkeypox were imported into the UK**. Other cases exported from Africa were subsequently identified in other countries.

Transmission

Monkeypox does not spread easily between people.

Spread of monkeypox may occur when a person comes into close contact with an infected animal (rodents are believed to be the primary animal reservoir for transmission to humans), an infected human, or materials contaminated with the virus. The virus enters the body through broken skin (even if breaks are not visible), the respiratory tract, or the mucous membranes (eyes, nose, or mouth).

Person-to-person spread is very uncommon, but may occur through:

- contact with clothing or linens (such as bedding or towels) used by an infected person
- direct contact with monkeypox skin lesions or scabs
- close exposure to the coughs or sneezes of an individual with a monkeypox rash

Clinical features

The incubation period is 5 to 21 days, but typically 6 to 16 days following exposure. The initial phase of typical clinical illness usually lasts 1 to 5 days; patients may experience a combination of fever and/or chills, lymphadenopathy, headache, myalgia, backache and exhaustion. Fever is present in most, but not all patients. This is followed by a second phase where a rash appears, during which time some existing signs and symptoms, including fever, may diminish or disappear. The distribution of the rash and the appearance of individual skin eruptions typically change over time.

The rash may be maculopapular initially, typically starting on the face before spreading peripherally, particularly to the palms of the hands and the soles of the feet. The initial rash classically evolves into vesicles and then pustules, often with umbilication, which eventually crust and then desquamate during the next two to three weeks. These characteristic pox lesions are typically 0.5 to 1cm diameter and may number from a few to several thousand. Involvement of the oral mucous membranes occurs in many cases; lesions may also occur on the genitals, conjunctivae and cornea in some patients. Localised rashes are seen occasionally, relating to the site of the initial exposure.

Most patients experience a mild, self-limiting illness, with spontaneous and complete recovery seen within 3 weeks of onset. However, severe illness can occur and sometimes results in death.

Patient Assessment

As part of an investigation into confirmed **monkeypox cases in the UK**, individuals that are identified as potential contacts of the case are contacted. These individuals are then asked to contact a named Public Health England Health Protection Team (HPT) if they develop compatible symptoms. However, if a patient who has been identified as a contact of a monkeypox case were to present to you, please **contact the local HPT** for advice.

It is unlikely that other patients presenting to primary care will have monkeypox. For persons who have travelled to/from Africa, fever is more likely to be caused by common tropical infections such as malaria or typhoid, which should be diagnosed and treated promptly.

Specialist assessment and laboratory investigation is essential. Patients of concern should be discussed with your local infection specialist in the first instance, who may then discuss the patient with the **Imported Fever Service (IFS)** (Tel: 0844 7788990). If it is agreed that monkeypox is a possible diagnosis, the HPT must be informed and the patient will need to be referred to a hospital with appropriate isolation facilities, ideally a local infectious diseases centre. The details of this process and any further assessment for the patient will be provided by the IFS.

Patients can be advised that specialist assessment will be free at the point of care, whatever their nationality

Infection prevention and control in the case of suspected monkeypox

The main risk for transmission would be from direct contact with skin lesions or through contact with a patient's clothing or linens that have been in contact with the lesions. Therefore, practitioners should avoid touching skin lesions with bare hands, wear disposable gloves and observe strict hand hygiene.

It is likely that patients would present in the early stages of the illness and as such there should be a low risk of environmental contamination during their initial presentation to primary care or during the patient examination.

If monkeypox is considered likely and the patient is referred to hospital, the room should not be used following transfer and the **nearest HPT** should be contacted for advice about cleaning and decontamination.