**Article type:** Letter

**Title:** Monkeypox virus contamination in an office-based workplace environment.

**Authors:** Barry Atkinson\(^1\)*, Susan Gould\(^2\)*, Antony Spencer\(^1\), Okechukwu Onianwa\(^1\), Jenna Furneaux\(^3\), James Grieves\(^1\), Sian Summers\(^4\), Tim Crocker-Biqué\(^5\), Tom Fletcher\(^2\), Allan M Bennett\(^1\) and Jake Dunning\(^6\).

**Affiliated addresses:**

\(^1\)Research and Evaluation, UK Health Security Agency, Porton Down, Salisbury, UK.

\(^2\)Department of Clinical Sciences, Liverpool School of Tropical Medicine, Liverpool, UK.

\(^3\)Rare and Imported Pathogens Laboratory, UK Health Security Agency, Porton Down, Salisbury, UK.

\(^4\)High Containment Microbiology, UK Health Security Agency, Porton Down, Salisbury, UK.

\(^5\)Faculty of Public Health and Policy, London School Hygiene and Tropical Medicine, London, UK.

\(^6\)NIHR Health Protection Research Unit in Emerging and Zoonotic Infections, Pandemic Sciences Institute, University of Oxford, Oxford, UK.

* These authors contributed equally to this work and share first authorship.

**Correspondence:** Barry Atkinson (barry.atkinson@ukhsa.gov.uk).

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More than 16,000 cases of monkeypox have been reported globally in 2022, predominately in non-endemic countries [1]. Although transmission in the current outbreak is typically via prolonged direct contact with confirmed cases, infection-competent monkeypox virus (MPXV) has been recovered from contaminated environments multiple days after last occupancy [2] raising the potential for fomite transmission. In addition, prolonged close contact such as working in an open-plan office could result in respiratory droplet transmission of MPXV [3,4].

In May 2022, an individual working in a non-clinical role in an administrative office within a hospital acquired MPXV infection following non-occupational exposure. The individual worked in a 15-desk open-plan office for one working day following onset of a mild, influenza-like illness, and took steps to reduce mixing and avoid close contact with others. Several COVID-19 control measures were still implemented within this office including a requirement to wear medical masks and regular hand hygiene. In addition, this office had permanent desk partitions between desk spaces. The individual reported skin lesions appeared two days after taking sickness absence at which point the office was closed to all staff pending a risk assessment and risk management plan. 17 staff contacts were identified, including six category 2 and four category 1 contacts according to UKHSA categorisation [5]; four individuals accepted post-exposure prophylaxis with Imvanex® vaccine when offered in accordance with UKHSA guidelines. No contacts developed symptoms consistent with monkeypox during their 21-day monitoring periods.

A decision to clean and decontaminate the office was made given its location within a healthcare facility and due to the environmental stability of orthopox viruses. This was
performed by professional decontamination staff following a protocol used during previous
monkeypox outbreaks [6]. The hospital performed a final decontamination of the office
using hydrogen peroxide vapour (Bioquell BQ-50 with 35% hydrogen peroxide solution).

Prior to decontamination, environmental sampling was performed to identify MPXV
contamination. Sampling occurred four days after the case was last in the office and two
days after office closure. Surface samples were collected from non-porous surfaces such as
desks and telephones using Copan UTM® swabs, and from porous surfaces such as carpets
and chair seats using the Sartorius MD8 Airport with gelatine filters. In addition, SKC
wearable samplers were utilized during the sample collection process to measure any re-
aerosolisation of MPXV. All samples were processed as previously described [7] and
analysed for the presence of MPXV DNA using qRT-PCR as previously reported [2,8].

Only 3/34 surface samples were positive for the presence of MPXV DNA with all positive
samples returning crossing threshold (Ct) values indicating low-level contamination (Figure
1). All three positive samples were from the case’s desk area including their telephone (Ct
37.7), keyboard (Ct 36.9) and a 10x10cm area of their desk (Ct 34.3). Five other surface
samples from the case’s desk were negative for MPXV DNA as were 26 surface samples
collected from other desks and high-touch areas throughout the office. All non-porous
samples were negative for MPXV DNA, as were both wearable samples.

Virus isolation was attempted on the Ct 34.3 positive desk sample using a previously
described method [7]; no evidence of replicating virus or cytopathic effect was observed
after 10 days of monitoring suggesting the absence of infection-competent virus. As
sampling was performed four days after occupancy by the infected individual, it is possible
that some level of DNA or viral degradation occurred prior to sampling, although the office
was windowless (minimising UV light degradation), was not cleaned prior to sampling, and MPXV is known to be environmentally stable.

It is notable that the patient reported skin lesions only emerged after they had taken leave from work due to illness, raising the possibility that the MPXV DNA detected may have come from respiratory secretions through droplets or contaminated hands. If so, it is possible that their use of a medical mask may have reduced environmental contamination by respiratory droplets containing virus.

Although this office may be similar to other offices in design, our findings should be seen as context-specific, including that the individual worked only during the early ‘prodromal’ phase of their monkeypox illness, several COVID-19 measures were still in place, and physical partitions were present between desk spaces. The limited detection of MPXV DNA and absence of secondary cases do not demonstrate that cleaning is unnecessary in an office where an infected person has worked, or that focussed cleaning of an infected person’s desk area is sufficient. In the absence of real-time environmental sampling to inform decontamination, and the fact that the office was within a hospital, our detection of environmental MPXV DNA supports the decision made to remediate the entire office. These data confirm that MPXV contamination can occur in workplace environments occupied by a person with early monkeypox illness and, accordingly, appropriate cleaning and decontamination measures should be considered in such situations.
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Authors’ contributions:

Conceptualisation and methodology: BA, SG, TF, AMB and JD.
Investigation: BA, SG, T-CB and JD.
Formal analysis: BA, AS, OO, JF, JG and SS.
Writing – original draft: BA, SG, TF, AMB and JD.
Writing – review and editing: All authors.

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agency for England and an executive agency of the UK Government’s Department of Health
and Social Care. The study protocol was subject to internal review by the Research Ethics
and Governance Group, which is the UKHSA Research Ethics Committee, and was granted
full approval.
Figure legend

Figure 1: Diagrammatic representation of the office environment associated with a confirmed case of monkeypox. Blue lines represent permanent office structures such as walls and office door; purple lines represent desk partitions (wooden partitions approximately 1.2 metres high enclosing work desks). Ct = crossing threshold value of MPXV DNA detected in sample.
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Desks 1, 6, 7, 8 and 13
- Keyboard and mouse (swab)
- Phone (swab)
- Desk (swab)
- Chair armrests (swab)
- Chair seat (vacuum)
- Floor (vacuum)

All samples negative

Miscellaneous
- Air vent A (swab)
- Air vent B (swab)
- Printer (swab)
- Interior door open button (swab)
- Interior door handle (swab)
- Shelf (swab)
- Wearable sampler A (air)
- Wearable sampler B (air)

All samples negative

Desk 12
- Desk (swab)  Ct 34.3
- Keyboard (swab)  Ct 36.9
- Phone (swab)  Ct 37.7
- Mouse (swab)
- Screen (swab)
- Barrier (swab)
- Chair armrests (swab)
- Hand cream bottle (swab)
- Chair seat (vacuum)
- Floor (vacuum)

All samples negative