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TRAVELERS BRINGING MEASLES BACK TO U.S., CDC SAYS

Agency reports 7 cases in babies during first two months of 2011

THURSDAY, April 7 (HealthDay News) -- Measles was declared eliminated in the United States in 2000, but cases continue to occur among U.S. residents who return from trips to other countries, as well as among foreign visitors to the United States, says a new government report.

"Measles importations and transmission from imported cases continue to pose a threat to U.S. residents," warns a team from the U.S. Centers for Disease Control and Prevention and various state health departments. "Travelers can be exposed to measles in the country of travel or while en route to and from that country, in airports or on airplanes," they add.

According to the researchers, young children are at greatest risk of complications or death from measles, which is highly contagious but can be prevented by vaccination.

In the first two months of this year, the CDC reported 13 cases of "imported measles" among U.S. residents, including seven cases of measles among American infants aged 6 to 23 months who had traveled to other countries.

The agency notes that that two-month total is comparable to the average annual caseload seen each year between 2001 and 2010.

Four of the children infected with measles in the 2011 cases had to be hospitalized due to severe measles-related complications, the CDC said.

It's likely that all of these cases could have been prevented if the children had received recommended vaccinations, the authors said.

Children aged 6 to 11 months should be given one dose of measles-mumps-rubella vaccine before traveling to other countries, and children aged 1 year and older should receive two doses (separated by at least 28 days) of the vaccine before international travel, the authors recommended.

Up-to-date vaccinations are also essential for international travelers of all ages, they added.

The authors also said doctors should consider measles as a possible diagnosis when dealing with patients with a skin rash who have recently traveled outside of the United States.

Fuente: Medisys

LIKELY SOURCE OF SERRATIA CONTAMINATION IDENTIFIED

The Alabama Department of Public Health and the Centers for Disease Control and Prevention have determined that the *Serratia marcescens* bacteremia in 12 hospitalized individuals who received TPN (total parenteral nutrition) has the same genetic fingerprint as the organism isolated from a container and stirrer used to mix the powdered amino acids, from the tap water spigot used for rinsing the container, and from the TPN.

A bag of compounded amino acids used in the production of TPN has also grown *Serratia marcescens*. Genetic fingerprint results are pending on the compounded amino acids.

The Alabama Department of Public Health is aware of 19 cases of *Serratia marcescens* in patients in six Alabama hospitals. Of these cases, 12 samples from individuals were matched with the bacterium found at Meds IV Pharmacy in Birmingham. Of the remaining seven cases in question, six have no samples available to test for a genetic match and one case is pending.

A failure in a step of the sterilization process in the compounding of TPN was most likely the cause of contamination. Use of these contaminated products led to a bacterial bloodstream infection in these 19 patients.

On March 16, ADPH was notified that an outbreak had occurred in two hospitals among patients receiving TPN. CDC's initial investigation identified TPN produced by Meds IV as a potential common source and determined that six hospitals received TPN from this pharmacy.

Illness with *Serratia marcescens* bacteremia occurred in approximately 35 percent of patients receiving TPN from Meds IV during March. Seventeen cases were reported in March, and two additional cases were retrospectively identified during the investigation, one in January and one in February.

The individuals affected are in the age range from 38 to 94 years; 8 males and 11 females were infected. The numbers of cases and deaths by hospital are as follows: Baptist Princeton, 7 cases, 4 deaths; Baptist Shelby, 5 cases, 2 deaths; Medical West, 3 cases, 1 death; Cooper Green Mercy, 1 case, no deaths; Baptist Medical Center Prattville, 1 case, 1 death; and Select Specialty Hospital of Birmingham, 2 cases, 1 death.

Meds IV was notified and informed its customers of the possibility of contamination. ADPH has been informed that impacted hospitals immediately stopped using TPN received from this pharmacy and that the pharmacy discontinued all production. On March 24, Meds IV recalled all of its IV compounded products.

ADPH continues an ongoing investigation of the outbreak of *Serratia marcescens* bacteremia in collaboration with the CDC, the U.S. Food and Drug Administration, the Alabama Hospital Association, and the State Board of Pharmacy. At this time, there have been no reports of contaminated TPN, from any other pharmacy, sent to hospitals in Alabama or any other state.

Fuente: Medisys