# Measles Frequently Asked Questions for Clinicians (v 3/27/2025)

## Initial Evaluation

- **What are the clinical features of measles?**

  Prodromal symptoms of measles usually begin 1-2 weeks after exposure and include malaise, cough, coryza, conjunctivitis and fever. Pathognomonic Koplik spots may be present during the prodromal phase. A maculopapular rash spreading from the head to the trunk to the lower extremities occurs approximately 3-4 days after symptom onset and is associated with high fevers up to 105°F. Patients are contagious 4 days prior to 4 days after rash onset.

- **When should I suspect measles in a patient with fever and rash?**

  Measles should be suspected in patients presenting with the above clinical features who report recent exposure to a patient with measles, or who have a history of international travel or travel to an area with ongoing measles outbreak in the month prior to symptom onset. Especially consider measles in unimmunized patients with the above clinical features and significant travel and/or exposure histories. During a local measles outbreak, measles should be suspected in any patient presenting with a clinically compatible illness.

- **What should I do if I suspect my patient has measles?**

  Immediately provide the patient with a surgical mask and remove them from common areas or waiting rooms. Place the patient in an airborne infection isolation room if available, otherwise place the patient in a private room keeping the door closed. Keep the patient masked while in the room. Only healthcare workers with documentation of immunity (2 doses MMR or positive measles IgG) should enter the patient's room using an N95 respirator or equivalent.

  Immediately notify the local public health department and send appropriate testing (see next section). To limit exposure following the visit, clean the exam room and keep the room closed for a minimum of 2 hours. Families should be instructed to keep their child at home until 4 days after rash onset, or until cleared by the health department.

- **What should I do if a family calls ahead with concerns their child has measles?**

  Gather information from the family regarding their child's symptoms, any contact with known measles cases, and any travel history in the past month. If the symptoms or exposure history are concerning for measles, the patient should be scheduled to be seen at the end of the day to minimize potential exposures. Arrangements should be made to have the family call upon arrival to allow a staff member to meet the family at the doorway to mask the patient and quickly escort the family into a room (staff should wear a fit-tested N95 respirator).

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## Reporting, Testing, and Referral

- **How do I report a suspected case of measles to public health?**

  Measles is a Class A reportable infectious disease in Ohio and requires immediate reporting via telephone to the local public health department where the patient resides upon recognition that a case, a suspected case, or a positive laboratory result exists. For patients residing in Franklin County, follow the Class A Disease reporting requirements of the Infectious Disease Reporting System (https://idrsinfo.org/report.php). For residents of surrounding counties, contact the local public health department where the patient resides.

- **How do I test for measles?**

  Prior to specimen collection in any patient with suspected measles, it is important to contact your local public health department. If testing is indicated, refer to the Nationwide Children's Laboratory Services Test Directory for "Measles Virus by PCR with Reflex" for testing guidance. Per ODH and CDC guidelines, both serology and PCR samples should be collected. Nasopharyngeal swabs are preferred over throat swabs for PCR detection. Please refer to the accompanying "Measles Testing Referral Process" document to coordinate referral for testing purposes only.

- **How should I refer pediatric patients with suspected measles who require further care?**

  Most children with measles can be cared for at home and do not require hospitalization. Complications such as dehydration and pneumonia may occur, however, requiring escalation of care. To ensure appropriate resources and decrease exposures, we are requesting clinicians call ahead if referring a patient with suspected measles to a Nationwide Children's facility. Please call our Physician Direct Connect line at (877) 355-0221 to coordinate referral or transfer.

## Prevention

- **When should I consider administering the MMR vaccine ahead of schedule?**

  The CDC recommends providing infants 6 months through 11 months of age one dose of MMR vaccine before any international travel (infants receiving one dose of MMR prior to their first birthday still require two doses starting at one year of age). During a local measles outbreak, public health officials may also recommend vaccination in infants younger than 12 months of age. Children 12 months of age or older who have received one dose of MMR vaccine should receive a second dose prior to any international travel, with doses separated by at least 28 days. Refer to ODH and CDC for the latest vaccination recommendations.

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## Prevention (Continued)

- **When should I consider vaccinating teenagers and young adults?**

  Unvaccinated older children and adolescents should receive 2 doses of MMR vaccine at least 4 weeks apart. Adults not at high risk of exposure are recommended to receive at least 1 dose of MMR, or have other evidence of immunity (i.e., laboratory evidence of immunity). Adults at high exposure risk (i.e., students at post-secondary institutions, healthcare workers, and international travelers) or who are household contacts of immunocompromised persons should receive 2 doses of MMR vaccine.

- **What if a family calls because they were notified their child was possibly exposed to measles?**

  Immunization records should be reviewed to ensure the child has received 2 doses of MMR vaccine. Vaccine-eligible children (as young as 6 months of age) who have not been vaccinated should receive an MMR dose within 72 hours of exposure.

  Immune globulin post-exposure prophylaxis should be given to eligible children within 6 days of exposure. Eligible children include 1) infants younger than 6 months of age, 2) infants 6 through 11 months of age who are beyond the 72-hour MMR window above, and 3) children who are severely immunocompromised.

  Refer to the AAP and CDC for the latest post-exposure prophylaxis guidelines.

- **What steps can I take to prevent exposures in my clinic?**

  Step 1: Ensure all healthcare staff have presumptive evidence of immunity to measles
  - Includes 2 doses of MMR or laboratory evidence of immunity

  Step 2: Rapidly identify suspected cases
  - Ensure systems are in place to alert staff of high-risk patients, including consideration of entryway signage & enhanced screening questions upon check-in / registration (i.e., travel history, vaccination status, measles exposure, close contact with persons displaying symptoms suspicious for measles, etc.)

  Step 3: Rapidly isolate suspected cases
  - Patients triaged as high-risk should be provided a facemask and immediately isolated into an Airborne Infection Isolation Room (AIIR). Use a private room and keep the door closed if an AIIR is not available.
  - Adhere to Standard and Airborne Precautions, including use of N95 respirators. Ensure appropriate downtime occurs prior to reopening the room for other patients. If the ventilation of the room is not known, keep the room closed for 2 hours between patients.