Chicago Department of Public Health

Health Alert

City of Chicago
Brandon Johnson, Mayor

www.chicagohan.org

Chicago Department of Public Health
Olusimbo Ige, MD, MS MPH, Commissioner

Chicago Mpox Outbreak, 2025

October 2, 2025

KEY MESSAGES

- **From June 1- September 30, 2025, 104 mpox cases have been reported to CDPH.**
- This is a 225% increase in reported mpox cases compared to the same time period in 2024 (N= 32).
- Of the 104 cases, 98% of cases were among symptomatic males. Half (50%) of the cases were unvaccinated, 38.5% were fully vaccinated and 11.5% were partially vaccinated against mpox.
- Of the cases for whom sexual orientation was known (n= 62), 60 were gay, bisexual or pansexual men.
- Of the 104 cases, 18 (17%) are living with HIV.
- No cases of clade I mpox have been reported in Chicago in 2025.
- **Healthcare providers are urged to remain diligent in screening for mpox, and vaccinating people at risk.** All suspected or confirmed mpox cases should be reported to CDPH within 24 hours. Report via the Illinois Disease Surveillance System (IDSS) or please call the CDPH mpox reporting hotline at 312-742-2883. If you have questions or concerns outside of business hours (8:30- 4:30pm), please call 311 to speak to a CDPH medical director.

Case Summary

From June 1st – September 30, 2025, 104 cases of mpox have been reported to the CDPH; 102 cases were male. Of those with known race/ethnicity (N= 93), 42(45%) were non-Hispanic (NH) White, 22(24%) Hispanic/Latinx, 18(19%) NH Black, and 11(12%) were another race/ethnicity. The median age was 34 years (range 20 - 68). Of the 104 cases, 18(17%) were living with HIV and 9(9%) were co-infected with an STI. Among these 104 cases, three hospitalizations have been reported. Travel history was available for 66 cases, revealing that 16 recently traveled with 4 cases reporting international travel. Of the 104 cases, 40(38.5%) were fully vaccinated, 12(11.5%) were partially vaccinated, and 52(50%) were unvaccinated.

Ongoing transmission of mpox highlights the importance of sustaining clinical awareness for new lesions and rash associated with mpox infection, administration of vaccine, and treatment for eligible individuals.

Anyone can get and spread mpox. Mpox is transmitted through close or intimate contact with a person with mpox, direct contact with an infected animal, or contact with contaminated objects.

Mpox and HIV

- Mpox can cause severe disease, especially among persons living with uncontrolled HIV infection.
- Among the hospitalized cases (n=3), all three were co-infected with HIV.
- Healthcare providers should ensure those with mpox and HIV are taking their antiretroviral medications or start taking antiretroviral medications as soon as possible.

Diagnosis

- Please review the CDC diagnostic guidelines here.

Clade-specific testing of mpox specimens

- Non-suspect Clade I MPOX testing should be conducted through commercial laboratories.
- Testing at the Illinois Department of Public Health Laboratories is reserved for suspect clade I MPOX or clinically urgent cases. For Chicago residents, CDPH approval continues to be required when requesting testing through the IDPH laboratory. Please review the Mpox testing job aid here.
- IDPH Laboratories require organizations to register and utilize the Illinois Electronic Test Ordering and Reports (IL-ETOR) portal for Mpox Clade I testing. Please visit the IL-ETOR Portal, click new user registration and complete the form to register.

Patient management:

- Consider mpox in patients presenting with rash, lymphadenopathy, or systemic symptoms, especially if they report close/intimate contract or travel to areas with known mpox outbreaks.
- Most patients with mpox have mild disease and can recover with supportive care.
- For severely ill patients with encephalitis, pneumonitis or highly immunocompromised patients at risk for severe disease (e.g., persons with uncontrolled HIV and a CD4 count <200 cells/mm^3, transplant recipients receiving immunosuppressive therapy), combination antiviral therapy with tecovirimat and either brincidofovir or cidofovir is recommended. Antivirals may also be considered for those with active skin conditions (eczema, impetigo, or other exfoliative skin conditions, pregnant or lactating patients or children under 18 years-old).
- All patients should avoid contact with others until all lesions have resolved, the scabs have fallen off, and a fresh layer of intact skin has formed. This process typically takes 2-4 weeks.
- Patients should isolate at home in a room or area separate from other household members and pets when possible. For more recommendations, see CDC guidelines.

Exposure management:

Post-Exposure Prophylaxis:

- Regardless of vaccination status, all individuals with potential exposures to mpox should monitor symptoms for 21 days. Contacts who remain asymptomatic can continue routine daily activities. If symptoms develop, they should immediately self-isolate and contact their healthcare provider.[1]

- Decisions regarding post-exposure prophylaxis (PEP) depend primarily upon the type of exposure. The Centers for Disease Control and Prevention (CDC) defines exposure risk as high, intermediate, uncertain to minimal risk, or no identifiable risk.
- Mpox vaccine (live, nonreplicating, modified vaccinia Ankara (MVA) can be given as PEP to those with known or presumed exposure to mpox virus. When given as PEP, vaccine should be given as soon as possible and ideally within 4 days of exposure; administration 4 to 14 days after exposure still may provide protection and is recommended.
- The standard route of administration for the JYNNEOS vaccine is subcutaneous and consists of two doses; the second dose should be administered 4 weeks after the first dose. However, if the second dose is delayed beyond 4 weeks, it should be administered as soon as possible to complete the series. Peak immunity is expected 14 days after the second dose of vaccine. An alternative regimen involving intradermal (ID) administration with an injection volume of 0.1mL may be used under an Emergency Use Authorization (EUA).[2]

Mpox Infection Prevention in Healthcare settings

- Immediately notify infection prevention and control staff if a patient is suspected to have mpox.
- Mpox infections among healthcare providers are rare; however, providers should wear proper PPE when caring for patients with suspected mpox. The recommended PPE includes:
    - Gown
    - Gloves
    - Eye protection
    - National Institute for Occupational Safety and Health (NIOSH)-approved particulate respirator equipped with N95 filters or higher
- Place the patient in a single-person room with a dedicated bathroom, if applicable, and keep the door closed. Special air handling (i.e., an Airborne Infection Isolation Room) is not required.
- Limit transport and movement outside of the patient room whenever possible. If transport is necessary, the patient should wear well-fitting source control (e.g., a surgical mask) and cover exposed lesions with a sheet or gown.
- Isolation precautions should be maintained until all lesions have crusted, crusts have separated, and a fresh layer of healthy skin has formed underneath.
- Standard cleaning and disinfection, laundry, and food service practices should be maintained, but wet cleaning methods are preferred over dry dusting, sweeping or vacuuming. Any potentially infectious medical waste should be handled as Category B waste.
- Potentially exposed healthcare personnel should be assessed and managed as indicated here.
- Full Infection Prevention and Control guidelines are available here.

STI Prevention

Mpox vaccination:

- Individuals at increased risk for mpox infection should be offered pre-exposure prophylaxis (PrEP) with the live, nonreplicating, modified vaccinia Ankara (MVA) vaccine (JYNNEOS in the US). JYNNEOS is approved for the prevention of smallpox and mpox.
- **Vaccination is expected to provide protection regardless of clade.**
- **No third dose is recommended at this time.**

STI Screening

- All patients with suspected mpox infection should also be screened for HIV and other STIs. Also, the diagnosis of one STI does not rule out mpox as co-infection may occur.

Bacterial STI prevention

- Providers should counsel all gay, bisexual and other MSM with a history of at least one bacterial STI in the last 12 months on Doxycycline post-exposure prophylaxis (DoxyPEP).
- Find further information on DoxyPEP here.

HIV PreP

- Patients with suspect mpox may also benefit from HIV PrEP. HIV PrEP protects against HIV during sex without a condom or if the condom fails and is available as an oral medication, or as a long-acting injectable.

For providers: If your organization is interested in receiving mpox vaccine supply from CDPH for uninsured and underinsured individuals, please fill out the survey here: https://redcap.link/2025mpoxvaxorderform

For more information about mpox, including upcoming vaccination events, please visit: https://www.chicago.gov/city/en/depts/cdph/provdrs/infectious_disease/supp_info/mpox-home.html

References

1. Mpox monitoring and risk assessment for persons exposed in the community. Centers for Disease Control and Prevention. https://www.cdc.gov/monkeypox/php/monitoring/index.html (Accessed 10.02.2025).
2. Interim Clinical Considerations for Use of vaccine for Monkeypox Prevention in the United States. https://www.cdc.gov/monkeypox/hcp/vaccine-considerations/vaccination-overview.html (Accessed 10.02.2025).