HEALTH ALERT
OCTOBER 9, 2012

New England Compounding Center (NECC) Recall and Meningitis

CDC and FDA are investigating a multistate outbreak of fungal meningitis, often with sequelae of stroke, associated with epidural injection of preservative-free methylprednisolone acetate (80mg/ml) manufactured by the New England Compounding Center (NECC). To date, 119 cases have been identified and 11 deaths have been reported in 10 states; none of these have occurred in California.

As of October 5, three lots of NECC-compounded methylprednisolone were recalled. None of the recalled drug lots were shipped to San Francisco. However, San Francisco facilities and clinicians could have received other products from NECC. To date, no other NECC products have been associated with contamination or infection. Nonetheless, NECC has ceased all operations, and has recalled all its products. A list of NECC products is available here: http://www.neccrx.com/. NECC has notified its customers to stop using its products immediately, to retain and secure them, and to follow instructions from the company.

**Actions requested of all clinicians:**

1. Immediately discontinue use of all NECC products.
2. Review CDC outbreak-associated case definitions below. Report cases and potential cases to the Communicable Disease Control Unit (CDCU) at (415) 554-2830. Reminder all meningitis cases are legally reportable in California.
3. Remain vigilant, and report to CDCU any infection identified in a patient known to have received an NECC product of any type.
4. Report complaints or problems associated with NECC products to FDA (By phone to 1-800-FDA-1088 or on line at www.fda.gov/medwatch/report.htm)

**CDC Case Definitions** (Any One of the Following Meets Case Criteria)

1. **Meningitis** with sub-acute onset (1-4 weeks) following epidural injection after May 21, 2012. (Including clinically diagnosed meningitis, consisting of one or more of: headache, fever, stiff neck, photophobia, and CSF profile consistent with meningitis e.g. pleocytosis +/- low glucose, elevated protein).
2. **Basilar stroke** 1-4 weeks following epidural injection after May 21, 2012, in a patient who has not received a lumbar puncture. These patients should have a lumbar puncture, if not contraindicated.
3. Evidence of spinal osteomyelitis or epidural abscess at the site of an epidural injection diagnosed 1-4 weeks after epidural injection after May 21, 2012.
4. **Septic arthritis** diagnosed 1-4 weeks following steroid joint injection after May 21, 2012. (Including clinically diagnosed septic arthritis, meaning new or worsening pain with presence of effusion, or new or worsening effusion.)

**Additional Resources:**
CDC Clinician guidance: http://www.cdc.gov/hai/outbreaks/clinicians/index.html.