DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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Health Awareness Notice for District of Columbia Healthcare Providers

Increase in Mpox Clade II Cases in the District of Columbia

SUMMARY

This notice is to inform providers of a recent increase in cases of clade II mpox in the District of Columbia. In 2025, 22 cases have been reported among DC residents with 8 cases reported in August alone. Cases continue to be primarily among men who have sex with men. Mpox is a viral disease transmitted from person to person through close physical contact, including sexual contact. Symptoms include a papular or nodular rash which may be accompanied by other general symptoms. When mpox is suspected, providers should complete a full skin and mucosal examination, a sexual and travel history, and collect lesion material for confirmatory testing. Treatment is primarily supportive, but antivirals can be considered for patients at high risk of severe disease. The JYNNEOS vaccine is recommended for people with certain risk factors for the prevention of mpox.

BACKGROUND

Mpox is an infectious disease caused by the *Monkeypox virus*. Mpox is a zoonotic disease, meaning it can be spread between people and animals. The virus is endemic, or found regularly, in parts of Central and West Africa. The natural reservoir of the virus is unknown, but various small mammals in these endemic regions have been affected with mpox. Mpox spreads through close or intimate contact with a person with mpox, direct contact with an infected animal, or contact with contaminated objects. There are two clades of mpox which can be spread, treated, and prevented in the same ways. Clade I is endemic to Central Africa and has historically caused more severe disease, although current outbreaks in Central and Eastern Africa have seen lower mortality rates. Clade II is endemic to West Africa and typically causes less severe disease. Clade II mpox was the cause of the global 2022 outbreak which primarily affected gay, bisexual, and other men who have sex with men.

Mpox is usually transmitted from person to person through close, sustained physical contact including skin-to-skin contact (such as touching or sex) and mouth-to-mouth or mouth-to-skin contact (such as kissing). Symptoms appear within 21 days of exposure typically between days 3-17. Symptoms include a painful or itchy rash which may be diffuse and can be accompanied by fever, headache, muscle aches, and enlarged lymph nodes. A person can spread mpox from the time symptoms begin, or even 1-4 days prior, until the rash has fully healed. Most people with mpox will recover in 2-4 weeks with supportive care. People at higher risk of severe disease who may need antivirals include people with weakened immune systems, people with active skin conditions, people who are pregnant or breastfeeding, and people under the age of 18.

Clade II mpox continues to circulate at low levels in the US and District of Columbia. In the District, there were 32, 23, and 22 clade II mpox cases reported in 2023, 2024, and 2025 respectively. In August 2025, 8 cases were reported among District residents, aligning with recent increases in neighboring jurisdictions. Local cases continue to be primarily among men who have sex with men.

There have been five reported cases of clade I mpox in the United States in people who had recently traveled to affected areas in Central and Eastern Africa. The cases are separate events and are not linked; no additional spread of mpox has been reported. Clade I mpox has not been reported in the District.

RECOMMENDATIONS FOR HEALTHCARE PROVIDERS

The classic presentation of monkeypox involves a characteristic diffuse centrifugal rash. Mpox lesions are deep-seated, well-circumscribed, and often have central umbilication. Lesions progress through four stages: macules, papules, vesicles, pustules – before scabbing over. Clinicians should perform a complete physical examination, including a thorough skin and mucosal (e.g., oral, genital, anal) examination for the characteristic vesiculo-pustular rash of mpox. This allows the clinician to detect lesions of which the patient may be unaware. Individuals who are vaccinated against mpox may have very mild symptoms, such as a single lesion, which can be challenging to distinguish from other sexually transmitted infections.

Fever and other symptoms including lymphadenopathy, malaise, headache, and muscle aches may occur before the rash, after the rash, or not at all. A person is considered infectious from the onset of symptoms until the lesions have crusted, the crusts have separated, and a fresh layer of healthy skin has formed underneath. The severity of illness can depend upon the initial health of the individual and the route of exposure.

It is critical that clinicians take a detailed sexual history and travel history for any patient with suspected mpox. In the current clade I outbreak originating in Central Africa, transmission has occurred through sexual activity, day-to-day household contact, and in healthcare settings when PPE was not available. In the ongoing clade II mpox outbreak, transmission has been almost exclusively associated with sexual contact. Lesions and symptoms of clade I and clade II mpox are indistinguishable without clade-specific testing. Consider clade I mpox in patients that have recent travel to Central and Eastern Africa. See CDC's Mpox in the United States and Around the World: Current Situation to learn more about regions with ongoing outbreaks.

Infection Control in Healthcare Settings

Transmission of mpox in healthcare settings has been rare. Standard contact and droplet precautions should be used for any patient presenting with symptoms of possible mpox.

- Place patients with suspected or confirmed mpox in a single room with a dedicated bathroom; special air handling is not necessary
- Limit transport of the patient. If transport is necessary, ensure the patient wears a mask and covers exposed skin lesions.

- When caring for patients with suspected mpox, use appropriate personal protective equipment including a gown, gloves, eye protection, and NIOSH-approved respirator equipped with N95 filters or higher.
- Standard cleaning and disinfection procedures should be performed using an EPA-registered hospital-grade disinfectant with an emerging viral pathogen claim.
- For more information visit: https://www.cdc.gov/mpox/hcp/infection-control/healthcare-settings.html

Testing for Mpox

Mpox is diagnosed using real-time PCR. Testing is available at many large commercial laboratories (including LabCorp and Quest) and the DC Public Health Lab. Skin lesion material, including swabs of the lesion surface, exudate, or lesion crusts are the recommended specimen types for laboratory testing of mpox virus specimens. Clinicians should collect two swabs from each lesion (generally from 2-3 lesions) in case additional testing, such as clade-specific testing, is needed for these patients.

Specimen Collection

1. Appropriate PPE should be worn during specimen collection.
2. Use sterile, dry synthetic swabs including, but not limited to polyester, nylon, or Dacron swabs (cotton swabs are unacceptable).

- Vigorously swab or brush the lesion with two separate sterile dry polyester or Dacron swabs.

3. Place swabs from lesions, crusts, and exudate in separate tubes.
4. Consult the laboratory to determine the acceptable specimen transport and storage conditions.

Tecovirimat (TPOXX)

Supportive care is the mainstay of mpox treatment. Tecovirimat, also known as TPOXX, is an antiviral drug stockpiled for smallpox preparedness. Initial analysis of data from two randomized clinical studies designed to assess the efficacy and safety of tecovirimat in treating mpox showed that tecovirimat was safe but didn't reduce the time to resolution of mpox lesions. However, the role of TPOXX in the treatment of severe disease or those at risk for severe disease needs further study. Providers may request TPOXX for patients who meet EA-IND eligibility requirements.

DC Health no longer has a local supply of tecovirimat. Requests for tecovirimat must go directly through the CDC. To request tecovirimat, email poxvirus@cdc.gov or register and submit a request via the CDC's TPOXX IND online registry. The CDC will require a clinical consultation for most cases. Please include DC Health in this consultation for awareness and potential follow-up at the DC Health and Wellness Center.

Guidance for Patients

Isolation and infection control at home:

- The CDC recommends that people with mpox remain isolated at home from the onset of symptoms until the lesions have crusted, the crusts have separated, and a fresh layer of healthy skin has formed underneath—given that this could take weeks, the CDC acknowledges that isolation at home for this length of time might not be possible in all situations.

- If people with mpox need to leave home before all lesions have resolved, they should cover all unhealed lesions with clothing or bandages, wear a well-fitting mask or respirator around others, avoid public transportation, wash their hands frequently, and avoid close or intimate contact with others and sharing personal items.

RECOMMENDATIONS FOR THE PUBLIC

Vaccination
The JYNNEOS vaccine is recommended for the prevention of mpox. JYNNEOS vaccine is now commercially available and may be covered by some insurances. Getting both doses provides the best protection. You should get two doses 4 weeks apart. The CDC recommends vaccination if:

- You had known or suspected exposure to someone with mpox
- You had a sex partner in the past 2 weeks who was diagnosed with mpox
- You are a gay, bisexual, or other man who has sex with men (MSM), or a person who has sex with gay, bisexual, or other MSM who in the past 6 months has had any of the following:
- A new diagnosis of one or more sexually transmitted diseases (e.g., chlamydia, gonorrhea, or syphilis)
- More than one sex partner
- You have had any of the following in the past 6 months:
- Sex at a commercial sex venue (like a sex club or bathhouse)
- Sex related to a large commercial event or in a geographic area (city or county for example) where mpox virus transmission is occurring
- You have a sex partner with any of the above risks
- You are at risk for occupational exposure to orthopoxviruses (e.g., certain people who work in a laboratory or a healthcare facility).

At this time, getting more than two mpox vaccine doses (a "booster") isn't recommended. If you've already had both recommended doses, you don't need any more, even if you've been exposed to someone with mpox. In addition, if you have had mpox infection and recovered, then natural immunity is present, and vaccination is not indicated.

Travel
In July 2025, the CDC issued a Level 2 Travel Health Notice for travelers to Liberia and Sierra Leone due to ongoing outbreaks of clade II mpox in the region. If you are planning to travel to this region and anticipate sexual contact with a new partner, mpox vaccination is recommended regardless of sexual orientation. If possible, get your first dose of the mpox vaccine at least 6 weeks before traveling. Get the second dose 4 weeks later. It takes about 2 more weeks to get the best protection against mpox.

CDC also recommends mpox vaccination for travelers to countries with sustained spread of clade I mpox if they anticipate certain sexual activities while traveling. As of August 6, 2025, the countries of Burundi, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Sudan, Tanzania,

Uganda, and Zambia are experiencing sustained human-to-human transmission of the virus; there is also evidence of sustained transmission in the Central African Republic and the Republic of the Congo.

REPORTING REQUIREMENTS

Mpox infections are immediately reportable in the District by phone at 844-493-2652 upon provisional diagnosis or the appearance of suspicious symptoms and confirmed by the submission of a case report within 24 hours. Report suspected or confirmed mpox cases to DC Health by submitting a Notifiable Disease and Condition Case Report Form.

ADDITIONAL RESOURCES

- Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)
- Clinical Features of Mpox | CDC
- Testing Patients for Mpox | CDC
- Poxvirus Molecular Detection Testing Submission Guidelines | DC PHL
- Travel Health Notices | CDC

REFERENCES

1. Mpox. World Health Organization, 26 August 2024. https://www.who.int/news-room/fact-sheets/detail/mpox
2. *Clinical Overview of Mpox.* Centers for Disease Control and Prevention, 30 April 2025. https://www.cdc.gov/mpox/hcp/clinical-overview/index.html
3. *Tecovirimat (TPOXX) for Treatment of Mpox*. Centers for Disease Control and Prevention, 3 June 2025. https://www.cdc.gov/mpox/hcp/clinical-care/tecovirimat.html
4. *Mpox, Infection Prevention and Control in Healthcare Settings.* Centers for Disease Control and Prevention, 8 July 2025. https://www.cdc.gov/mpox/hcp/infection-control/healthcare-settings.html
5. *Mpox Vaccination.* Centers for Disease Control and Prevention, 8 July 2025. https://www.cdc.gov/mpox/vaccines/index.html

Please contact the DC Health Division of Epidemiology-Disease Surveillance and Investigation at:
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