COVID-19 Update

Kathleen Winter, PhD, MPH

June 16, 2022
Kentucky COVID-19 New Cases by Week (n = 1,378,045)

Last Updated June 12, 2022
COVID-19 hospitalization, ICU, and ventilator census in Kentucky hospitals - July 11, 2020 – June 12, 2022

Last Updated June 12, 2022

Shift in hospital census data source from WebEOC to TeleTracking on May 16, 2022
COVID-19 Case Rates by Vaccination Status, Age-standardized*

Data ranges from 10/01/21 through 6/02/22; data are provisional and subject to change; the primary series complete includes individuals who have received the second dose of an mRNA vaccine or the Janssen vaccine ≥2 weeks prior to the illness; unvaccinated individuals have no evidence of vaccination in KYIR. Additional/booster dose received includes individuals who received an additional dose of any COVID-19 vaccine on or after August 13, 2021. Note: this does not consider whether the vaccine recipient is immunocompromised and also includes booster doses. For people ages 18 years and older, data are included starting October 01, 2022, to enable fair comparisons to the additional/booster dose group. For people ages 12-17, data are included starting January 01, 2022. This slide is updated twice monthly, on the first and third week of the month.

*Age-standardized case rates adjust for differences in the age distribution of the population by applying the observed age-specific mortality rates for each population to a standard population.
COVID-19 Mortality Rates by Vaccination Status, Age-standardized*

Data ranges from 10/01/21 through 6/02/22; data are provisional and subject to change; the primary series complete includes individuals who have received the second dose of an mRNA vaccine or the Janssen vaccine >2 weeks prior to the illness; unvaccinated individuals have no evidence of vaccination in KYIR. Additional/booster dose received includes individuals who received an additional dose of any COVID-19 vaccine on or after August 13, 2021. Note: this does not consider whether the vaccine recipient is immunocompromised and also includes booster doses. For people ages 18 years and older, data are included starting October 01, 2022, to enable fair comparisons to the additional/booster dose group. For people ages 12-17, data are included starting January 01, 2022. This slide is updated twice monthly, on the first and third week of the month.

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What Clinicians Need to Know About Available Therapeutic Options for COVID-19

Overview

Medications are available that can reduce chances of severe illness and death from COVID-19 infection. Oral antivirals are available that can reduce chances of severe illness and death from COVID-19 infection. The Food & Drug Administration issued emergency use authorizations for certain antiviral medications and monoclonal antibodies to treat mild to moderate COVID-19 in people who are more likely to get sick. The National Institutes of Health also provides COVID-19 treatment guidelines for healthcare providers for treating COVID-19 at home or in an outpatient setting. During this COCA Call, subject matter experts will present an overview of COVID-19 therapeutic options, including indications, efficacy, and distribution.

Date: Thursday, June 16, 2022
Time: 2:00 PM – 3:00 PM ET

A few minutes before the webinar starts, please click on the Zoom link below to join:
https://www.zoomgov.com/j/1603960029?
pwd=Z0x1SE1mR3ZNUXFk3hBckw
3aFhYUT09

If you are unable to attend the live COCA Call, the recording will be available for
COVID-19 vaccines for <5y

- FDA advisory committee met June 14-15 and voted to expand the EUAs for Moderna and Pfizer for children
  - Moderna 12y-17y
  - Moderna 6y-11y
  - Moderna 6m-5y
  - Pfizer 6m-4y
- ACIP meeting June 17-18 to discuss recommendations for use.
- Vaccines could arrive early next week.

- COCA call on Wednesday?
Monkeypox Virus Update and Guidance

Kathleen Winter, PhD, MPH

June 16, 2022
Background on monkeypox virus

➢ Orthopoxvirus (same genus as smallpox virus).
➢ Characteristic rash illness preceded by prodrome (fever, lymphadenopathy, ILI).
   • Rash typically starts on tongue/mouth and progresses outwards to limbs. Concentrates on face, arms, legs.
   • Lesions typically similar size and stage.
   • Lesions are painful and become umbilicated.
➢ Incubation period 7-14 days (range 5-21).
➢ Infectious period starts with symptoms and lasts until lesions scab and fall off.
➢ Typical illness lasts 2-4 weeks.
Situation update

➢ Endemic, though uncommon, in central and west Africa.
➢ US: 49 cases from 17 states.
➢ Global: >1400 cases from 33 countries.
➢ Most cases in Europe and U.S. are among men who identify as gay, bisexual, or men who have sex with men.
➢ Several cases have had atypical presentation w/ genital and/or perianal lesions, proctitis, and no prodrome.
➢ Not a STI in the typical sense, but may be transmitted during sexual and intimate contact.
➢ Cases likely to be identified in outpatient settings and STI clinics.
Clinician Screening Guidance

For patients presenting with symptoms consistent with monkeypox virus infection:

➢ **Screen for epidemiologic risk factors:**
  • Travel history to an outbreak-affected or endemic country.
  • Contact with a person with confirmed or suspected monkeypox or who has a similar appearing rash.
  • Man who has close or intimate in-person contact with other men, including those met through online website, dating app, bar or party.
  • Contact with a dead/live animal that is an African endemic species or used a product derived from such animals.

➢ **Don N95 mask, eye protection, gown and gloves** when entering the patient’s room and performing exam.

➢ **Consider other STIs** and common causes of genital ulcers, rash, and ILI. Additional clinical guidance and pictures available at:
  • [CDC COCA Call slides](https://www.cdc.gov/vhf/monkeypox/coca-call-monkeypox.html) and [CDC website: clinical recognition](https://www.cdc.gov/monkeypox/clinical-guidance.html)
Case Definitions

➢ **Suspect Case:** *(patients to consider testing)*
   • New rash consistent with monkeypox virus infection; **OR**
   • At least one epidemiologic risk factor in prior 21 days and high clinical suspicion for monkeypox virus

➢ **Probable Case:**
   • Positive detection of orthopoxvirus by PCR or IHC testing *(state lab)*

➢ **Confirmed Case:**
   • Positive detection of monkeypox virus by PCR or culture *(CDC lab)*
Exclusion Criteria

➢ An alternative diagnosis can fully explain the illness (order testing per clinical judgement); **OR**

➢ An individual with symptoms consistent with monkeypox but who does not develop a rash within 5 days of illness onset; **OR**

➢ Negative test for orthopoxvirus or monkeypox virus
If monkeypox virus is suspected

- Contact facility infection control.
- Acquire digital photos of lesions, with patient consent.
- Contact KDPH at 888-9REPORT (888-973-7678) for consultation and to obtain approval for testing.

If orthopoxvirus testing is approved by KDPH:

- Obtain 2 or more dry lesion swabs.
- Swab or brush lesion(s) vigorously (do not unroof; swab the exterior and base/advancing line of the lesion) with two separate dry Dacron or sterile nylon or polyester swabs with a plastic, wood, or thin aluminum shaft. Do not use other types of swabs.
- Place swabs in separate individual sterile containers and DO NOT ADD ANY VIRAL OR UNIVERSAL TRANSPORT MEDIA. Refrigerate immediately (2--8°C) or freeze (-20°C or lower) if after-hours collection.
If orthopoxvirus is confirmed

A confirmed orthopoxvirus result at DLS is a presumed case of monkeypox.

- Specimen will be sent to CDC for confirmatory monkeypox testing (TAT 2-5 days).

Healthcare, social, and sexual contact exposures while symptomatic need assessed.

Case investigation and contact tracing tools are currently under development at CDC.

Use of Tecovirimat (TPOXX) antiviral medication for treatment of patient may be considered (acquired through KDPH/CDC from Strategic National Stockpile).
Management of Close Contacts

➢ Transmission of monkeypox typically requires prolonged close interaction with a symptomatic individual.
➢ Risk to healthcare personnel if not fully donned in PPE.
➢ Exposure Assessment:
  • **High Risk**: unprotected contact with skin, lesions, body fluid or contaminated material/linens; in patient’s room during aerosol-generating procedures without N95 and eye protection.
  • **Medium Risk**: <6 ft for >3 hrs without, at minimum, a surgical mask; contact to patient skin or contaminated material while wearing gloves but no gown.
  • **Low/Uncertain Risk**: Being in the same room for any duration without wearing eye protection or N95.
Management of Close Contacts

➢ No controlled movement needed for asymptomatic exposed contacts.

➢ Symptomatic exposed contacts should self-isolate and contact public health.

➢ **High, Intermediate, or Low/Uncertain** risk contacts are recommended to be monitored for 21 days following the exposure.
  • Contact should monitor temperature twice daily.

➢ Use of smallpox vaccine for postexposure prophylaxis (PEP) is recommended contacts with high risk exposure.

➢ Airline exposures considered Intermediate or Low/Uncertain risk.
Smallpox Vaccines

- Smallpox vaccines provide some level of protection against monkeypox viruses.

- **ACAM2000**
  - Replicating vaccina virus; 100 dose vials.
  - Licensed to prevent smallpox; IND for prevention of monkeypox virus.
  - **Multiple-puncture technique with bifurcated needle**
  - Once inoculated, a lesion will develop at the site (“take”).
    - Virus is shed from lesion and can spread to other parts of the body or other people.
      - Inoculation site must be covered with semi-occlusive dressing
      - Frequent handwashing following touching or dressing vaccination site
  - Not for immunocompromised persons; many other contraindications.

- **JYNNEOS**
  - Nonreplicating modified virus; single dose vial.
  - Licensed for PrEP and PEP to prevent smallpox and monkeypox.
  - 1-2 dose subcutaneous injection.
    - 1 dose if previously vaccinated for smallpox
    - 2 doses 4 weeks apart

- Both vaccines can only be acquired through KDPH/CDC from the Strategic National Stockpile.
Resources

➢ CDC website: clinical recognition of Monkeypox virus
➢ CDC COCA Call webinar (recorded) what clinicians need to know about Monkeypox
➢ CDC COCA Call slides
➢ CDC MMWR on use of Jynneos vaccine