



Epi Update for Thursday, August 4, 2022

Office of the Public Health Medical Director
Center for Acute Disease Epidemiology (CADE)
Bureau of HIV, STD, and Hepatitis

Iowa Department of Public Health (IDPH)

Items for this week's Epi Update include:

- **Monkeypox update**
- **Parechovirus (PeV) circulating in the United States**
- **Impact of COVID-19 on antimicrobial resistance in the U.S.**
- **In the news: Bacteria that causes rare disease melioidosis discovered in U.S. environmental samples**
- **Infographic: Invest in prevention**

Monkeypox update

An ongoing outbreak of monkeypox has spread across several countries that don't normally report monkeypox, with the highest case counts occurring the U.S, Europe, and Canada. As of August 3, 26,208 cases have been identified in 87 countries. A total of 6,616 cases have been identified in the U.S., with New York (1,666), California (826), and Illinois (547) reporting the most cases. A total of 11 cases have been identified in Iowa.

Men who have sex with men make up a high number of cases. However, anyone who has been in close contact with someone who has monkeypox is at risk. The virus is spreading mostly through close, intimate contact with someone who has monkeypox.

The rash associated with monkeypox involves vesicles or pustules that are deep-seated, firm or hard, and well-circumscribed; the lesions may umbilicate or become confluent and progress over time to scabs. Presenting symptoms typically include fever, chills, distinctive rash, or new lymphadenopathy; however, onset of perianal or genital lesions in the absence of fever has been reported. The rash can be confused with other diseases (e.g., secondary syphilis, herpes, chancroid, and varicella zoster). A high index of suspicion for monkeypox is warranted when evaluating people with a characteristic rash, particularly for men who report sexual contact with men and individuals reporting travel history or contact with a case of monkeypox.

On July 28, CDC released a HAN to alert clinicians on commercial testing capability, collecting clinical specimens for testing, and using TPOXX® (tecovirimat) for treating monkeypox. To view the HAN, visit <https://emergency.cdc.gov/han/2022/han00471.asp>.

SHL has also released a Laboratory Update detailing guidelines and requirements for testing at http://shl.uiowa.edu/technicalupdates/2022_08_01_Monkeypox_announcement.pdf.

Clinicians must report suspected monkeypox cases to IDPH as soon as monkeypox is suspected and prior to collecting specimens.

- Contact IDPH by calling 515-242-5935 during business hours or 515-323-4360 outside of business hours.
- Contact SHL by calling 319-335-4500 or 1-800-421-4692.

For more information about the ongoing monkeypox outbreak, visit www.cdc.gov/poxvirus/monkeypox/response/2022/index.html.

Parechovirus (PeV) circulating in the United States

A recent CDC Health Advisory describes a national increase of circulating parechovirus (PeV) infections in neonates and young infants. Clinicians are encouraged to include PeV in the differential diagnoses of infants presenting with fever, sepsis-like syndrome, or neurologic illness (seizures, meningitis) without another known cause and to test for PeV in children with signs and symptoms compatible with PeV infection. To date, all PeV positive specimens tested and typed at CDC were type PeV-A3.

Parechovirus testing is available through commercial laboratory assays and multiplex platforms from meningitis and encephalitis. SHL will accept specimens for parechovirus identification testing and parechovirus positive specimens for subtyping, which will be sent to CDC Picorna Lab for testing. Testing turnaround time from CDC may take up to two weeks.

To view the full Health Advisory, visit <https://emergency.cdc.gov/han/2022/han00469.asp>.

Impact of COVID-19 on antimicrobial resistance in the U.S.

CDC has released a comprehensive analysis on the impact of the COVID-19 pandemic on antimicrobial-resistant (AR) infections in the U.S. showing surges in AR infections and antibiotic use in hospitals during the first year of the pandemic. This reflects a reversal of progress noted in the *2019 AR Threats Report*, which showed a reduction of AR deaths by 18% overall from 2012 to 2017.

Key findings conclude the threat of AR infections is not only still present but has gotten worse in the U.S. - with resistant hospital-onset infections and deaths both increasing at least 15% during the first year of the pandemic. During the first year of the pandemic nationally, more than 29,400 people died from AR infections commonly associated with health care. Nearly 40% of these got the infection while in the hospital.

Unfortunately, pandemic-related challenges weakened many infection prevention and control practices in U.S. health care facilities, undoing some progress on combating antimicrobial resistance. Infection prevention and control practices include hand hygiene, cleaning equipment, separating patients, and appropriately using personal protective equipment.

To view the full CDC analysis, visit www.cdc.gov/drugresistance/covid19.html.

To help strengthen infection prevention and control practices in Iowa health care facilities, the IDPH Healthcare Associated Infections Program offers free, on-site infection prevention and control assessments for any health care facility or setting. The assessment includes both a comprehensive review of written policies and protocols as well as infection prevention observations. Any facility can request an assessment by emailing HAI-AR@idph.iowa.gov.

In the news: Bacteria that causes rare disease melioidosis discovered in U.S. environmental samples

www.cdc.gov/media/releases/2022/p0727-Melioidosis.html

Infographic: Invest in prevention



To view in full size, visit www.cdc.gov/drugresistance/images/covid19/invest-in-prevention.jpg.

Have a healthy and happy week!

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