SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

SCHAN South Carolina Health Alert Network

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DPH Health Advisory

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Cluster of Clade I Mpox Cases in South Carolina: Key Actions for Clinicians and Public Health Practitioners

Summary

The South Carolina Department of Public Health (DPH) has identified the first cases of clade I mpox (monkeypox) within the state. Although clade I and clade II mpox present similarly and are managed with the same clinical and public health approaches, the detection of clade I locally represents a shift in mpox activity and highlights the importance of early recognition and prompt public health reporting. Most people with mpox infection will recover with supportive care, but severe illness can occur, particularly in people who are immunocompromised. Clinicians should maintain a high index of suspicion for mpox in patients presenting with compatible signs and symptoms. initiate supportive care early, order tests that are available through commercial laboratories, and recommend vaccination for people at increased risk of mpox exposure.

Background

Mpox is caused by monkeypox virus, which includes two recognized clades—clade I and clade II—each with two known subclades (Ia, Ib, IIa, IIb). These clades cause clinically similar illness, and transmission occurs primarily through close contact, including intimate or household, with a symptomatic person, or through direct contact with infectious secretions or contaminated materials. The United States first experienced widespread mpox transmission in 2022 due to clade IIb, and although case counts have declined since that outbreak, sporadic clade IIb infections continue to occur.

Clade I mpox remains endemic in Central and Eastern Africa, where both clade Ia and clade Ib contribute to ongoing transmission. Since 2024, clade Ib infections have also been identified among travelers leaving affected regions, and several Western European countries have reported locally acquired cases in people without a travel history. Transmission patterns observed in these outbreaks have included sexual exposure followed by household spread. Although clade I mpox was historically reported to have a higher case-fatality rate, recent outbreak data suggest that the case-fatality rate for both clades is low, particularly when optimal supportive care is available. No deaths have been reported among approximately 150 clade Ib cases identified in high-income countries.

The first clade I mpox case in the United States was identified in November 2024. Clade I activity has since expanded, with more than 90 confirmed cases reported across 23 states and Puerto Rico. Most affected people have been gay, bisexual, or other men who have sex with men, with many reporting recent travel to areas experiencing active outbreaks or close contact with travelers. Since August 2026, an increasing proportion of cases have occurred in people without recent international travel, suggesting emerging domestic transmission. More than 10 jurisdictions have reported cases without known travel exposure, indicating a likely transition to sustained clade Ib transmission in the United States.

In late September 2026, DPH received an initial report of mpox infection. Clade I infection was subsequently confirmed for this case, representing the first identified clade I mpox case in South Carolina. To date, four cases in men have been identified, but epidemiologic investigations suggest this is likely an undercount. Epidemiologic investigations are underway to assess potential links among cases, recent travel, reported exposures, and household or sexual contact histories. No severe disease has been reported at this time. Like the outbreak in 2022 and other recent domestic cases, this cluster is primarily among men who have sex with men but not exclusive to this group.

Recommendations for Clinicians and Public Health Practitioners

Clinical Recognition and Evaluation

Clinicians should:

- Maintain a high index of suspicion for mpox in patients presenting with compatible signs and symptoms. Clade I and clade II mpox are clinically indistinguishable, and diagnostic and management approaches are the same. Key symptoms and clinical features include:
    - Systemic symptoms such as fever, chills, malaise, headache, myalgias, and often painful lymphadenopathy may precede onset of skin lesions.
    - A characteristic vesiculopustular rash that may be localized or diffuse and progresses through typical stages.
    - Painful or pruritic lesions, sometimes with marked edema, including anogenital or oral lesions that can cause severe pain, proctitis, or odynophagia.
    - More extensive or atypical presentations in people with HIV or other immunocompromising conditions.
- Obtain a thorough history that includes recent travel, close or household exposures, and sexual history; U.S. cases have disproportionately affected gay, bisexual, and other men who have sex with men and people with HIV.
- Conduct a complete skin and mucosal examination (oral, genital, anal), as patients may be unaware of lesions in the anogenital region.

  Because coinfections are common and HIV-associated immunocompromise increases the risk of severe mpox, clinicians should evaluate all sexually active patients with suspected mpox for HIV and STIs, including syphilis, gonorrhea, and chlamydia. Treat according to CDC STI guidelines.

Laboratory Testing

- Mpox is diagnosed using real-time PCR tests performed on lesion specimens. These tests are available through commercial laboratories and are results are typically available within two to four

days. Clinicians should confirm accepted specimen types and transport media with the testing laboratory, as requirements may vary.

- Clade I mpox is classified as a Select Agent, requiring Form notification to the Federal Select Agent Program and exposure determination. Hospitals with Confirmed mpox Clade I patients should reach out to the South Carolina Public Health Laboratory, Special Pathogens Unit (803-896-0777), for assistance. Other entities submitting positive Clade I samples should reach out to their local DPH Epi contact if assistance is needed.
- Clinicians should collect specimens from accessible lesions using sterile synthetic swabs. Do not intentionally unroof or aspirate lesions during collection.
- Clinicians should notify DPH if they have a patient with mpox-compatible symptoms and, if needed, request guidance on available testing. DPH is unable to offer testing services but will coordinate clade determination testing for confirmed cases.

Clinical Management

- There is no FDA-approved antiviral treatment for mpox infection. Tecovirimat was not found to be effective for symptom management or disease clearance for mpox Clade II. DPH does not have a stock of tecovirimat. Clinicians should:
    - Initiate supportive care early, including analgesia tailored to symptom severity, hydration, and management of pruritus or secondary bacterial infection. Most patients with mpox who do not have severe disease or risk factors for severe disease will recover with supportive care alone.
    - Monitor for complications such as ocular infections, neurologic involvement, myopericarditis, and complications associated with mucosal (oral, rectal, genital) lesions. Severe or uncontrolled disease may occur in people with moderate or severe immunocompromise, including those with advanced HIV (CD4 <200) or solid organ transplant recipients. For people with HIV and low CD4 cell counts, immune system reconstitution with ART is essential.
    - Consider using medical countermeasures (MCMs) for patients with severe disease or those at increased risk for severe outcomes, including people who are severely immunocompromised, pregnant or breastfeeding, pediatric patients, or people with atopic dermatitis or other conditions affecting skin integrity. Several MCMs may be considered for these patients, including tecovirimat (TPOXX), brincidofovir, and cidofovir. Tecovirimat is the first therapeutic typically considered when mpox-directed treatment is indicated. TPOXX and brincidofovir are obtained through the Strategic National Stockpile, while cidofovir is commercially available.
    - Clinicians should contact DPH for consultation whenever MCMs are being considered; DPH will assist with clinical guidance, access to therapeutics, and coordination with CDC as needed.
- For eligible patients with severe complications or at high risk for severe mpox, combination therapy with tecovirimat plus brincidofovir or tecovirimat plus cidofovir is recommended.
- For patients with ocular involvement, ophthalmology consultation is recommended; trifluridine ophthalmic solution may be used when clinically indicated.

Vaccination and Post-Exposure Prophylaxis (PEP)

- Vaccination with JYNNEOS remains the primary strategy for preventing mpox, including infections caused by clade I. The vaccine is FDA-approved for adults aged 18 years and older and may be administered to people younger than 18 years under an Emergency Use Authorization.

- Adequate vaccine supply is available nationally. The preferred regimen is two subcutaneous doses administered 28 days apart.
- A booster dose of Jynneos is not currently recommended for mpox prevention (outside of occupational laboratory exposure). Cases of mpox in previously vaccinated people are possible but are often less severe and shorter in duration.
- Vaccination is recommended for people at increased risk of mpox exposure, including:
    - Gay, bisexual, and other men who have sex with men; transgender or nonbinary people with recent sexual risk factors (e.g., a new STI diagnosis, multiple sex partners, sex at a commercial sex venue, or sex associated with a large public event in an area with mpox transmission).
    - Sexual partners of people with these risk factors.
    - People who anticipate activities or exposures that may increase their risk.
- Vaccination is safe and effective for people with HIV who are immunocompetent. There is urgent need to offer vaccination to people with HIV and with behavior that increases risk for mpox infection.
- JYNNEOS may be offered to pregnant or breastfeeding people who meet risk criteria; data remain limited, and clinicians should use shared decision making to discuss potential risks and benefits.
- Post-exposure prophylaxis (PEP) with JYNNEOS may be offered to people with a known or presumed exposure to mpox (e.g., sexual or intimate mucosal contact with a person with mpox, or contact of broken skin or mucous membranes with mpox lesions or bodily fluids).
- PEP should be administered as soon as possible—ideally within four days of exposure—and may provide partial protection if given four to 14 days after exposure.
- For infants younger than 6 months, Vaccinia Immune Globulin Intravenous (VIGIV) should be considered instead of JYNNEOS. VIGIV is available only through CDC via the Strategic National Stockpile and requires consultation with DPH.
- The JYNNEOS vaccine is available commercially. DPH does not have a stock of JYNNEOS and has not received an allocation from the SNS. Providers can prescribe the vaccine to a patient at a commercial pharmacy if they don't carry the vaccine in the office.

Infection Prevention and Patient Isolation

- Encourage patients to avoid close, including intimate, contact with people who have mpox-compatible symptoms.
- Follow recommended infection prevention and control practices when evaluating patients, including use of appropriate PPE (gown, gloves, eye protection, and a NIOSH-approved respirator) and avoiding direct contact with lesions or contaminated materials.
- In healthcare settings, implement mpox infection-control measures, including placing patients in a single room, using recommended PPE, and ensuring the patient uses well-fitting source control (e.g., a medical mask) when transport or close contact with others is unavoidable. Perform hand hygiene, avoid shaking or handling linens in ways that may disperse lesion material, and ensure appropriate cleaning and disinfection of equipment and environmental surfaces. Patients with mpox who are not hospitalized should isolate at home and avoid contact with others until the rash has resolved, all scabs have fallen off, and a fresh layer of intact skin has formed; this healing process often takes two to four weeks.

- During isolation, advise patients to keep lesions covered, avoid close or intimate contact, avoid sharing bedding, towels, clothing, or personal items, use a separate bathroom if available, clean high-touch surfaces regularly, and use well-fitting source control (e.g., a medical mask) when close contact with others in the home cannot be avoided; household members should wear a well-fitting mask during prolonged close interactions.
- Advise patients recovering from mpox to continue using condoms for 12 weeks after lesion resolution.

Resources for Additional Information

CDC Provider Resources

- Clinical Overview of Clade I and Clade II Monkeypox
  https://www.cdc.gov/monkeypox/hcp/clinical-overview/index.html
- Collecting and Handling Specimens for Monkeypox PCR Testing
  https://www.cdc.gov/monkeypox/hcp/diagnosis-testing/collecting-specimens.html
- Caring for Patients with Monkeypox
  https://www.cdc.gov/monkeypox/hcp/clinical-care/index.html
- Pain Management and Supportive Care
  https://www.cdc.gov/monkeypox/hcp/clinical-care/pain-management.html
- Tecovirimat for the Treatment of Mpox

  Tecovirimat for the Treatment of Mpox | New England Journal of Medicine
- Clinical Considerations for Monkeypox in Immunocompromised People
  https://www.cdc.gov/monkeypox/hcp/clinical-care/immunocompromised-people.html
- Clinical Considerations for Monkeypox in Children and Adolescents in the U.S.
  https://www.cdc.gov/monkeypox/hcp/clinical-care/pediatric.html
- Monkeypox Clinical Care and Treatment During Pregnancy
  https://www.cdc.gov/monkeypox/hcp/clinical-care/pregnancy.html
- Interim Clinical Considerations for Management of Ocular Monkeypox
  https://www.cdc.gov/monkeypox/hcp/clinical-care/ocular-infection.html
- Interim Clinical Treatment Considerations for Severe Manifestations of Mpox – United States, February 2023
  https://www.cdc.gov/mmwr/volumes/72/wr/mm7209a4.htm?s_cid=mm7209a4_w
- Vaccine for Monkeypox Prevention in the United States
  https://www.cdc.gov/monkeypox/hcp/vaccine-considerations/
- Monkeypox Infection Control
  https://www.cdc.gov/monkeypox/hcp/infection-control/index.html
- Isolation and Infection Control At Home
  https://www.cdc.gov/monkeypox/hcp/infection-control/at-home.html

SC DPH Resources

- Mpox Homepage
  https://dph.sc.gov/diseases-conditions/infectious-diseases/mpox

Previous Monkeypox HANs

- 11/19/2024: First Case of Clade I Mpox Diagnosed in the United States
  https://dph.sc.gov/professionals/health-professionals/health-services-facilities/south-carolina-health-alert-network
- 9/23/2024: Prevention Strategies for Mpox, including Vaccinating People at Risk via Sexual Exposure, for U.S. Travelers Visiting Countries with Clade I Mpox Outbreaks
  https://dph.sc.gov/sites/scdph/files/2024-09/10587-CHU-09-23-2024-Mpox.pdf
- 8/7/2024: Mpox Caused by Human-to-Human Transmission of Monkeypox Virus in the Democratic Republic of the Congo with Spread to Neighboring Countries
  https://dph.sc.gov/sites/scdph/files/2024-08/10584-CHU-08-07-2024-MPXV.pdf
- 12/7/2023: Mpox Caused by Human-to-Human Transmission of Monkeypox Virus with Geographic Spread in the Democratic Republic of the Congo
  https://dph.sc.gov/sites/scdph/files/media/document/10569-CAD-12-07-2023-MPOX.pdf
- 5/15/2023: Potential Risk for New Mpox Cases
  https://dph.sc.gov/sites/scdph/files/media/document/10552-CHU-05-12-2023-MPOX.pdf

Additional Provider Resources

- Atlas of mpox lesions: a tool for clinical researchers, 28 April 2023
  https://www.who.int/publications/i/item/WHO-MPX-Clinical-Lesions-2023.1

DPH contact information for reportable diseases and reporting requirements

Reporting of **Monkeypox** is consistent with South Carolina Law requiring the reporting of diseases and conditions to your state or local public health department. (State Law # 44-29-10 and Regulation # 60-20) as per the DPH 2026 List of Reportable Conditions.

Federal HIPAA legislation allows disclosure of protected health information, without consent of the individual, to public health authorities to collect and receive such information for the purpose of preventing or controlling disease. (HIPAA 45 CFR §164.512).

Regional Public Health Offices – 2026

Mail or call reports to the Epidemiology Office in each Public Health Region

MAIL TO:

Lowcountry	Midlands	Pee Dee	Upstate
3685 Rivers Avenue, Suite 201 N. Charleston, SC 29405 Fax: (843) 953-0051	2000 Hampton Street Columbia, SC 29204 Fax: (803) 251-3170	1931 Industrial Park Road Conway, SC 29526 Fax: (843) 915-6506	352 Halton Road Greenville, SC 29607 Fax: (864) 282-4373

CALL TO:

Lowcountry	Midlands	Pee Dee	Upstate
Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg Office: (843) 441-1091 Nights/Weekends: (843) 441-1091	**Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda, York** Office: (888) 801-1046 Nights/Weekends: (888) 801-1046	**Clarendon, Chesterfield, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg** Office: (843) 915-8886 Nights/Weekends: (843) 409-0695	**Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, Union** Office: (864) 372-3133 Nights/Weekends: (864) 423-6648

For information on reportable conditions, see
dph.sc.gov/professionals/health-professionals/sc-list-reportable-conditions

DPH Bureau of Communicable Disease Prevention & Control
Communicable Disease Epidemiology Section
P.O. Box 2046 · West Columbia, SC 29171
Phone: (803) 898-0861· Fax: (803) 898-0897
Nights / Weekends: 1-888-847-0902

Categories of Health Alert messages:

Health Alert	Conveys the highest level of importance; warrants immediate action or attention.
Health Advisory	Provides important information for a specific incident or situation; may not require immediate action.
Health Update	Provides updated information regarding an incident or situation; unlikely to require immediate action.
Info Service	Provides general information that is not necessarily considered to be of an emergent nature.