

Mumps

Mumps is an acute viral illness. Parotitis and orchitis were described by Hippocrates in the 5th century BCE. In 1934, Johnson and Goodpasture showed that mumps could be transmitted from infected patients to rhesus monkeys and demonstrated that mumps was caused by a filterable agent present in saliva. This agent was later shown to be a virus. Mumps was a frequent cause of outbreaks among military personnel in the prevaccine era, and was one of the most common causes of aseptic meningitis and sensorineural deafness in childhood. During World War I, only influenza and gonorrhea were more common causes of hospitalization among soldiers. A multistate mumps outbreak in 2006 resulted in more than 6,000 reported cases.

Mumps Virus

Mumps virus is a paramyxovirus in the same group as parainfluenza and Newcastle disease virus. Parainfluenza and Newcastle disease viruses produce antibodies that cross-react with mumps virus. The virus has a single-stranded RNA genome.

The virus can be isolated or propagated in cultures of various human and monkey tissues and in embryonated eggs. It has been recovered from the saliva, cerebrospinal fluid, urine, blood, milk, and infected tissues of patients with mumps.

Mumps virus is rapidly inactivated by formalin, ether, chloroform, heat, and ultraviolet light.

Pathogenesis

The virus is acquired by respiratory droplets. It replicates in the nasopharynx and regional lymph nodes. After 12 to 25 days a viremia occurs, which lasts from 3 to 5 days. During the viremia, the virus spreads to multiple tissues, including the meninges, and glands such as the salivary, pancreas, testes, and ovaries. Inflammation in infected tissues leads to characteristic symptoms of parotitis and aseptic meningitis.

Clinical Features

The incubation period of mumps is 14 to 18 days (range, 14 to 25 days). The prodromal symptoms are nonspecific, and include myalgia, anorexia, malaise, headache, and low-grade fever.

Parotitis is the most common manifestation and occurs in 30% to 40% of infected persons. Parotitis may be unilateral or bilateral, and any combination of single or multiple salivary glands may be affected. Parotitis tends to occur within the first 2 days and may first be noted as earache and tenderness on palpation of the angle of the jaw. Symptoms tend to decrease after 1 week and usually resolve after 10 days.

Mumps

- Acute viral illness
- Parotitis and orchitis described by Hippocrates in 5th century BCE
- Viral etiology described by Johnson and Goodpasture in 1934
- Frequent cause of outbreaks among military personnel in prevaccine era

Mumps Virus

- Paramyxovirus
- RNA virus
- One antigenic type
- Rapidly inactivated by chemical agents, heat, and ultraviolet light

Mumps Pathogenesis

- Respiratory transmission of virus
- Replication in nasopharynx and regional lymph nodes
- Viremia 12-25 days after exposure with spread to tissues
- Multiple tissues infected during viremia

Mumps Clinical Features

- Incubation period 14-18 days
- Nonspecific prodrome of myalgia, malaise, headache, low-grade fever
- Parotitis in 30%-40%
- Up to 20% of infections asymptomatic

Mumps Complications

CNS involvement	15% of clinical cases
Orchitis	20%-50% in post-pubertal males
Pancreatitis	2%-5%
Deafness	1/20,000
Death	Average 1 per year (1980 – 1999)

As many as 20% of mumps infections are asymptomatic. An additional 40% to 50% may have only nonspecific or primarily respiratory symptoms.

Complications

Central nervous system (CNS) involvement in the form of aseptic meningitis (inflammatory cells in cerebrospinal fluid) is common, occurring asymptotically in 50% to 60% of patients. Symptomatic meningitis (headache, stiff neck) occurs in up to 15% of patients and resolves without sequelae in 3 to 10 days. Adults are at higher risk for this complication than are children, and boys are more commonly affected than girls (3:1 ratio). Parotitis may be absent in as many as 50% of such patients. Encephalitis is rare (less than 2 per 100,000 mumps cases).

Orchitis (testicular inflammation) is the most common complication in postpubertal males. It occurs in as many as 50% of postpubertal males, usually after parotitis, but it may precede it, begin simultaneously, or occur alone. It is bilateral in approximately 30% of affected males. There is usually abrupt onset of testicular swelling, tenderness, nausea, vomiting, and fever. Pain and swelling may subside in 1 week, but tenderness may last for weeks. Approximately 50% of patients with orchitis have some degree of testicular atrophy, but sterility is rare.

Oophoritis (ovarian inflammation) occurs in 5% of post-pubertal females. It may mimic appendicitis. There is no relationship to impaired fertility.

Pancreatitis is infrequent, but occasionally occurs without parotitis; the hyperglycemia is transient and is reversible. Although single instances of diabetes mellitus have been reported, a causal relationship with mumps virus infection has yet to be conclusively demonstrated; many cases of temporal association have been described both in siblings and individuals, and outbreaks of diabetes have been reported a few months or years after outbreaks of mumps.

Deafness caused by mumps virus occurs in approximately 1 per 20,000 reported cases. Hearing loss is unilateral in approximately 80% of cases and may be associated with vestibular reactions. Onset is usually sudden and results in permanent hearing impairment.

Electrocardiogram changes compatible with myocarditis are seen in 3%–15% of patients with mumps, but symptomatic involvement is rare. Complete recovery is the rule, but deaths have been reported.

Other less common complications of mumps include arthralgia, arthritis, and nephritis. An average of one death from mumps per year was reported during 1980–1999.

Laboratory Diagnosis

The diagnosis of mumps is usually suspected based on clinical manifestations, in particular the presence of parotitis.

Mumps virus can be isolated from clinical specimens. The preferred sample for viral isolation is a swab from the parotid duct, or the duct of another affected salivary gland. Collection of viral samples from persons suspected of having mumps is strongly recommended. Mumps virus can also be detected by polymerase chain reaction (PCR).

Serology is the simplest method for confirming mumps virus infection and enzyme immunoassay (EIA), is the most commonly used test. EIA is widely available and is more sensitive than other serologic tests. It is available for both IgM and IgG. IgM antibodies usually become detectable during the first few days of illness and reach a peak about a week after onset. However, as with measles and rubella, mumps IgM may be transient or missing in persons who have had any doses of mumps-containing vaccine. Sera should be collected as soon as possible after symptom onset for IgM testing or as the acute-phase specimen for IgG seroconversion. Convalescent-phase sera should be collected 2 weeks later. A negative serologic test, especially in a vaccinated person, should not be used to rule out a mumps diagnosis because the tests are not sensitive enough to detect infection in all persons with clinical illness. In the absence of another diagnosis, a person meeting the clinical case definition should be reported as a mumps case.

Additional information about laboratory testing for mumps infection is available on the CDC website at www.cdc.gov/mumps/lab/index.htm.

Epidemiology

Occurrence

Mumps occurs worldwide.

Reservoir

Mumps is a human disease. Although persons with asymptomatic or nonclassical infection can transmit the virus, no carrier state is known to exist.

Transmission

Mumps is spread through airborne transmission or by direct contact with infected droplet nuclei or saliva.

Temporal Pattern

Mumps incidence peaks predominantly in late winter and

Mumps Laboratory Diagnosis

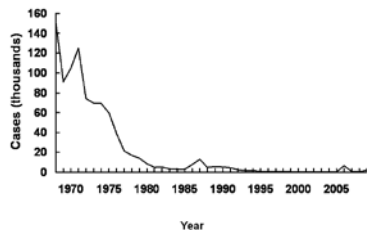
- Isolation of mumps virus
- Detection of mumps antigen by PCR
- Serologic testing
 - positive IgM antibody
 - significant increase in IgG antibody between acute and convalescent specimens

Mumps Epidemiology

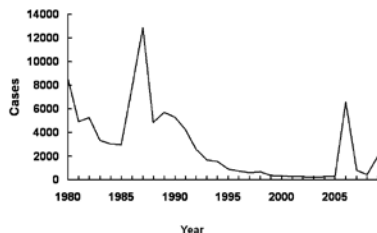
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|--------------------|---|
| • Reservoir | Human
Asymptomatic infections may transmit |
| • Transmission | Respiratory drop nuclei |
| • Temporal pattern | Peak in late winter and spring |
| • Communicability | 3 days before to 4 days after onset of active disease |

Mumps

Mumps—United States, 1968-2009



Mumps—United States, 1980-2009



spring, but the disease has been reported throughout the year.

Communicability

Contagiousness is similar to that of influenza and rubella, but is less than that for measles or varicella. The infectious period is considered to be from 3 days before to the 4th day of active disease; virus has been isolated from saliva 7 days before to 9 days after onset of parotitis.

Secular Trends in the United States

Mumps became a nationally reportable disease in the United States in 1968. However, an estimated 212,000 cases occurred in the United States in 1964. Following vaccine licensure, reported mumps decreased rapidly. Approximately 3,000 cases were reported annually in 1983–1985 (1.3–1.55 cases per 100,000 population).

In 1986 and 1987, there was a relative resurgence of mumps, which peaked in 1987, when 12,848 cases were reported. The highest incidence of mumps during the resurgence was among older school-age and college-age youth (10–19 years of age), who were born before routine mumps vaccination was recommended. Mumps incidence in this period correlated with the absence of comprehensive state requirements for mumps immunization. Several mumps outbreaks among highly vaccinated school populations were reported, indicating that high coverage with a single dose of mumps vaccine did not always prevent disease transmission, probably because of vaccine failure.

Since 1989, the number of reported mumps cases has steadily declined, from 5,712 cases to a total of 258 cases in 2004. In 2006, the United States experienced a multi-state outbreak involving 6,584 reported cases of mumps. This resurgence predominantly affected Midwestern college students with the highest attack rates occurring among those living in dormitories. In the following two years, the number of reported cases returned to usual levels, and outbreaks involved fewer than 20 cases.

Beginning in June 2009, the largest U.S. mumps outbreak since 2006 has occurred. The index case was an 11 year old male infected in the United Kingdom, where approximately 7,400 reports of laboratory-confirmed mumps were received by the Health Protection Agency in 2009. A total of 3,502 outbreak-related cases were reported, primarily from New York. The outbreak was confined primarily to Orthodox Jewish communities, with less than 3% of cases occurring among persons outside these communities. The largest percentage of cases (53%) occurred among persons aged 5–17 years, and 71% of the patients were male. Among the

patients for whom vaccination status was reported, 90% had received at least 1 dose of mumps-containing vaccine, and 76% had received 2 doses.

Like the mumps outbreaks that occurred in 2006, much of the 2009-2010 outbreak occurred in congregate settings, where prolonged, close contact among persons facilitated transmission. Although school settings and large household sizes likely promoted transmission, the high vaccination coverage in the affected communities likely limited the size of the outbreak. In addition, high vaccination coverage and less intense exposures in surrounding communities are the most plausible reasons that the few cases outside of the affected communities have not caused other outbreaks.

For information about the clinical case definition, clinical classification and epidemiologic classification of mumps see www.cdc.gov/vaccines/pubs/surv-manual/default.htm.

Mumps Vaccine

Characteristics

Mumps virus was isolated in 1945, and an inactivated vaccine was developed in 1948. This vaccine produced only short-lasting immunity, and its use was discontinued in the mid-1970s. The currently used Jeryl Lynn strain of live attenuated mumps virus vaccine was licensed in December 1967.

Mumps vaccine is available combined with measles and rubella vaccines (as MMR), or combined with measles, rubella, and varicella vaccine as MMRV (ProQuad). The Advisory Committee on Immunization Practices (ACIP) recommends that MMR be used when any of the individual components is indicated. Single-antigen mumps vaccine is not currently available in the United States.

Mumps vaccine is prepared in chick embryo fibroblast tissue culture. MMR and MMRV are supplied as a lyophilized (freeze-dried) powder and are reconstituted with sterile, preservative-free water. The vaccine contains small amounts of human albumin, neomycin, sorbitol, and gelatin.

Immunogenicity and Vaccine Efficacy

Mumps vaccine produces an inapparent, or mild, noncommunicable infection. More than 97% of recipients of a single dose develop measurable antibody. Seroconversion rates are similar for single antigen mumps vaccine, MMR, and MMRV. Postlicensure studies conducted in the United States during 1973–1989 determined that one dose of mumps or MMR vaccine was 75%–91% effective. A study from the United Kingdom documented vaccine effectiveness of 88% with two

Mumps Vaccine

- **Composition** Live virus (Jeryl Lynn strain)
- **Efficacy** 95% (Range, 90%-97%)
- **Duration of Immunity** Lifelong
- **Schedule** At least 1 dose
- **Should be administered with measles and rubella (MMR) or with measles, rubella and varicella (MMRV)**

Mumps (MMR) Vaccine Indications

- **One dose (as MMR) for preschool-age children 12 months of age and older and persons born during or after 1957 not at high risk of mumps exposure**
- **Second dose (as MMR) for school-age children and adults at high risk of mumps exposure (i.e., healthcare personnel, international travelers and students at post-high school educational institutions)**

doses. The duration of vaccine-induced immunity is believed to be greater than 25 years, and is probably lifelong in most vaccine recipients.

Vaccination Schedule and Use

One dose of mumps-containing vaccine is routinely recommended for all preschool-age children 12 months of age and older and for persons born during or after 1957 not at high risk of mumps exposure. The first dose of mumps-containing vaccine should be given on or after the first birthday.

Mumps-containing vaccine given before 12 months of age should not be counted as part of the series. Children vaccinated with mumps-containing vaccine before 12 months of age should be revaccinated with two doses of MMR vaccine, the first of which should be administered when the child is at least 12 months of age.

In 2006, ACIP recommended a second dose of mumps vaccine for school-age children and for adults at high risk of mumps exposure (i.e., healthcare personnel, international travelers, and students at post-high school educational institutions). The combined MMR vaccine is recommended for both doses to ensure immunity to all three viruses.

The second dose of MMR vaccine should be given routinely at age 4 through 6 years, before a child enters kindergarten or first grade. The recommended health visit at age 11 or 12 years can serve as a catch-up opportunity to verify vaccination status and administer MMR vaccine to those children who have not yet received two doses of MMR. The second dose of MMR may be administered as soon as 4 weeks (i.e., 28 days) after the first dose.

Only doses of vaccine with written documentation of the date of receipt should be accepted as valid. Self-reported doses or a parental report of vaccination is not considered adequate documentation. A clinician should not provide an immunization record for a patient unless that clinician has administered the vaccine or has seen a record that documents vaccination. Persons who lack adequate documentation of vaccination or other acceptable evidence of immunity should be vaccinated. Vaccination status and receipt of all vaccinations should be documented in the patient's permanent medical record and in a vaccination record held by the individual.

MMRV is approved by the Food and Drug Administration for children 12 months through 12 years of age (that is, until the 13th birthday). MMRV should not be administered to persons 13 years of age or older.

For the first dose of measles, mumps, rubella, and varicella vaccines at age 12 through 47 months, either MMR vaccine

and varicella vaccine or MMRV vaccine may be used. Providers who are considering administering MMRV vaccine should discuss the benefits and risks of both vaccination options with the parents or caregivers. Unless the parent or caregiver expresses a preference for MMRV vaccine, CDC recommends that MMR vaccine and varicella vaccine should be administered for the first dose in this age group. For the second dose of measles, mumps, rubella, and varicella vaccines at any age (15 months through 12 years) and for the first dose at 48 months of age or older, use of MMRV vaccine generally is preferred over separate injections of its equivalent component vaccines (i.e., MMR vaccine and varicella vaccine).

Mumps Immunity

Generally, persons can be considered immune to mumps if they were born before 1957, have serologic evidence of mumps immunity, have documentation of physician-diagnosed mumps, or have documentation of vaccination with at least one dose of live mumps vaccine on or after their first birthday. Demonstration of mumps IgG antibody by any commonly used serologic assay is acceptable evidence of mumps immunity. Persons who have an “equivocal” serologic test result should be considered susceptible to mumps.

For unvaccinated personnel born before 1957 who lack laboratory evidence of measles, mumps and/or rubella immunity or laboratory confirmation of disease, healthcare facilities should consider vaccinating personnel with two doses of MMR vaccine at the appropriate interval (for measles and mumps) and one dose of MMR vaccine (for rubella), respectively. For unvaccinated personnel born before 1957 who lack laboratory evidence of measles, mumps and/or rubella immunity or laboratory confirmation of disease, healthcare facilities should recommend two doses of MMR vaccine during an outbreak of measles or mumps and one dose during an outbreak of rubella.

Postexposure Prophylaxis

Neither mumps immune globulin nor immune globulin (IG) is effective postexposure prophylaxis. Vaccination after exposure is not harmful and may possibly avert later disease.

Contraindications and Precautions to Vaccination

Persons who have experienced a severe allergic reaction (anaphylaxis) to a vaccine component or following a prior dose of mumps vaccine should generally not be vaccinated with MMR.

Mumps Immunity

- Born before 1957
- Serologic evidence of mumps immunity
- Documentation of physician-diagnosed mumps
- Documentation of adequate vaccination

MMR Vaccine Contraindications and Precautions

- Severe allergic reaction to vaccine component or following prior dose
- Pregnancy
- Immunosuppression
- Moderate or severe acute illness
- Recent blood product
- Personal or family (i.e., sibling or parent) history of seizures of any etiology (MMRV only)

Measles and Mumps Vaccines and Egg Allergy

- Measles and mumps viruses grown in chick embryo fibroblast culture
- Studies have demonstrated safety of MMR in egg allergic children
- Vaccinate without testing

In the past, persons with a history of anaphylactic reactions following egg ingestion were considered to be at increased risk of serious reactions after receipt of measles- or mumps-containing vaccines, which are produced in chick embryo fibroblasts. However, data suggest that most anaphylactic reactions to measles- and mumps-containing vaccines are not associated with hypersensitivity to egg antigens but to other components of the vaccines (such as gelatin). The risk for serious allergic reactions such as anaphylaxis following receipt of these vaccines by egg-allergic persons is extremely low, and skin-testing with vaccine is not predictive of allergic reaction to vaccination. As a result, MMR may be administered to egg-allergic children without prior routine skin-testing or the use of special protocols.

MMR vaccine does not contain penicillin. A history of penicillin allergy is not a contraindication to MMR vaccination.

Pregnant women should not receive mumps vaccine, although the risk in this situation is theoretic. There is no evidence that mumps vaccine virus causes fetal damage. Pregnancy should be avoided for 4 weeks after vaccination with MMR vaccine.

Persons with immunodeficiency or immunosuppression resulting from leukemia, lymphoma, generalized malignancy, immune deficiency disease, or immunosuppressive therapy should not be vaccinated. However, treatment with low-dose (less than 2 mg/kg/day), alternate-day, topical, or aerosolized steroid preparations is not a contraindication to mumps vaccination. Persons whose immunosuppressive therapy with steroids has been discontinued for 1 month (3 months for chemotherapy) may be vaccinated. See Measles chapter for additional details on vaccination of immunosuppressed persons, including those with human immunodeficiency virus infection.

Persons with moderate or severe acute illness should not be vaccinated until the illness has improved. Minor illness (e.g., otitis media, mild upper respiratory infections), concurrent antibiotic therapy, and exposure or recovery from other illnesses are not contraindications to mumps vaccination.

Receipt of antibody-containing blood products (e.g., immune globulin, whole blood or packed red blood cells, intravenous immune globulin) may interfere with seroconversion following mumps vaccination. Vaccine should be given 2 weeks before, or deferred for at least 3 months following, administration of an antibody-containing blood product. See Chapter 2, General Recommendations on Immunization, for details.

A family history of diabetes is not a contraindication for vaccination.

Adverse Reactions Following Vaccination

Mumps vaccine is very safe. Most adverse events reported following MMR vaccine (such as fever, rash, and joint symptoms) are attributable to the measles or rubella components. No adverse reactions were reported in large-scale field trials. Subsequently, parotitis and fever have been reported rarely. A few cases of orchitis (all suspect) also have been reported.

Rare cases of CNS dysfunction, including cases of deafness, within 2 months of mumps vaccination have been reported. The calculated incidence of CNS reactions is approximately one per 800,000 doses of Jeryl Lynn strain of mumps vaccine virus. The Institute of Medicine (1993) concluded that evidence is inadequate to accept or reject a causal relationship between the Jeryl Lynn strain of mumps vaccine and aseptic meningitis, encephalitis, sensorineural deafness, or orchitis.

Allergic reactions, including rash, pruritus, and purpura, have been temporally associated with vaccination, but these are transient and generally mild.

See the Measles and Varicella chapters for information about adverse reactions following MMRV vaccine.

Vaccine Storage and Handling

MMR vaccine can be stored either in the freezer or the refrigerator and should be protected from light at all times. MMRV vaccine should be stored frozen between -58°F and +5°F (-50°C to -15°C). When MMR vaccine stored in the freezer, the temperature should be the same as that required for MMRV, between -58°F and +5°F (-50°C to -15°C). Storing MMR in the freezer with MMRV may help prevent inadvertent storage of MMRV in the refrigerator.

Diluent may be stored at refrigerator temperature or at room temperature.

After reconstitution, MMR vaccines must be stored at refrigerator temperature and protected from light. Reconstituted vaccine should be used immediately. If reconstituted vaccine is not used within 8 hours, it must be discarded. MMRV must be administered within 30 minutes of reconstitution.

Selected References

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MMR Adverse Reactions

• Fever	5%-15%
• Rash	5%
• Joint symptoms	25%
• Thrombocytopenia	<1/30,000 doses
• Parotitis	rare
• Deafness	rare
• Encephalopathy	<1/1,000,000 doses

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