HEALTH ADVISORY # 222

Measles Health Alert

TO: West Virginia Healthcare Providers, Hospitals and Other Healthcare Facilities

FROM: Matt Christiansen, MD, MPH, State Health Officer, West Virginia Department of Health, Bureau for Public Health

DATE: April 24, 2024

LOCAL HEALTH DEPARTMENTS: Please distribute to community health providers, hospital-based physicians, infection control preventionists, laboratory directors, and other applicable partners

OTHER RECIPIENTS: Please distribute to association members, staff, etc.

The West Virginia Department of Health (DH) has **confirmed a case of measles** in a partially vaccinated Monongalia County resident who recently traveled internationally. This is the first case of measles reported in West Virginia since 2009. State health officials are working closely with Monongalia County Health Department staff to investigate the case and conduct contact tracing. DH is not aware of any broader community public exposures for the confirmed case, however in an abundance of caution, we are alerting clinicians to the presence of measles in Monongalia County and asking providers to consider measles in patients who present with compatible symptoms.

On March 18, 2024, the Centers for Disease Control and Prevention (CDC) issued a health advisory to inform clinicians and public health officials of an increase in global and U.S. measles cases and to provide guidance on measles prevention for international travelers ≥6 months and all children aged ≥12 months who do not plan to travel internationally. Measles cases continue to be brought into the U.S. by travelers who are infected while in other countries. Most importations come from unvaccinated U.S. residents. Declines in measles vaccination rates globally have increased the risk of measles outbreaks worldwide, including in the U.S. Many countries, including popular travel destinations, are experiencing measles outbreaks. As of April 18, 2024, the Centers for Disease Control and Prevention (CDC) has been notified of 125 confirmed U.S. cases of measles across 18 jurisdictions.

Measles is almost entirely preventable through vaccination. Measles, Mumps, and Rubella (MMR) vaccines are safe and highly effective, with two doses being 97% effective against measles (one dose is 93% effective). Healthcare providers should ensure children are current on routine immunizations, including MMR. All U.S. residents traveling internationally, regardless of destination, should be current on their MMR vaccinations.

Recommendations for Healthcare Providers

1. Routine MMR vaccination is recommended for all children, with their first dose of MMR at age 12 to 15 months and their second dose at 4 to 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 vaccines are recommended for healthcare personnel, college students and international travelers.

2. For persons who plan to travel internationally, healthcare providers should encourage timely vaccination of all individuals aged ≥6 months of age who lack evidence of measles immunity.
    - Infants aged 6 through 11 months should receive one dose of MMR vaccine before departure. Infants who receive a dose of MMR vaccine before their first birthday should receive two more doses of MMR vaccine, the first of which should be administered when the child is age 12 through 15 months and the second at least 28 days later.
    - Children 12 months or older should receive 2 doses of MMR at least 28 days apart.
    - Teenagers and adults without evidence of measles immunity should receive two doses of MMR vaccine separated by at least 28 days.
3. At least one of the following is considered evidence of measles immunity for international travelers:
    - Birth before 1957;
    - Documented administration of two doses of live measles virus vaccine (MMR, MMRV, or other measles-containing vaccine);
    - Laboratory (serologic) proof of immunity or laboratory confirmation of disease.
4. Consider measles in patients who:
    - Present with febrile rash illness and the "three Cs": cough, coryza, or conjunctivitis who has travelled internationally or were exposed to someone with confirmed measles, especially travelers who were in countries with ongoing outbreaks.
5. Measles is a Category I Disease which is immediately reportable (even suspect cases) to the local health department (LHD). If unable to reach your LHD, please contact the Office of Epidemiology and Prevention Services (OEPS) at 1-800-423-1271 ext. 1, 304-558-5358 ext. 2, or the 24/7 answering service at 304-342-5151.
6. Please implement Interim Infection Prevention and Control Recommendations for Measles to prevent healthcare exposures.
7. Laboratory confirmation of measles is critical to track the spread and prioritize prevention efforts. If testing through the state public health laboratory, Office of Laboratory Services, approval is required from your local health department. Detection of measles-specific IgM antibody in serum and measles RNA by real-time polymerase chain reaction (RT-PCR) in a respiratory specimen are the most common methods for confirming measles infection. Urine samples may also contain virus, and when feasible to do so, collecting both respiratory and urine samples can increase the likelihood of detecting measles virus.
    - Nasopharyngeal (NP) swab should be collected 0-5 days after rash onset; after 5 days NP swab should be accompanied by urine.
    - Measles specific IgM antibody may not be present until ≥72 hours after rash onset but persists for about 30 days after rash onset.
    - Urine PCR test is most sensitive between ≥72 hours and 10 days after rash onset.

For questions about this health alert, contact the Office of Epidemiology and Prevention Services, Division of Infectious Disease Epidemiology (DIDE) at (304) 558-5358 ext. 2.