Long-term Household Contamination With Monkeypox Virus Investigated

An investigation by CDC and state health authorities in Utah found monkeypox virus on many frequently used household surfaces, blankets, furniture, and other objects in a home where residents had been isolating for weeks. Although monkeypox is mainly spread through skin-to-skin contact in the current outbreak, the authors noted that “transmission via contaminated objects or surfaces is also possible.”

Researchers collected specimens from 30 high-touch household objects and surfaces in 9 areas of the home of 2 individuals who had been in isolation for 20 days with mild travel-associated monkeypox infections. Investigators, wearing personal protective equipment, collected samples while the individuals were still symptomatic.

Seventy percent of the samples tested positive for the monkeypox virus via polymerase chain reaction (PCR) testing. Three items with fabric surfaces tested positive, including a couch, chaise lounge, and blankets. Seventeen hard surfaces also tested positive, including light switches, handles, a toilet seat, a coffee maker, a shower attachment, a banister, a tube of medicine, and a computer mouse and keyboard. However, none of the samples yielded a positive viral culture test. The authors suggest that cleaning or the passage of time may have inactivated the virus found on surfaces.

They recommended that individuals living with or visiting an infected person’s home wear a mask, avoid touching potentially contaminated surfaces, wash their hands, and avoid sharing utensils, clothing, bedding, or towels. They also suggested that affected households follow CDC guidelines for disinfection.

Bus and Urban Transit Workers Have Highest COVID-19 Risk

Workplace COVID-19 outbreaks were about 5 times more common and nearly twice as deadly in the bus and urban transit industry than all industries combined in California, found an analysis led by the California Department of Public Health.

Using state data collected between January 2020 and May 2022, the authors identified 340 confirmed workplace outbreaks, 5641 outbreak-associated COVID-19 cases, and 537 worker deaths. Overall, public transportation industries had about 1.4 times as many COVID-19 outbreaks as did all sectors combined. But certain workers and types of transit work were disproportionately affected. Workplace outbreaks were 5.2 times more common in bus and urban transit and 3.6 times more common in the air transportation industry than in all industries combined. Mortality was also 1.8 times higher in the bus and urban transit industries than in all industries combined.

“Workers in public transportation industries are at higher risk for COVID-19 workplace outbreaks and mortality than the general worker population in California and should be prioritized for COVID-19 prevention strategies,” the authors wrote. Workplace protection measures may include targeted vaccination efforts, access to antiviral treatment, public health messaging for workers, improved ventilation, and use of well-fitted masks or respirators by workers and public transit riders, the authors wrote.

Interim Guidance for Monkeypox Among Patients With HIV

A new CDC interim guidance outlines considerations for preventing and treating monkeypox virus infections among people living with HIV.

Men who have sex with men (MSM) and are living with HIV infection are overrepresented in the current multinational monkeypox outbreak. Preliminary data from the European Union, England, and the US suggest that, for those whose HIV status is known, 28% to 51% of MSM who have monkeypox also have HIV, according to the guidance authors. But whether HIV infection or shared
risk factors for monkeypox and HIV acquisition explain the risk is unknown.

“Although it is possible that poorly controlled HIV would increase the risk for monkeypox after exposure, evidence from other diseases suggests that persons with HIV who are receiving antiretroviral therapy and have robust CD4 [cell] counts are not at increased risk for most infections, including opportunistic infections,” the authors wrote.

The guideline recommends that all individuals with new or existing HIV infection and monkeypox infection should continue to receive antiretroviral therapy and opportunistic infection prophylaxis as indicated for HIV to prevent rebounding HIV or other conditions that could complicate monkeypox treatment. Pre-HIV or post-HIV exposure prophylaxis should also begin or continue among individuals with monkeypox.

To assess the risk of serious illness in individuals with HIV and monkeypox, the guideline recommends that clinicians should consider patients’ CD4 cell counts and HIV viral suppression and should consider using tecovirimat, the recommended first-line treatment for monkeypox. If this treatment is indicated, drug interactions should not preclude using both tecovirimat and antiretroviral therapy. Clinicians should also weigh the benefits and risks of pre-monkeypox and postmonkeypox exposure vaccine prophylaxis. The JYNNEOS vaccine, which uses a live, nonreplicating modified vaccinia Ankara virus licensed for smallpox and monkeypox prevention, is the preferred vaccine for people with HIV, according to the guideline.

The replication-competent live vaccinia virus vaccine ACAM2000 licensed for smallpox prevention is contraindicated for people with HIV because of the risk of severe adverse effects in immunocompromised persons, according to recommendations from the CDC’s Advisory Committee on Immunization Practices. People with HIV should also take precautions to prevent monkeypox infection, including isolating from infected individuals and their pets, avoiding close contact or sexual activity with infected people, and seeking postexposure vaccination if exposed. — Bridget M. Kuehn, MSJ

Note: Source references are available through embedded hyperlinks in the article text online.