

HEALTH ADVISORY



Public Health
Prevent. Promote. Protect.

Region 4 Public Health
Clark, Cowlitz, Skamania, Wahkiakum
counties, and Cowlitz Tribe

To: Physicians and other health care providers

Please distribute a copy of this information to each provider in your organization.

Questions regarding this information may be directed to the following Region 4 health officers:

Alan Melnick, MD, MPH, CPH

Health officer for Clark, Skamania and Wahkiakum counties

Steven Krager, MD, MPH

Deputy health officer for Clark, Skamania and Wahkiakum counties

James Miller, MD, MPH

Acting health officer for Cowlitz County

Alert categories:

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; no immediate action necessary.

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Confirmed measles cases in Clark and Wahkiakum counties



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Summary

Clark County Public Health (CCPH), in partnership with Wahkiakum County Health and Human Services, is investigating three confirmed cases of measles among adults who are unvaccinated. Symptom onsets occurred in mid- to late-December, and all three cases report isolating at home during their contagious periods.

CCPH is not aware of any public exposures for the three confirmed cases. However, in an abundance of caution, health officers are alerting providers to the presence of measles in Southwest Washington and asking providers to consider measles in patients who present with compatible symptoms.

Requested actions

- 1. Please consider measles in patients who:**
 - Present with febrile rash illness and the “three Cs”: cough, coryza (runny nose) or conjunctivitis (pink eye)
 - Recently traveled internationally or were exposed to someone with confirmed measles
- 2. Please implement the infection prevention practices, outlined below, to prevent health care exposures.**
- 3. Report suspect measles cases immediately to your local health department (contact information on last page).**
 - Clark County providers, please complete the [Suspect Measles Worksheet](#) and call the Infectious Diseases program at 564.397.8182.

Specimen collection recommendations

Laboratory confirmation of measles is critical to track the spread and prioritize prevention efforts. If testing through the Washington State Public Health lab, approval is required from your local health department.

Collect **ALL** of the following specimens if using a commercial lab or testing through the state public health lab is approved:

1. Nasopharyngeal (NP) swab for measles PCR (preferred respiratory specimen):

- NP swab should be collected 0-5 days after rash onset; after 5 days, NP swab should be accompanied by urine.
 - Swab the posterior nasal passage with a Dacron or rayon swab and place the swab in 2-3 mL of viral transport medium. Store specimen in refrigerator and transport on ice.
 - Throat swab also acceptable.
2. Urine for measles PCR:
- Urine PCR test is most sensitive between ≥ 72 hours and 10 days after rash onset.
 - Collect at least 50 mL of clean voided urine in a sterile container (sputum specimen containers also work very well for transporting urine) and store in refrigerator.
3. Serum for measles IgM and IgG testing:
- Measles specific IgM antibody may not be present until ≥ 72 hours after rash onset but persists for about 30 days after rash onset.
 - Draw blood in a red or tiger top (serum separator) tube. The ideal amount of blood is 4-5mL, 1mL being the minimum in order to yield enough serum to perform testing.
 - Let specimen sit at room temperature for one to four hours to clot, then spin down to separate serum.
 - Pipette serum into a new red top tube. Can send a tiger top tube as is.
 - Store serum specimen in a refrigerator until it can be transported on ice.

Infection prevention

Measles primarily spreads through large droplets but can also be transmitted through the airborne route. The virus can be transmitted through the latter route up to two hours after a contagious patient coughed or sneezed, according to the Centers for Disease Control and Prevention (CDC).

Preventing health care exposures is critical to keep high-risk groups safe. When possible, use phone triage and assessment to determine if patients who might have measles need to be seen in-person.

Up-to-date vaccination status makes measles much less likely. Please implement interventions listed below in your clinical settings to minimize exposure to others.

- If the patient is already in the clinic/waiting room, room them immediately.
- Use a negative pressure room if available; regardless keep exam room door closed.
- Perform all labs and clinical interventions in the exam room if possible.
- The exam room should not be used for two hours after the patient has left.
- Patients who are under evaluation for measles should isolate at home until the diagnosis is clarified.

Prevention/vaccination recommendations

- Unvaccinated eligible children and adults who were exposed to measles should only receive vaccine within 72 hours (unlikely given how long it takes to identify, diagnose and report) and should **NOT** receive the vaccine before the end of the incubation

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- period, because of the 5 percent chance of a vaccine rash, which could be confused with measles.
- For persons who plan to travel internationally, health care providers should encourage timely vaccination of all persons aged ≥ 6 months who lack evidence of measles immunity. One dose of MMR vaccine is recommended for infants aged 6-11 months traveling internationally, and two doses for persons aged ≥ 12 months, with a minimum interval of 28 days between doses. Infants who get one dose of MMR vaccine before their first birthday will still require two more doses (one dose at 12 through 15 months, another at least 28 days later) in order to be considered up to date for MMR.
 - Routine MMR vaccination is recommended for all children, with the first dose given at age 12-15 months and a second dose at age 4-6 years. Unless they have other evidence of immunity, adults born after 1956 should get at least one dose of MMR vaccine, and two appropriately spaced doses of MMR vaccine are recommended for health care personnel, college students and international travelers.
 - Passive immunization with immune globulin (IG) can prevent or attenuate infection with measles if given within 6 days after exposure. IG is recommended primarily for susceptible household contacts and other close contacts who are at increased risk of severe infection (e.g., children < 1 year old, pregnant women without evidence of measles immunity, and severely immunocompromised persons). IG is not recommended for close contacts who have received one dose of vaccine on or after the first birthday unless they are immunocompromised.
 - Patients should be warned that IG may modify but not prevent measles infection and may also increase the incubation period to 21 days.
 - The recommended dose for IG administered intramuscularly (IGIM) is 0.5 ml/kg (maximum dose 15 ml) and for IG given intravenously (IGIV) is 400 mg/kg. To be effective, IG must be administered as soon as possible but not more than 6 days after exposure. The recommended methods of IG administration for the groups at increased risk are as follows (Page 17, [MMWR, Vol. 62/No. RR-4](#)):
 - **Infants < 1 year old.** IGIM should be administered to all infants aged < 12 months who have been exposed to measles. For infants aged 6 through 11 months, MMR vaccine can be administered in place of IG if administered within 72 hours of exposure.
 - **Pregnant women without evidence of measles immunity.** IGIV should be administered to pregnant women without evidence of measles immunity who have been exposed to measles. IGIV is recommended to administer doses high enough to achieve estimated protective levels of measles antibody titers.
 - **Immunocompromised patients.** Severely immunocompromised patients who are exposed to measles should receive IGIV prophylaxis regardless of immunologic or vaccination status because they might not be protected by the vaccine.
 - Severely immunocompromised patients include patients with severe primary immunodeficiency; patients who have received a bone marrow transplant until at least 12 months after finishing all immunosuppressive treatment, or longer in patients who have developed graft-versus-host disease; patients on treatment for ALL within and until at least 6 months after completion of immunosuppressive chemotherapy; and patients with a diagnosis of AIDS or HIV-infected persons with severe immunosuppression defined as CD4 percent $< 15\%$ (all ages) or CD4 count < 200 lymphocytes/mm³ (aged > 5 years)

and those who have not received MMR vaccine since receiving effective ART. Some experts include HIV-infected persons who lack recent confirmation of immunologic status or measles immunity.

- Unless known to be susceptible to measles (i.e. unvaccinated and with no history of measles disease), persons without documentation of immunity should have blood drawn prior to administration of IG, if possible, to test for the presence of measles IgG (prior immunity). However, administration of IG should not be delayed past 72 hours when results of immunity testing are pending.
- Susceptible contacts who received IG for measles prophylaxis should subsequently be immunized against measles no earlier than 6 months after IGIM administration or 8 months after IGIV administration provided the person is then aged ≥ 12 months and the vaccine is not otherwise contraindicated.

Additional guidance for health care providers

- CDC: [Measles](#)
- CDC: [Provider Resources for Vaccine Conversations with Patients](#)
- Washington State Department of Health: [Measles](#)

Thank you for your partnership.

Local health jurisdiction	Phone	Fax
Clark County Public Health	564.397.8182	564.397.8080
Cowlitz County Health & Human Services	360.414.5599	360.425.7531
Skamania County Community Health	509.427.3850	509.427.0188
Wahkiakum County Health and Human Services	360.795.6207	360.795.6143