COMMONWEALTH of VIRGINIA
Department of Health
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STATE HEALTH COMMISSIONER
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October 1, 2012

Dear Clinician,

This letter is being sent to physicians in southwestern Virginia to inform you of a cluster of patients with meningitis that presented after receiving epidural spinal injections. Only two facilities in Virginia, both in the southwestern region of Virginia, are known to have received the medication of concern, certain lots of methylprednisolone acetate. To date, no cases associated with this cluster have been reported in Virginia, but your patients may contact you in response to a notification that they receive from one of the facilities that performed their spinal injections.

The Centers for Disease Control and Prevention (CDC) recently notified the Virginia Department of Health (VDH) and several other state health departments of a cluster of meningitis associated with epidural spinal injections. Patients have presented with signs/symptoms of meningitis within 7-28 days of receiving one or more spinal injections during the period of July 30 - September 18, 2012. Lumbar puncture has yielded CSF with low glucose, elevated protein and high neutrophil-predominant white cell count. Gram stains and bacterial cultures have been negative. *Aspergillus fumigatus* has been isolated from one patient. Several patients had cerebrovascular accidents in deep brain locations.

The source of these infections is not yet known but public health officials, including CDC and the Food and Drug Administration, are currently evaluating a number of different products used during these procedures and conducting outreach to pain clinics in multiple states. One medication used for all of the infected patients was methylprednisolone acetate from one compounding pharmacy, which recently recalled three lots of this product.

Because the exact source of these infections is not yet known, VDH is in contact with the two facilities in the southwestern region of Virginia that are known to have received methylprednisolone acetate from this manufacturer between July 1, 2012 and September 28, 2012. Local health departments are working with those facilities to ensure patients are contacted and instructed to seek medical attention if they develop symptoms including worsening headache, fever, stiff neck, sensitivity to light, or stroke (localized weakness, numbness, slurred speech). Patients will be counseled to seek immediate evaluation if these symptoms exist, and to let a physician know about this investigation and the concern for possible *Aspergillus* infection. If you have patients that contact you with signs and symptoms consistent with the cases in this investigation and who report receiving a spinal injection within the time frame above, please contact your local health department immediately.

In summary, CDC is only aware of infections occurring in patients who received spinal injections and is targeting urgent outreach to these patients. We are aware that facilities may have performed injections at other body sites and, because the source of these infections is not yet known, we are asking you to remain alert for and promptly report complications associated with these other types of injections.

As always, thank you for your ongoing partnership with the Virginia Department of Health. If you have further questions about this investigation, please contact your local health department.

Sincerely,

David H. Trump, MD, MPH, MPA
State Epidemiologist & Director, Office of Epidemiology