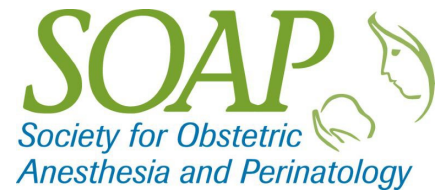


Monkeypox – What to Know!



Information for obstetric anesthesia care

Society for Obstetric Anesthesia and Perinatology (SOAP)

Education Committee

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Monkeypox has recently spread across several countries, including the United States. In light of the current outbreak of monkeypox virus infection, the Education Committee of the Society for Obstetric Anesthesia and Perinatology (SOAP) is sharing the following considerations and suggestions outlined below. Please note that these approaches are not to be interpreted as guidelines or standards of care. Rather, this is interim guidance based on expert opinion of a group of SOAP representatives and differs from SOAP's more formal consensus statements based on systematic reviews and Delphi processes. This content will be updated as needed and integrates information and links to recommendations from the WHO and CDC.

Monkeypox spreads primarily through direct contact with infectious sores, scabs, or body fluids. Monkeypox can spread during intimate contact between people, including during sex or touching parts of the body with monkeypox sores. It also can be spread by respiratory secretions during prolonged, face-to-face contact.

The development of initial symptoms (e.g., fever, malaise, headache, weakness) marks the beginning of the prodromal period. A couple of days after fever develops, patients may develop a rash that can last 2-4 weeks, often beginning on one part of the body and then spreading to other parts of the body. The rash develops and progresses from macules, to papules, to vesicles, and then to pustules, followed by umbilication, scabbing, and desquamation. A patient is considered infectious starting with the initial prodromal symptoms and remains so until all skin lesions have crusted, scabs have fallen off, and a fresh layer of skin has formed.

Additional Background:

1. Information about monkeypox infection during pregnancy is limited.
2. Serious, adverse pregnancy outcomes have been reported, including preterm birth, pregnancy loss and stillbirth.
3. The signs and symptoms of monkeypox virus infection – fever, lymphadenopathy, headache, myalgias, rash – appear similar in pregnant people and non-pregnant people; it is unknown, however, if pregnant people are more susceptible to monkeypox virus or if infection is more severe during pregnancy.

General considerations and preparation:

1. Maintain a heightened awareness and consider monkeypox in pregnant persons who have a rash illness.
2. Pregnant people with suspected or confirmed monkeypox infection require **enhanced droplet** precautions.
3. A negative pressure room is **not** required for routine care but may be considered for aerosol generating procedures.
4. Anesthesia providers should wear proper personal protective equipment (PPE), including gown, gloves, a fit-tested N95 respirator, and eye protection.
5. Patients should wear a mask as tolerated, and support persons should adhere to PPE requirements.
6. Limit the number of care providers to a minimum.
7. The benefits of skin-to-skin contact on breastfeeding and infant physiology must be balanced with the risk of neonatal transmission of Monkeypox virus and potential for severe disease in newborns. Therefore, direct contact between a patient in isolation for monkeypox and their newborn is not advised. Breast milk expressed from a patient who is symptomatic or isolated should be discarded while breastfeeding is delayed.
8. Additional infection prevention, including care of the environment, for control of Monkeypox in healthcare settings can be found at <https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html>

Neuraxial anesthesia:

1. Placement of neuraxial anesthesia should rely on the usual considerations since there is currently no available guidance.
2. There are currently no data regarding the risk of CNS infection after neuraxial techniques for in patients with monkey pox. The theoretical risk for CNS infection should be weighed against the risks associated with alternative methods of analgesia and anesthesia. It is likely best to avoid needle contact with open sores.
3. Assign the most experienced anesthesia provider whenever possible for procedures.

General anesthesia:

1. All personnel should wear proper personal protective equipment (PPE), including gown, gloves, a fit-tested N95 respirator, and eye protection.
2. A high efficiency particulate air (HEPA) filter at the patient side of the breathing circuit may be advisable.

About the Society for Obstetric Anesthesia and Perinatology

The Society for Obstetric Anesthesia and Perinatology (SOAP) was founded in 1968 to provide a forum for discussion of problems unique to the peripartum period. SOAP is comprised of more than 2,000 anesthesiologists, obstetricians, pediatricians, and basic scientists from around the world who share an interest in the care of the pregnant patient and the newborn. SOAP's mission is to advance and advocate for the health of pregnant women and their babies through research, education, and best

practices in obstetric anesthesia care. To learn more, visit soap.org. The educational materials presented here are the individual authors' opinions and not medical advice, are not intended to set out a legal standard of care, and do not replace medical care or the judgment of the responsible medical professional in light of all the circumstances presented by an individual patient. The materials are not intended to ensure a successful patient outcome in every situation and are not a guarantee of any specific outcome. Materials are subject to periodic revision as additional data becomes available. Opinions, beliefs, and viewpoints expressed by the authors do not necessarily reflect the opinions, beliefs, and viewpoints of SOAP or any of its members, employees, or agents.

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