Measles: Identification and Management of Suspected Cases  
(Version 2.0, May 7, 2019)

Triage febrile rash illnesses by phone, or immediately upon arrival, to assess need for control measures.

Does the Patient Have Signs and Symptoms of Measles?

Prodrome with;
• fever (at least 101°F),
• cough,
• coryza,
• conjunctivitis,
Followed in 3-5 days by;
• generalized descending maculopapular rash, and
• Koplik spots (may not be present).

AND

Have risk factors for measles (history of international travel, contact with travelers or links to a known outbreak or case, or no/unknown immunity).

Note: one dose of measles vaccine is 93% effective and two doses are 97% effective at preventing measles (www.cdc.gov/measles)

Manage as clinically indicated
Consider other differential diagnoses for the illness and address as indicated
Seek commercial testing for pathogens of concern as desired (i.e., Influenza, Group A Streptococcus)

Minimize Risk of Transmission

• Measles is a highly infectious airborne illness.
• Identify febrile rash illnesses prior to, or immediately upon, arrival to expedite evaluation in a private room and minimize patient exposures.
  • Have the patient avoid the waiting room (use a side/back entrance).
  • Have the patient wear a surgical mask.
  • Conduct patient evaluation in a room that can be left vacant for at least 2 hours after the patient's visit.

Suspect Case Management

• Isolate patient immediately
• Exclude from childcare/school/workplace for at least 4 days after the onset of rash.
• Reassess isolation based on diagnosis.
• Provide supportive treatment and treatment of complications.

Positive measles test (PCR or IgM) OR high suspicion for active measles infection after public health consultation?

• Notify receiving facilities of diagnosis.
• Identify patients/visitors and staff that shared the same airspace with the case, up to 2 hours later.
• Review the measles evidence of immunity status of patients and staff potentially exposed at your practice.
• Provide vaccine within 3 days or immunoglobulin within 6 days of exposure, as indicated.
• Exclude all healthcare staff without evidence of immunity from day 5 through day 21 following the exposure.