

Health Advisory

Continued Measles Vigilance

October 27, 2025

SUMMARY POINTS

- Measles activity is increasing [globally](#), and cases continue to be identified in the United States. There are outbreaks worldwide in countries where measles had previously been considered eliminated, including Canada, Mexico, Israel, and the United Kingdom.
- Ensure routine and catch-up MMR vaccination.
- Ask patients about upcoming travel plans and give an early dose of MMR at 6-11 months for children traveling internationally or to outbreak areas domestically.
- In the United States, the large outbreak in Texas has resolved, but there are currently outbreaks occurring in other areas of the United States.
- Providers should continue to maintain a high index of suspicion for measles in unvaccinated individuals who present with a fever and a typical rash.

Background

Measles is a highly contagious, acute viral illness that begins with a fever, cough, coryza (runny nose), and conjunctivitis (pink eye), lasting 2–4 days prior to rash onset. The rash typically occurs 3–5 days after symptoms begin and usually appears on the face and spreads downward. The virus is transmitted by direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes. The measles virus can remain infectious in the air and on surfaces for up to 2 hours after an infected person leaves an area. Infected people are contagious from 4 days before the rash starts through 4 days afterwards. The incubation period for measles from exposure to fever is typically about 11–12 days but ranges from 7-21 days. Measles can cause severe health complications, including pneumonia, encephalitis, and death.

In the United States (U.S.), the large outbreak in Texas has resolved, while sporadic travel-associated cases and smaller outbreaks continue to be detected. As of October 21, 2025, 1618 confirmed cases of measles were reported in the U.S. during 2025, including the large outbreak in the southwest, with 803 cases in Texas and 100 cases in New Mexico. To date, 16 cases have been identified in Pennsylvania and 10 in New Jersey. Nationally, 3 confirmed deaths due to measles have occurred in 2025.

Infection Prevention and Control

- Maintain a high suspicion for measles in individuals who are not immune and present with measles symptoms.
- Create triage policies to quickly identify and isolate patients who could have measles, including questions about recent measles exposures, including international travel, and symptoms. If possible, consider preliminary triage at the door.
- Follow [infection prevention and control recommendations](#).
- Immediately place individuals who may have measles in airborne infection isolation rooms (AIIR), since measles spreads between rooms through shared airspace. If an AIIR isn't available, the patient should be placed in a single room with the door closed and must mask until they can be placed in an AIIR. If AIIR was not used, the room should remain vacant for 2 hours after the patient leaves the room.
- All staff should don a N95 respirator. Use other personal protective equipment (PPE) as needed for specific tasks and conduct hygiene before donning PPE and after doffing PPE.
- Outpatient providers should notify hospital emergency rooms (ER) prior to referring patients to present to the ER so that patients can be quickly isolated. Outpatient providers should not send patients to the ER until they are able to convey safe entry directions from the ER. Patients 2 years of age and older should be told to mask when presenting to the ER.
- Maintain documentation of measles immunity for healthcare workers and other employees to ensure continuity of operations after an exposure.

Reporting and Testing Patients with Suspected Measles

- Contact PDPH by calling 215-685-6741 during regular business hours or 215-686-4514 (press 1 for Unified Dispatch and ask for the Division of Disease Control On-Call Staff) after hours, weekends, and holidays to coordinate measles testing if you suspect measles in a patient. Healthcare facilities that are located outside of Philadelphia should contact their local health departments or PADOH to coordinate testing. Test concurrently for other respiratory viruses.
- Specimens for measles PCR testing should be sent to the PADOH Bureau of Laboratories (BOL). While PCR testing is available commercially, results will not be received in a timely manner.
- Providers should collect a [nasopharyngeal \(NP\) or oropharyngeal \(OP\) and urine specimen for measles PCR](#). Urine specimens should only be submitted if a NP or OP swab is submitted.
- Use a flock-tipped plastic shaft swab in viral transport media or universal transport media for the NP or OP swab.
- Collect the urine specimen in a sterile container (minimum 50 ml).
- Ensure each specimen tube or container is labeled with the patient's name, date of birth, specimen type, and specimen collection date.
- Also, complete a [PADOH BOL Specimen Collection](#) for each specimen with the test type listed as Measles PCR. Complete all sections of the form and place the form in the separate pocket compartment of the specimen bag.
- Refrigerate if specimens are not transported or shipped immediately. Ship on cold packs.
- Advise the patient to isolate from others while test results are pending and note that further guidance will be given when test results are available.
- Consider sending measles IgG serology through commercial labs for individuals who don't have documentation of measles immune status and are potential contacts. This will help avoid a quarantine but must be done in the first 6 days after exposure before an individual could be potentially infectious. PDPH may be able to help coordinate a home blood draw after that time if necessary for contacts of confirmed measles cases.

Vaccination

- Administer routine and catch-up vaccination with MMR vaccine.
- Adults born before 1957 are considered measles immune unless they are part of specific [groups](#).
- Adults who were vaccinated from 1963-1968 may have received killed (inactivated) vaccine. People vaccinated during that time who received killed vaccine or who are not sure what vaccine they received should be revaccinated.
- Adults born from 1957-1989 likely received 1 dose of MMR. There is no need to revaccinate unless they are part of [specific groups](#) (e.g., international travelers, healthcare workers, etc.).
- An early first dose of MMR is also recommended for infants 6-11 months of age [before international travel](#). It is not recommended before domestic travel at this time unless traveling to an outbreak location. This dose will not count as part of the child's routine vaccination, and the child will need to get a dose after 12 months to start the routine series.
- An early second dose of MMR should be given to children 12 months through 3 years before they travel internationally and at least 28 days after the previous dose. This dose counts towards the child's routine series. Ensure that children aged 4 years and above are up to date on 2 MMR doses.

Resources

- [American Academy of Pediatrics Think Measles: Recognizing and Addressing Measles in Pediatric Practice](#)
- [Measles Preparedness and Response in Healthcare Settings](#)
- [CDC Clinician Update on Measles Cases and Outbreaks in the United States](#)
- [PDPH Vaccine Materials Order Form](#)