NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

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To: Healthcare Providers, Healthcare Facilities, and Local Health Departments (LHDs)

From: New York State Department of Health

HEALTH ADVISORY: CONFIRMED MEASLES CASES IN MULTIPLE UNDER-IMMUNIZED COMMUNITIES

Please distribute to: Hospitals, Local Health Departments, Laboratories, Emergency Departments, Family Medicine, Pediatrics, Adolescent Medicine, Internal Medicine, Infectious Disease, Infection Control, and other Primary Care Providers.

Summary

- The New York State Department of Health is notifying medical facilities and health care providers to be on alert for measles in under-immunized communities.
- Emergency room personnel and health care providers should be on alert for patients who have: (1) febrile rash illness and symptoms consistent with measles (e.g., cough, coryza, or conjunctivitis), and (2) have had contact with individuals with symptoms consistent with measles/known measles. Individuals may or may not have had recent travel to areas with ongoing measles outbreaks.
- Measles is one of the most contagious vaccine preventable infections. Individuals are contagious from four days before to four days after rash onset. The prodrome, before the rash, may include fever, cough, coryza, and conjunctivitis.
- Ask about immunization. This is particularly important in patients with symptoms consistent with measles illness or the prodrome.
- Call ahead to the emergency room if you are sending patients with symptoms of measles for care.
- **Report patients with suspected measles immediately to the local health department of the patient's residence. Do not wait for laboratory confirmation to report.**
    - If you have urgent questions regarding measles during evenings, weekends, or holidays, call 866-881-2809.

Background

Since July 13, 2026, there have been wild-type measles cases confirmed in unvaccinated individuals in Allegany, Chenango, Madison, Otsego, Seneca, Steuben, and Tioga counties. While a few cases have been associated with travel to other states,

local transmission has also occurred. Additionally, there have been multiple unsubstantiated reports of suspected measles cases in the Capital, Central, and Western regions which have prompted some previously unimmunized individuals to request vaccination. Wild-type measles has also been detected in wastewater samples collected in Montgomery and Yates County.

Clinical Signs and Symptoms

Measles typically presents as an acute viral illness characterized by fever and generalized maculopapular rash (Figure 1). Signs and symptoms appear 7 to 21 days after initial exposure. The prodrome may include cough, coryza, and conjunctivitis. Koplik spots, which appear as white to blue slightly raised spots surrounded by a red halo, are sometimes seen on the inner cheeks opposite the molars several days before a rash develops. The rash usually starts on the face, proceeds down the body, and may include the palms and soles. The rash initially appears as discrete macules which may become confluent or papular and which last several days (Figure 2,3). Symptoms may be mild, absent, or atypical in persons who have some degree of immunity to measles virus before infection (e.g., in previously vaccinated persons). Serious side effects of measles can include pneumonia, encephalitis, hospitalization, and death. Measles in pregnant individuals can cause fetal loss.

Figure 1 (Source CDC/PHIL)

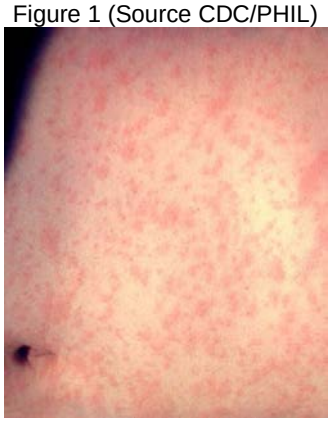
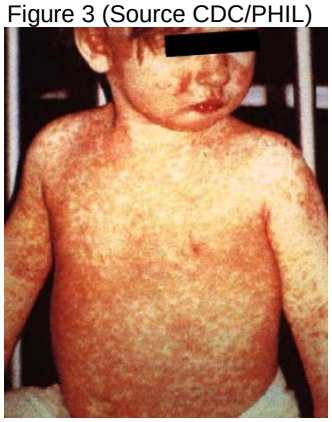


Figure 2 (Source CDC/PHIL)

Figure 3 (Source CDC/PHIL)



Measles Vaccination in Outbreak Areas

In an outbreak area, children (without contraindications) should receive MMR vaccine as soon as they are eligible. In the current situation where measles has affected multiple under-immunized communities and where there is suspected under-reporting, this includes children who belong to a community where at least one measles case has occurred or where there are credible reports that measles is circulating.

- **Infants 6-11 months of age** should receive one dose (this dose does not count toward the routine two-dose schedule)
- **Children aged 1 year and older should receive two MMR vaccine doses as early as possible**, 28 days apart (school requirements will be fulfilled by 2 doses given after 1 year of age, 28 days or more apart)
- Sample outbreak area pediatric MMR vaccination schedule:
    - Dose 1 at 6-11 months, dose 2 at 12 months, dose 3 at 13-15 months

- Children over 1 year of age who have not received 2 MMR doses (administered at 1 year of age or older) should receive the two-dose schedule as soon as possible.

Measles Testing

Healthcare providers should test for measles in individuals presenting with rash and fever, cough, conjunctivitis, and coryza, especially if they have traveled to or from areas with known measles outbreaks or have known exposure to measles. Please see testing guidelines here. Testing should include:

- Collection of a nasopharyngeal swab for reverse transcription-polymerase chain reaction (RT-PCR). Ideally 0-3 days after rash onset and up to 10 days after rash onset.
- Blood for serology should be collected to detect measles-specific IgM antibodies. IgM is most sensitive 3 or more days after rash onset and may be negative from days 0-3 after rash onset.
- Urine samples can also contain the measles virus. Collection should occur within 10 days of rash onset. Collecting both respiratory and urine samples may improve test sensitivity, especially if individuals are at the end of the PCR detection window.

Infection Prevention and Control in Healthcare Facilities

- To promptly identify suspected cases of measles and prevent exposures, screen patients for rash with fever at the point of entry of a healthcare facility and inquire about recent international or domestic travel and possible exposure to measles.
- Immediately institute Standard plus Airborne Precautions for patients with known or suspected measles and call ahead for patients being referred to other healthcare facilities to prevent healthcare-associated exposures.
- Place the patient in a single-patient airborne infection isolation room.
    - If a single-patient airborne infection isolation room is unavailable, mask the patient immediately (age 2 and over). Place the patient in a private exam room with the door closed and have them continue to wear a mask. After the patient leaves, it should remain vacant for at least 2 hours.
- Review CDC Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings for additional guidance, including guidance on minimizing, identifying and managing measles exposures in healthcare settings.

Measles Post-Exposure Prophylaxis (PEP)

Individuals who are exposed to measles and do not have evidence of immunity against measles should be offered post-exposure prophylaxis (PEP). Do **not** administer MMR vaccine and IG simultaneously, as this practice invalidates the vaccine.

- **MMR Vaccine as Measles PEP:**
  The MMR (measles, mumps, rubella) vaccine may offer protection against measles when administered within 72 hours of exposure. Its effectiveness can vary based on the timing of vaccination and the nature of the exposure. In

settings with limited contact, such as schools and medical offices, post-exposure prophylaxis with MMR vaccine has been shown to be effective when administered within this timeframe. For individuals aged ≥6 months exposed to measles, MMR vaccination within 72 hours of exposure is preferred over human immune globulin (IG) because it can induce protection against subsequent exposures and might modify the course of the disease if infection occurs.

- **Immune Globulin (IG) Products as Measles PEP:**
  Human immune globulin (IG), a blood product that provides antibodies for short-term prevention of infectious diseases like measles, can be administered as post-exposure prophylaxis. The United States uses multiple IG preparations, including intramuscular (IGIM), intravenous (IGIV), and subcutaneous (IGSC) forms, with varying measles antibody potency requirements. IG administration within 6 days of exposure can prevent or modify measles in nonimmune persons.

  It is important to note that immune globulin is not specific to measles but can be used for post-exposure prophylaxis to provide passive immunity. The decision to use immune globulin should be based on individual patient risk assessment, including age, immunization status, and exposure details. It is crucial to follow specific guidelines for administering IG, especially in high-risk groups such as infants under 12 months, pregnant women without measles immunity, and severely immunocompromised patients. For individuals aged ≥6 months exposed to measles, MMR vaccination within 72 hours of exposure is preferred over human immune globulin (IG).

  Historically, IGIM has been used to prevent or attenuate measles disease when administered within 6 days of exposure. However, its effectiveness can be dose-dependent, and volume limitations may restrict its use in individuals weighing more than 30 kg.

- **Recommended Dose and Use of IG for PEP:**
  The dose of IGIM for post-exposure prophylaxis is 0.5 mL/kg of body weight (maximum dose = 15 mL), while IGIV is given at 400 mg/kg. IG should be prioritized for those in high-risk settings and can be administered based on the individual's exposure risk and immune status.

- **For more information**, see the PEP summary table:
  https://www.health.ny.gov/diseases/communicable/measles/providers/docs/pep_table.pdf

Healthcare providers should administer post-exposure prophylaxis judiciously, considering the individual's risk of exposure, immune status, and potential for severe disease. It is imperative to act swiftly following exposure to minimize the risk of measles transmission and outbreak.

Avoiding Exposures
Healthcare professionals should ensure that all staff and patients are aware of the symptoms of measles and the importance of notifying healthcare facilities before visiting if they suspect they have measles. To avoid exposure:

- Screen patients for fever and rash and ask about recent travel or exposure to measles at the first point of contact (e.g., during appointment scheduling and at the reception desk).
- Implement immediate masking and isolation procedures for suspected measles cases to prevent the spread within healthcare settings.
- Use and provide personal protective equipment (PPE) and ensure strict adherence to infection control practices.

Reporting
Suspected measles cases must be reported immediately to the local health department of the patient's residence. Article 28 facilities should also notify the regional epidemiologist of suspected measles cases.

- The local health department in New York State (outside New York City) can assist in arranging testing at the Wadsworth Center Laboratory, and for specimens to arrive at the lab within 24 hours of collection, when feasible.

Specimen Collection
Follow Wadsworth Center Laboratory's tip sheet and collect either a nasopharyngeal swab or throat swab for reverse transcription polymerase chain reaction (RT-PCR), as well as a blood specimen for serology, from patients with suspected measles for testing at the lab. Urine may also contain virus, so collect a urine sample in addition when feasible. Follow the packaging and shipping instructions on the tip sheet.

Public Health Action
Those who are infected should be instructed to isolate for four days after they develop a rash; standard and airborne precautions should be followed in healthcare settings. People who are suspected of being exposed to measles who cannot readily show that they have evidence of immunity against measles should be offered post-exposure prophylaxis (PEP).

Educate patients about vaccines that provide protection against measles and make sure your patients are all up-to-date on measles vaccine. Healthcare providers and local health departments should coordinate response activities with each other and consider offering MMR vaccine clinics to prevent an outbreak in your community.