



HEALTH ALERT

Measles in Ohio: Recognition, Reporting, and Prevention

March 31, 2025

Summary and Action Items

- The Ohio Department of Health (ODH) recently reported 11 measles cases in March 2025; 10 of which are linked to an outbreak. ODH is working with the Ashtabula County Health Department, Knox Public Health, Allen County Public Health, and other impacted health departments to identify and notify those who may have been exposed and to promote opportunities for vaccination.
- Measles is extremely contagious and declines in measles vaccination rates globally have increased the risk of outbreaks. During 2022, an outbreak centered in central Ohio totaled 85 cases. Most large outbreaks of measles in the U.S. have occurred among close-knit and under-vaccinated communities.
- Many [international locations](#) are reporting ongoing measles transmission, including neighboring [Ontario, Canada](#). The Centers for Disease Control and Prevention (CDC) recently released a [health advisory](#) for an expanding measles outbreak in the U.S. with most cases occurring in Texas and New Mexico.
- ODH is reminding clinicians and public health officials to remain alert for [signs and symptoms of measles](#), particularly among people who have not yet received a measles-containing vaccine (MCV), including those who may have postponed or missed doses. Providers should also consider outreach to patients who are eligible for MCV to encourage routine immunization.
- Measles is a [Class A reportable disease](#). If measles is suspected, facilities should implement appropriate [infection prevention and control measures](#) and report any case, suspected case, or positive laboratory result **immediately via telephone** to the [local public health department](#) in which the patient resides. Prompt recognition, reporting, and implementation of infection prevention and control measures are critical to limiting the spread of disease.

Background

Measles is a highly contagious viral illness that typically begins with a prodrome of fever, cough, coryza (runny nose), and conjunctivitis (pink eye), lasting two to four days prior to rash onset. Modified measles can occur in infants who still have maternal antibodies and in those who received a measles vaccine or immune globulin soon after exposure. Measles can cause severe health complications, including pneumonia, encephalitis (inflammation of the brain), and death. Complications from measles are more common among children younger than 5, adults older than 20, pregnant women, and people with compromised immune systems. As many as one in 20 children with measles gets pneumonia, the most common cause of death from measles in young children.

The virus is transmitted by direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes. Measles virus can remain infectious in the air and on surfaces for up to two hours after an infected person leaves an area. Infected people are contagious from four days before rash onset to four days after. The incubation period for measles from exposure to fever is usually about 10 days (range seven to 12 days), and from exposure to rash onset is usually about 14 days (range seven to 21 days).

The measles, mumps, rubella (MMR) vaccine is highly protective against measles infection. CDC recommends all children get two doses of MMR vaccine, starting with the first dose at 12-15 months of age, and the second dose at 4 through 6 years of age. MMR vaccine can also be given to adults born after 1957 who are not vaccinated, or whose vaccination status is unknown. For individuals not protected by prior immunization or disease, CDC recommends that all persons older than 6 months receive MMR vaccine prior to travelling internationally or to an area with ongoing measles transmission.

Recognition

Consider measles as a diagnosis in anyone with a febrile illness and clinically compatible symptoms (e.g., a generalized [maculopapular rash](#) with cough, coryza, or conjunctivitis). A clinical history should include assessment for known contact to someone with measles, recent travel to areas with measles transmission, including international travel or travel to outbreak areas within the U.S., and MMR vaccination status.

Collection of virologic and serologic specimens is recommended for confirmation of disease. For patients with suspected measles, collect **both** respiratory (oropharyngeal or nasopharyngeal) and serum specimens for testing. Measles testing can be performed by commercial laboratories.

Testing for measles virus is also available through the ODH laboratory (ODHL) for [eligible clinical specimens](#). To request approval for testing at ODHL:

- Healthcare providers should contact the [local public health department](#) in which the patient resides.
- Local health departments should contact the Bureau of Infectious Diseases Vaccine Preventable Disease Epidemiology program to request specimen approvals using established chains of communication.

For additional clinical information for healthcare providers, please visit the [CDC website](#).

Reporting

Report a case, suspected case, and/or positive laboratory result **immediately via telephone** to the [local public health department](#) in which the patient resides. If patient residence is unknown, report immediately via telephone to the local public health department in which the reporting healthcare provider or laboratory is located. Local public health departments should report immediately via telephone the case, suspected case, and/or a positive laboratory result to ODH.

Prevention

Recommend MMR vaccine for all eligible patients who are unvaccinated or not fully vaccinated. Immunization schedules can be found on the CDC website [here](#).

Persons with suspected or confirmed measles infection should be isolated, including exclusion from school or childcare center, for four days following the onset of rash. Contacts who might be susceptible should be immunized with measles vaccine as soon as possible after exposure. Measles vaccine given within 72 hours after exposure may prevent or reduce the severity of disease. Immune globulin (IG) can prevent or modify measles in a susceptible person if given within six days of exposure. IG may be especially indicated for susceptible household contacts less than one year of age, pregnant women, or immunocompromised persons, for whom the risk of complications is increased.

Please see the [Measles Chapter in the ODH Infectious Disease Control Manual](#) and [CDC website](#) for additional guidance on the public health management of cases and contacts and infection prevention and control measures.

To minimize the risk of measles transmission in healthcare settings, healthcare personnel should do the following:

1. Query patients with a febrile rash illness about a history of travel (including international travel or travel to outbreak areas within the U.S.), contact with foreign visitors, transit through an international airport, or possible exposure to a person with measles in the three weeks prior to symptom onset. The possibility of measles should be considered for patients with such a history and symptoms consistent with measles.
2. Mask patients with suspected measles immediately, if tolerated. Encourage respiratory etiquette.
3. Do not allow patients with suspected measles to remain in the waiting room or other common areas; isolate patients with suspected measles immediately in an airborne infection isolation room if one is available. If such a room is not available, place the patient in a private room with the door closed. For additional infection control information, please refer to the [CDC's control measures for measles](#).
4. If possible, allow only healthcare personnel with documentation of two doses of MMR vaccine or laboratory evidence of immunity to measles (i.e., measles IgG positive) to enter the patient's room.
5. Healthcare personnel should wear an N95 or higher-level respirator regardless of presumptive evidence of immunity. A user seal check should be performed each time the respirator is donned.
6. If possible, do not allow susceptible visitors in the patient room.
7. Do not use the examination room for at least two hours after the possibly infectious patient leaves.
8. If possible, schedule patients with suspected measles at the end of the day.
9. Notify the local health department in whose jurisdiction the patient resides immediately by telephone about any patients with suspected measles.
10. Notify any location where the patient is being referred for additional clinical evaluation or laboratory testing about the patient's suspected measles status, and do not refer patients with suspected measles to other locations unless appropriate infection control measures can be implemented at those locations. The patient must wear a mask, if feasible.
11. Instruct patients with suspected measles and exposed persons to inform all healthcare providers of the possibility of measles prior to entering a healthcare facility so appropriate infection control precautions can be implemented.
12. Make note of the staff and other patients who were in the area during the time the patient with suspected measles was in the facility and for two hours after they left. If measles is confirmed, exposed people will need to be assessed for measles immunity.
13. For additional details about prevention measures in healthcare settings, refer to CDC's [Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings](#).

Contact Information

For general questions related to measles, healthcare providers and facilities should contact their [local health department](#). Ohio local health departments should contact the ODH Bureau of Infectious Diseases at 614-995-5599 or VPDEpi@odh.ohio.gov.

Resources

- [ODH Infectious Disease Control Manual Measles Chapter](#).
- [CDC Measles Guidance for Healthcare Providers](#).
- [CDC Manual for the Surveillance of Vaccine-Preventable Diseases Measles Chapter](#).
- [CDC Measles: Plan for Travel](#).