We must learn from the past in responding to monkeypox

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Our experience with the monkeypox virus brings to mind some of the most painful aspects of the response to the COVID-19 pandemic: downplaying the risk, insufficient testing capacity, a lack of demographic data on cases, difficulties with contact tracing, poor access to supplies in the strategic national stockpile, and overall uncertainty giving rise to ever-increasing misinformation.

Despite calls from the AMA and others to strengthen our nation’s public health infrastructure and bolster our nation’s preparedness for the next crisis, the reality is that there’s a lot more work to do. Our public health system is still responding to COVID-19 while now facing an outbreak of monkeypox, which the World Health Organization recently declared a global health emergency, and the first reported polio case in the U.S. in more than a decade.

A rare viral illness

Monkeypox, first identified in 1958, is an orthopox virus in the same viral family as smallpox—but it causes milder symptoms and is rarely fatal. Symptoms can include a rash that can appear like blisters or pimples, fever, chills, headache and body aches, exhaustion and swollen lymph nodes. Those most at risk for serious illness and death include children, people with compromised with immune systems, people who are pregnant or breastfeeding, and those with a history of eczema, according to the Centers for Disease Control and Prevention (CDC).

The disease can be spread in multiple ways, including direct contact with the infectious rash, intimate physical contact, contact with an infected animal, or contact with clothing, linens or other items contaminated by the rash or body fluids. The illness caused by the virus often lasts between two to four weeks, and an infected person can spread the virus from the time symptoms appear until the subsequent rash has fully healed.

While monkeypox is often described as mild, some patients who have contracted the virus during the current outbreak have described the skin lesions as “debilitatingly painful.” You can find additional
information and answers to frequently asked questions from the AMA.

Until this year, monkeypox was seldom reported outside of central and western Africa. The CDC noted that only two cases of monkeypox were reported in the U.S. last year.

Today, there are more than 15,000 cases documented in more than 65 countries that have not historically reported monkeypox. The U.S. count topped 2,300 as of July 21, with cases reported in most states. As is true with current COVID-19 case counts, however, the total number of monkeypox infections is almost certainly higher than these figures indicate.

**Challenges with the response**

What’s different with monkeypox is the fact we already have effective vaccine, and have an opportunity to contain the current outbreak by robust testing, disease surveillance, contact tracing, and vaccine administration. But this window will close if we respond in the same uncoordinated way we did to COVID-19 in the first half of 2020, which played a key role in its rapid and relentless spread.

While testing for monkeypox was initially made available through public health laboratories, many health professionals are unfamiliar with their public health departments and how to access this testing. Delays in receiving test results hampered contract tracing efforts. With testing through commercial and academic laboratories increasing, access to testing should be less of an issue, though the cost of testing through these labs could be a potential barrier.

Demographic data on monkeypox cases remains a challenge. It needs to be recognized that CDC does not have direct authority to require data reporting. The CDC gets data from 50 states and 3,000-plus local jurisdictions and territories, which requires the execution of data-sharing agreements. We know from the experience with COVID-19 that demographic data is important to inform the equitable allocation of resources.

Furthermore, while the Jynneos vaccine is available through the strategic national stockpile, 780,000 doses were stored at the supplier in Denmark and were awaiting the completion of the Food and Drug Administration (FDA) on-the-ground inspection and authorization before they could be shipped to the U.S. That inspection was expected to be completed this fall, but the timeline was accelerated and was finished in mid-July. The limited access to vaccine doses, which are being made available to public health departments, has been frustrating—but the supply is improving.

Additionally, antivirals such as TPOXX (tecovirimat) are also available through the SNS, but physicians and other clinicians need to request access through their state or territorial health department or CDC Emergency Operations Center. Because the FDA initially approved the drug only
for treating smallpox, patients have been required to enroll in a clinical study to gain access. The trial requirements are highly labor-intensive. The CDC, in coordination with FDA, is working on a revised, simplified protocol to reduce data-collection and reporting requirements.

Public messaging

It is vitally important for us to recall the public health lessons learned from the early days of the HIV epidemic some 40 years ago, when erroneous messaging fostered irrational fears and fueled persistent stigma and bias against the LGBTQ+ population. Viruses can infect anyone, without regard to social standing, sexual orientation or any other demographic consideration. That having been said, it is important to understand and clearly communicate risk factors and steps to prevent transmission.

If recent history has taught us anything, it is that we must take nothing for granted in responding to any outbreak of viral illness. We must consistently and sustainably fund public health infrastructure, support incentives to help recruit and retain staff within the governmental public health workforce, modernize public health data systems and promote interoperability between health care and public health systems, and ensure equitable access to public health funding and programs.

Improving communication between health departments and the health professionals licensed within their jurisdictions will also improve our response to disease threats, not only for monkeypox, but for all of the public health emergencies that are certain to follow.