PAEDIATRIC ACUTE CARE GUIDELINE	
Measles	
Scope (Staff):	All Emergency Department Clinicians
Scope (Area):	Emergency Department

This document should be read in conjunction with this DISCLAIMER
http://kidshealthwa.com/about/disclaimer/

Measles

Background

Transmission and Epidemiology:

- Highly infectious
- Droplet spread or direct contact with secretions (the child is usually coughing)
- The virus may be suspended in the air for up to an hour after an infected person leaves the room or waiting area
- Patients are infectious for 3-4 days prior to the rash developing and a further 4-6 days from onset of rash
- After exposure to measles, it is usually about 10 days (range 7-18 days) to the onset of fever and about 14 days until the onset of rash

Examination

- The child appears miserable, febrile and unwell
- The 3 C's
    - Cough
    - Coryza
    - Conjunctivitis
- Coarse blotchy maculopapular rash (Morbilliform)
- Koplik spots appear 1-4 days before the rash appears - white spots on the bright red buccal mucosa of the cheek opposite the premolar

Investigations

At PMH: Contact on call Microbiology to ensure rapid processing

- Measles antibodies (IgM and IgG)
- Measles IgM appears 1-2 days after the appearance of the rash and persists for 1 month
- NPA – for viruses and urgent PCR
- Urine for measles PCR

Management

Public Health Management

- Upon suspicion of measles, isolate immediately within the department. See ED Guideline: Rash Management
- Suspected measles cases should always be discussed with the PMH Clinical Microbiologist (to coordinate local response)
- Laboratory confirmation is always required
- Take a contact history
- Susceptible contacts may be advised to be immunised by their GP (for up to 72 hours after the first exposure). Alternatively they may have Normal Immunoglobulin from 72 hours to 7 days after the first exposure.
- Advise isolation at home until results become available. If positive, the exclusion time is 6 days from the onset of the rash
- If possible, avoid hospitalisation, because of the infectivity. Admit for clinical condition warranting interventions only.

Complications

- Pneumonia - is the most common cause of death in measles and may progress onto bronchiolitis obliterans
- Acute otitis media
- Diarrhoea and vomiting
- SSPE (Sub Acute Scelerosing Pan Encephalitis) - a rare late complication

Nursing

- Patient must be nursed in negative pressure isolation room
- Personal Protective Equipment (PPE) must be worn when assessing patient

Tags

antibodies, buccal, conjunctivitis, coryza, cough, droplets, exclusion, fever, igg, igm, infectious, isolation, koplik spots, maculopapular, measles, mucosa, photophobia, public health, rash, virus, white spots

References

• PMH Emergency Department Guidelines: Measles - Last Updated November 2014
• Dowse G. (2010) Epidemiology of vaccine preventable diseases in Western Australia. Australia. Department of Health
• Dowse G. (2010) Public health management of 200 key vaccine preventable diseases. Australia. Department of Health
• NSW Health. (2008) Measles response protocol for NSW public health units. NSW Australia.
• WA Health Operational Directive OD 0123/08 Measles: National Guidelines for Public Health Units

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