



Guidance for Measles Testing

Attention Rowan County Health Care Provider,

Rowan County Public Health remains prepared for potential exposures or outbreaks of measles.

Please follow the recommended guidance below if you suspect any case of measles in your facility.

1. Implement airborne precautions as soon as suspicion arises. Mask and isolate the patient in a room with a closed door (negative pressure room if available). Only allow health care workers with presumptive evidence of measles immunity to attend to the patient.
2. Refer to the attached testing algorithm and NC Measles Risk Assessment prior to proceeding to testing.
3. Perform throat or nasopharyngeal PCR testing using a Dacron-tipped swab with aluminum or plastic shaft in universal transport media (UTM) or viral transport media (VTM).
4. Report this suspected case to Rowan County Public Health (local health department): [Click Here](#)

Measles is airborne and can circulate in a room for two (2) hours after a patient leaves. Anyone in the same room at the same time or within the two-hour window is considered exposed. Please take proper precautions.

Lab testing activates a cascade public health action, please consider any potential differentials when assessing patient, such as recent MMR vaccination, recent antibiotic use, syphilis, hand foot and mouth disease, fifth disease, or contact dermatitis. If you decide to test, please notify us. A web platform for reporting suspect cases is in progress, we will send updated information once operational.

MMR vaccination remains the top measles-prevention tool. Please help our community stay up to date on vaccinations.

Please call 704-216-8968 with potential case information, questions, or concerns.

Alyssa Harris, MPH
Public Health Director

Darren Kelly, MD
Medical Director

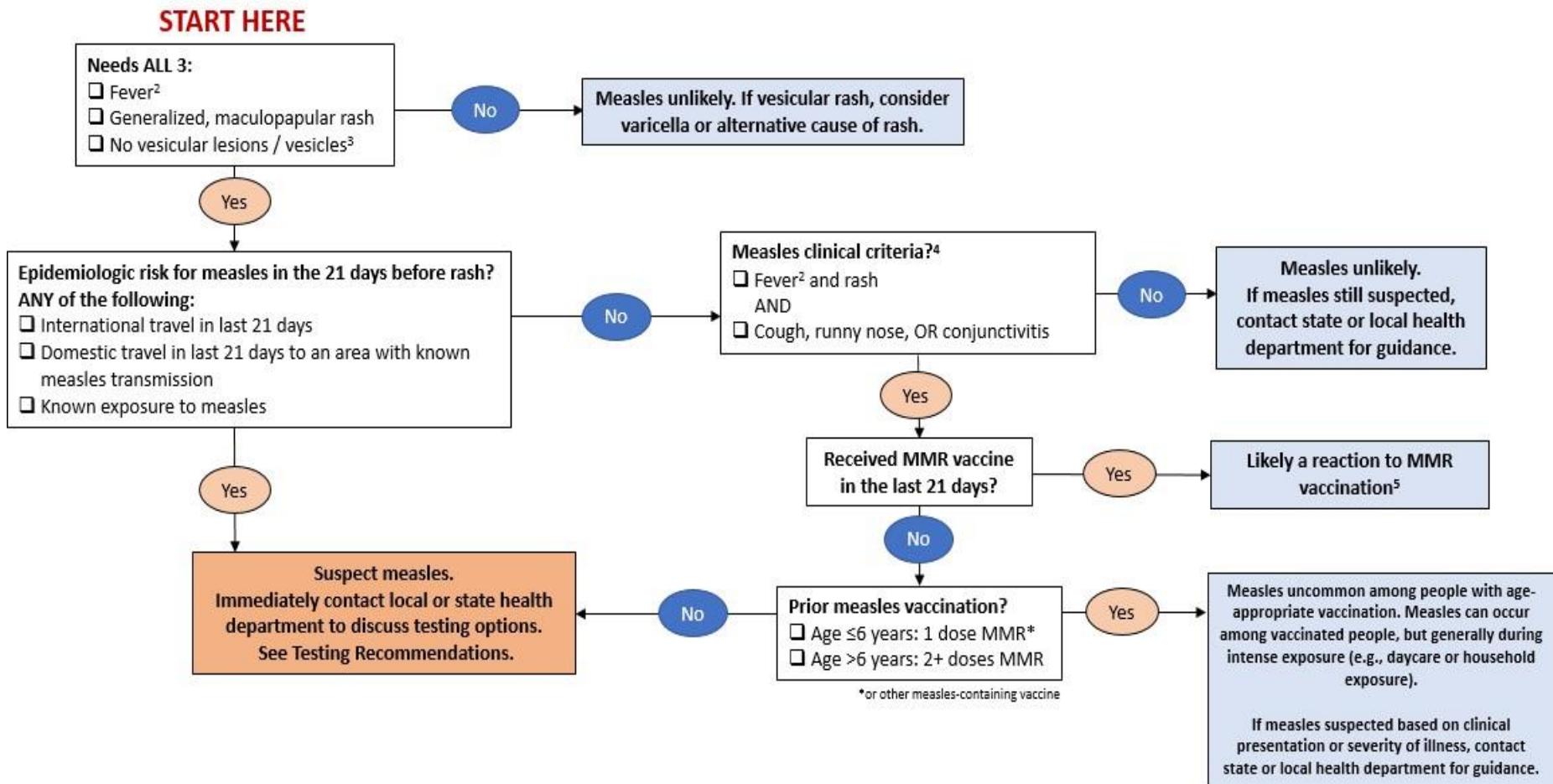
Ashley Brooks, BSN, RN, CPHN
Nursing Supervisor, Communicable Disease

North Carolina Risk Assessment

Score of 3 - consider testing
Score of 4- more likely; approve testing

	0 (Low Risk)	1 (Some Risk)	2 (High Risk)
Immune Status Evaluate evidence of immunity	Documented vaccinations(s); OR Birth before 1957; OR lab evidence of disease or immunity (e.g. positive titer)	No vaccination records available; patient is unsure	Unvaccinated; never had disease
Clinical Presentation Typical prodrome: fever 101°F or 38.3°(and at least one of cough, coryza, or conjunctivitis Typical rash: generalized, maculopapular rash lasting 3 days, starting at hairline or face, spreading down to trunk and extremities	Very atypical presentation (e.g.) no fever or no rash; OR Other causes of rash more likely: parvovirus (Fifth disease), hand foot, and mouth (coxsackie virus), roseola (humanherpes virus 6-7), scarlet fever (strep pyogenes), RMSF, syphilis (if sexually active), dengue, recent antibiotics or new medications, contact with cases of other rash illness with known etiology	Not typical prodrome (e.g.) fever begin at same time as rash, some symptoms not present): OR Not typical rash (e.g. starts on truck or extremities)	Typical prodrome; AND Typical rash
Epidemiologic Risk Evaluate potential sources of exposure	No exposure to confirmed cases; AND no travel to places outside of patient's typical setting	Unsure/unknown; OR Travel to low risk area (place with no known transmission, no airport)	Epi linkage to confirmed cases; OR travel to areas with known transmission; OR Time spent in airport

Evaluating a patient presenting with rash when there is no local measles transmission¹



NOTES

1. This testing algorithm is intended to be used by bedside providers in settings where there is not local measles transmission. This assumes that the pre-test probability for most people without known epidemiologic risk for measles and who do not meet case criteria will be low. In setting with active measles transmission, the threshold at which to pursue testing may be lower, and a more permissive algorithm could be considered.
2. Either a measured or patient/family-reported fever is adequate; fever may not be measured at the time of healthcare evaluation due to normal fluctuation or to use of antipyretics (e.g., ibuprofen).
3. A vesicular rash is not consistent with measles and should prompt consideration of other causes of rash (e.g., varicella/chickenpox).
4. Measles clinic criteria (per CSTE case definition) include all the following:
 - a. Generalized maculopapular rash
 - b. Fever
 - c. Cough, coryza (runny nose), or conjunctivitis (also known as the “3 C’s”)
5. Up to 5% of MMR recipients will get a short-lived, mild febrile rash. This is more common with the first dose of MMR. People who experience this vaccine reaction are not contagious to other around them. If a person has received MMR within 21 days before rash onset, but also has epidemiologic risk for measles, then specialized testing may be required and should be discussed with local or state public health authorities.