



# COMMONWEALTH of VIRGINIA

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## **UPDATE: FUNGAL INFECTIONS ASSOCIATED WITH CONTAMINATED PRODUCT**

December 19, 2012

Dear Colleague:

This letter is being sent to physicians in Virginia to update you on the outbreak of fungal meningitis among patients who received injections containing contaminated preservative-free methylprednisolone acetate (MPA) from three recalled lots prepared by the New England Compounding Center (NECC). In Virginia, this product was used only by Insight Imaging in Roanoke and New River Valley Surgery Center in Christiansburg. As of December 19, 2012, VDH is reporting 51 cases of probable or laboratory-confirmed fungal infections, including two (2) deaths; 49 (96%) cases were meningitis and two (4%) were epidural abscesses. No fungal infections of peripheral joints have been reported in Virginia to date. Our most recent case was identified on November 26, 2012. While the frequency of case reports has decreased over time, we continue to remain vigilant and respond to any reports of infection that may be associated with the outbreak. For more detailed information on this outbreak both nationally and in Virginia, visit our fungal meningitis webpage found here: <http://www.vdh.virginia.gov/news/Alerts/Meningitis/index.htm>.

Patients in Virginia who were exposed to the contaminated lots of preservative-free MPA have been under public health or clinical surveillance since early October and have received weekly phone calls to assess their clinical status. Carilion Roanoke Memorial Hospital and Lewis Gale Hospital have been critical partners in this investigation. In addition to diagnosing and treating many complex fungal meningitis cases, these clinical teams also coordinated routine follow-up of exposed patients who did not meet case definition during their diagnostic workup. VDH recently ended our active public health surveillance phone calls by notifying patients with a final call and a letter summarizing what signs and symptoms to be aware of in the coming weeks. Exposed persons have been advised to seek immediate medical attention if they have any new or worsening symptoms of meningitis (e.g., headache, fever, stiff neck, photophobia); inflammation at the site of injection; or cauda equina syndrome (e.g., pain or numbness in one or both legs, changes in urination or bowel function).

### **Updated Information Regarding Contamination of Additional NECC Products**

On December 3, 2012, the Centers for Disease Control and Prevention (CDC) released a Health Update summarizing laboratory findings of additional contamination in NECC products other than MPA. CDC and FDA have identified additional microbial contamination in unopened vials of betamethasone, cardioplegia, and triamcinolone solutions that were distributed and then ultimately recalled by NECC. Although CDC has received reports of illness in patients who have received these medications, including some patients who had evidence of meningeal inflammation, to date CDC has no reports of laboratory-confirmed bacterial or fungal meningitis, spinal, or paraspinal infections caused by these products. The available epidemiological and laboratory data do not, at this time, support evidence of an outbreak of infections linked to usage of non-methylprednisolone NECC products. The most recent CDC Health Update can be found here: <http://emergency.cdc.gov/HAN/han00337.asp>.

While the outbreak associated with preservative-free MPA products was primarily limited to southwest Virginia, other injectable NECC products were distributed throughout the Commonwealth. In mid-October, facilities in Virginia that received NECC products were notified of the distribution of those products. Consistent with FDA guidance, on October 17, 2012, VDH sent a letter to providers recommending providers notify patients who received any injectable NECC product on or after May 21, 2012, with particular attention to triamcinolone, betamethasone, and cardiplegia solutions.

**In light of the evolving nature of outbreaks and additional information about non-MPA products, we ask that you continue to remain alert and consider the possibility that infections may continue to result from prior injections of various NECC products. Please report infections or other conditions potentially related to NECC products to FDA's MedWatch at 1-800-332-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch) and to your local health district.**

Thank you for your collaboration during this outbreak investigation. In order to remain abreast of important details regarding the most up-to-date clinical guidance or for information about notification or follow up of patients who were impacted, please check the CDC and FDA websites regularly.

Thank you,

Maureen E. Dempsey, MD, FAAP  
Acting State Health Commissioner