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Clinical Pearls

Clinical Pearls help prepare residents for the future by providing them with insights about what they should know about a specific subject area by the time they complete their residency.

Measles pearls for residents

By John Trinidad, MD, MPH, FAAD

Pearl #1: Measles remains rare but clinically relevant in the United States, with outbreaks driven by under-immunization. Dermatologists should maintain vigilance despite low current case counts. As of Jan. 29, 2026, 588 confirmed measles cases have been reported in the United States, all outbreak-associated and linked to outbreaks that began in 2025.(1) In contrast, 2025 saw 2,144 confirmed cases across 45 jurisdictions, underscoring the episodic but persistent risk of resurgence when vaccination coverage declines.(2)

Pearl #2: Dermatologists play a critical role in early recognition of measles based on its characteristic clinical progression. Measles classically presents with a prodrome of fever, cough, coryza, and conjunctivitis, followed by Koplik spots and a morbilliform eruption that begins at the hairline and spreads caudally with palmoplantar sparing.(3) Early recognition is essential, as patients are highly contagious before rash onset and during early eruption. Images and clinical considerations can be found at this AAD resource: **www.aad.org/member/clinical-quality/clinical-care/emerging-diseases/measles/clinical-information**.

Pearl #3: Suspected measles is a public health emergency requiring immediate isolation, testing, and reporting. Any patient with suspected measles should be masked, placed in airborne isolation if available, and reported immediately to local or state health departments. Dermatology practices should avoid sending suspected cases to waiting rooms or non-isolated clinical areas and should coordinate testing and evaluation with public health authorities.(3)

Pearl #4: Office preparedness is essential to prevent nosocomial transmission. Dermatology offices should have protocols in place for screening febrile rash illnesses, identifying immune versus non-immune staff, and rapidly isolating suspected cases. Ensuring staff immunity through documented MMR vaccination and having clear escalation pathways reduces practice-level risk during outbreaks. If your office does not have an airborne infection isolation room (AIIR), refer/transfer the patient to a facility where an AIIR is available. Notify the facility and accepting physician of any incoming measles patients. Learn how to prepare for a patient with suspected measles with this AAD resource: **www.aad.org/member/clinical-quality/clinical-care/emerging-diseases/measles/office-preparedness**.

Pearl #5: Vaccination remains the most effective preventive strategy, and dermatologists should reinforce evidence-based counseling. Measles requires approximately 95% population immunity to prevent sustained transmission.(3) A single dose of MMR vaccination is 93% effective against measles. A second dose increases effectiveness to 97%.(4) Dermatologists are well positioned to provide vaccine education, counter misinformation, and encourage appropriate immunization, particularly in communities with known gaps in coverage. DR

References:

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