INFECTION CONTROL LITIGATION

Measles in the Waiting Room

Infection Control When an Old Disease Comes Back

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For about 25 years, measles was rare in the U.S. The country was declared to have eliminated ongoing transmission in 2000. That's over. There were more than 2,000 confirmed cases in 2025, and by mid-2026 the year's count had already passed 2025's, the highest since elimination, according to Johns Hopkins analysts. Public health experts expect the U.S. to lose elimination status, and the Pan American Health Organization's regional commission is scheduled to review it in November 2026.

Healthcare facilities are especially exposed. Measles is one of the most contagious diseases known. It's airborne, and the virus can linger in a room for up to two hours after the patient leaves. People are contagious for days before the rash, when they look like they have a bad cold with fever. And the people most likely to suffer serious complications (infants too young to vaccinate, nonimmune pregnant women, immunocompromised patients) are exactly the people sitting in clinic and ER waiting rooms. Many clinicians practicing today have never seen a case.

WHAT INFECTION CONTROL REQUIRES

CDC's interim infection prevention recommendations for measles in healthcare settings, updated August 19, 2025, come down to a handful of things.

First, catch it early. Facilities should have a way to flag patients with fever and rash, or known exposure, as soon as they arrive, ideally before they sit down: entrance signs, check-in questions, phone triage before the visit.

Then isolate right away: mask the patient and move them into an airborne infection isolation room (negative pressure, at least 6 air changes an hour in existing facilities and 12 in new construction), with the door closed. If none is available, use a private room with the door closed

and plan a transfer. Keep patients on airborne precautions for 4 days after rash onset, or the whole illness if immunocompromised.

Everyone who goes into the room wears a fit-tested N95 or equivalent, immune or not. Ideally, only staff with documented immunity provide care.

Staff are supposed to have presumptive evidence of immunity: two documented doses of MMR, lab evidence of immunity or disease, or birth before 1957. During outbreaks, two doses are recommended regardless of birth year.

And when there's an exposure, move fast. Identify patients, visitors, and staff who shared the air space while the patient was there and for up to two hours after. Nonimmune contacts may get MMR within 72 hours or immune globulin within 6 days. Exposed nonimmune staff are excluded from work from day 5 through day 21 after exposure (through day 28 if they received immune globulin).

A FICTIONAL CASE

An unvaccinated 4-year-old comes to a busy pediatric urgent care with fever, cough, runny nose, red eyes, and a rash that started that morning. The family was in an outbreak area ten days earlier, but nobody asks about travel. The child waits in the main waiting room for 90 minutes, sharing it with a 7-month-old there for an ear infection. Measles is diagnosed, and the health department is notified the next day. Twelve days later the infant develops measles, then pneumonia, and is hospitalized.

SHOULD THEY HAVE CAUGHT IT AT THE DOOR?

Fever, cough, runny nose, red eyes, and rash is the classic picture. Was there a sign asking patients with fever and rash to alert staff? Did check-in include rash or exposure questions? Did anyone ask about travel or local outbreaks? Had the clinic received health department alerts, and what did it do with them?

ONCE MEASLES WAS SUSPECTED

When did someone first think of it? Was the child masked and moved? If the clinic had no isolation room, what was the plan? How long did the child sit in the shared space, and who else was there?

THE EXPOSURE RESPONSE

After diagnosis, did the clinic work with the health department to identify everyone exposed? Was the infant's family contacted, and when? The windows are short, 72 hours for vaccine and six days for immune globulin, and a 7-month-old would generally be a candidate for immune

globulin and in some circumstances the vaccine. Families usually don't know about an exposure until someone calls them, so the clinic's list of who was in the room, and how fast it reached the health department, can decide whether protection was even possible.

REPORTING

Measles is reportable in every state, and suspected cases generally must be reported immediately, often by phone, without waiting for lab results. A day's delay can cost exposed people their chance at prophylaxis. The report time, and what the facility did while waiting, belongs in the timeline.

WHEN IT'S MISSED ENTIRELY

Early measles can look like any viral illness, and the rash can be mistaken for a drug reaction. A patient sent home with "viral syndrome" and back days later has exposed more people each time. In a missed-diagnosis case, look at the symptoms and history, whether vaccination status was documented, whether local outbreaks were known, and whether measles was considered. If suspected, was testing done promptly (typically PCR from a throat or nasal swab plus serology)?

FACILITY PREPARATION AND STAFF

Did the facility have an airborne infection or measles policy, staff training, immunity records, an isolation room or written alternative, and a process for acting on public health alerts? Many facilities updated plans during the 2025–2026 outbreaks; when they did so matters. Staff exposures raise their own issues: a nonimmune worker who works during the exclusion window can spread measles to patients, and a facility that didn't track immunity may not know who to exclude.

CAUSATION AND DAMAGES

Measles has a fairly predictable incubation period, usually about 11 to 12 days to first symptoms and about two weeks to rash. Illness in that window with no other known exposure makes a strong link, and health department investigations often include viral genotyping that can connect cases. Complications include pneumonia and encephalitis and, rarely, a fatal brain disease years later, with infants and immunocompromised people at highest risk.

RECORDS WORTH REQUESTING

- Visit records with check-in and triage timestamps
- Waiting room logs or sign-in sheets showing who was present and when
- Infection control, airborne isolation, and measles policies and training records
- Public health alerts received and the facility's response

- Staff immunity records and exposure/exclusion records
- Exposure notification records and timing
- The health department's case and contact investigation file, including genotyping

SOURCES

- CDC, *Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings* (updated Aug. 19, 2025)
- Johns Hopkins International Vaccine Access Center, "2026 U.S. Measles Cases Surpass 2025 Level" (2026); CIDRAP, "US 'highly likely' to lose measles elimination status this fall" (2026)

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a measles or other airborne exposure case and want the patient followed from the front door and everyone who shared the air accounted for, we'd welcome the conversation.

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