Managing Patients with Suspected Measles – Infection Prevention and Control Overview

Isolation and Immunisation are the most important tools in reducing the spread of infection.

Canterbury Primary Response Group

Incubation time

- Typically there are 8-12 days between exposure and onset of symptoms (i.e. first prodromal symptoms such as fever, coryza, conjunctivitis and cough).
- The time between exposure and onset of symptoms can vary from 7-18 days.
- The average interval between exposure and rash is 14 days.

Period of infectivity

- Patients are infectious from 5 days prior to onset of rash until 4 days after onset of rash (approximately 9 days).
- Immunocompromised patients may be infectious for the entire duration of the illness.

Isolation - what you can do within your practice

- Phone messages should ask potential measles patients (measles-like symptoms or contact with a known measles patient) to phone the practice before arrival.
- Display notices at all practice entrances to echo this message.
- On arrival patients should be asked to wait in their cars until they can be seen (or kept in an area away from other patients if they have arrived on foot).
- Patients should be assessed in their cars initially, or in a designated area in the practice which is away from other patients and can be easily cleaned after use.

Infection prevention & control management for patients with suspected Measles

- Measles is droplet spread, and is highly infectious. Patients meeting the clinical case definition should be managed with “Airborne Precautions” during the "period of infectivity" (see above).
- Non-immune exposed patients should be managed with Airborne Precautions until 21 days post exposure or 4 days after development of rash regardless of whether they have received vaccination or immunoglobulin.
- Immunocompromised patients (including pregnant women) who have been exposed should be managed with Airborne Precautions until 21 days post exposure or for the duration of illness regardless of whether the patient received immunoglobulin.
- Non-immune healthcare staff (e.g. born in NZ after 1969, other countries differ with MMR implementation year, without documentation of adequate vaccination or clinically diagnosed measles) should not be permitted to assess patients with Measles. If non-immune healthcare staff and visitors need to enter the room they should wear a fitted N-95 masks.
- Hand hygiene is the single most important step in reducing the spread of infection, have hand hygiene products are readily available for both patients and staff.
- Remember cough etiquette, have tissues and bins available.
- Ensure cleaning of assessment areas (e.g. bleach, alcohol wipes). The room should not be used for at least 2 hours after being vacated by the infectious patient and should be cleaned prior to being reoccupied as the measles virus can remain within the environment for up to 2 hours post consultation.

Personal Protective Equipment (PPE)

- **Masks**: *Note, masks stop droplets, but do not stop measles virus particle air penetration.*
  - Patients - provide with a surgical mask and the door to the room should be kept closed.
  - All Clinical staff - Ideally N95 (if unavailable, surgical) masks when taking a nasopharyngeal swab.
  - Eye/face mucosa protection - mask (or goggles) when taking nasopharyngeal swab.
- **Gloves:**
  - When potential to be exposed to respiratory secretions and taking nasopharyngeal swab.
  - For cleaning surfaces post consultation.
- **Gown/Apron**
  - Clinical staff who will be seeing other patients within the following 2 hrs could consider wearing a single use gown to prevent spread due to droplet contamination of clothing.