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Notes from the Field

Case of Legionnaires Disease Associated with a Home Device Used to Mix Powdered Infant Formula — United States, 2025

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On November 17, 2025, an infant girl aged 10 months was admitted to Georgetown University Hospital with fever, tachypnea, and chest retractions (Figure). She had previously been admitted 32 days earlier (October 16) for treatment of systemic-onset juvenile idiopathic arthritis macrophage activation syndrome, a life-threatening condition caused by uncontrolled activation of macrophages and T-cells. She had been discharged with immunosuppressant medications on November 5 and had remained stable at home. At routine follow-up outpatient visits on November 10 and 13, her condition was unchanged. While at home, she was fed formula prepared using a powdered infant formula mixing device. This type of device holds water and powdered formula and is designed to quickly dispense ready-to-drink, clump-free, warm formula. At the time of her November 17 hospital admission, although results from clinical testing for multiple pathogens* were negative, a chest radiograph showed left upper lobe consolidation. On November 21, a microbial cell–free DNA blood test (mcfDNA) (Karius Spectrum) was positive for *Legionella pneumophila*. On November 28, results from an *L. pneumophila* serogroup 1 urinary antigen test (UAT) (BinaxNOW *Legionella* urinary antigen card) were positive. No respiratory specimens were available for culture. Legionnaires disease primarily affects adults aged >50 years; cases in infants and children are rare (*1*). Infection is typically acquired through inhalation of aerosolized water, although infection from aspiration also occurs (*2*).

* Respiratory multipathogen polymerase chain reaction (PCR) panel (adenovirus, *Bordetella pertussis*, *Chlamydia pneumoniae*, Coronavirus_229E, Coronavirus_HKU1, Coronavirus_NL63, Coronavirus_OC43, SARS-CoV-2, human metapneumovirus, human rhinovirus/enterovirus, influenza A, influenza A H1, influenza A H3, influenza A H1N1/pdm09, influenza B, *Mycoplasma pneumoniae*, parainfluenza 1–4, and respiratory syncytial virus), blood culture, fungal blood culture, methicillin-resistant *Staphylococcus aureus* nares swab, *Aspergillus galactomannan* antigen, Fungitell (1,3)-beta-D-glucan assay, *Streptococcus pneumoniae* urinary antigen test, and cytomegalovirus and adenovirus plasma PCRs.

Investigation and Outcomes

Assessment of Potential Sources

Because the infant had health care exposures (recent hospitalization and outpatient visits) during the 14-day Legionnaires disease incubation period, potential health care and household sources were evaluated. This activity was reviewed by CDC, deemed not research, and conducted consistent with applicable federal law and CDC policy.†

Although routine hospital water testing on November 20 did not detect *Legionella* bacteria or abnormal chlorine values, the facility cannot be excluded as a source. No additional aerosol-generating exposures (e.g., humidifiers or showers) were identified at the home or health care facility. The infant's primary potential exposure was formula prepared using a powdered infant formula mixing device (Baby Brezza Formula Pro Advanced Baby Formula Dispenser). This device stored water and powered infant formula in separate reservoirs. When activated, the device heated water to a user-specified temperature (using fixed presets), mixed in the powder, and dispensed ready-to-drink formula.

† 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. Sect. 241(d); 5 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq.

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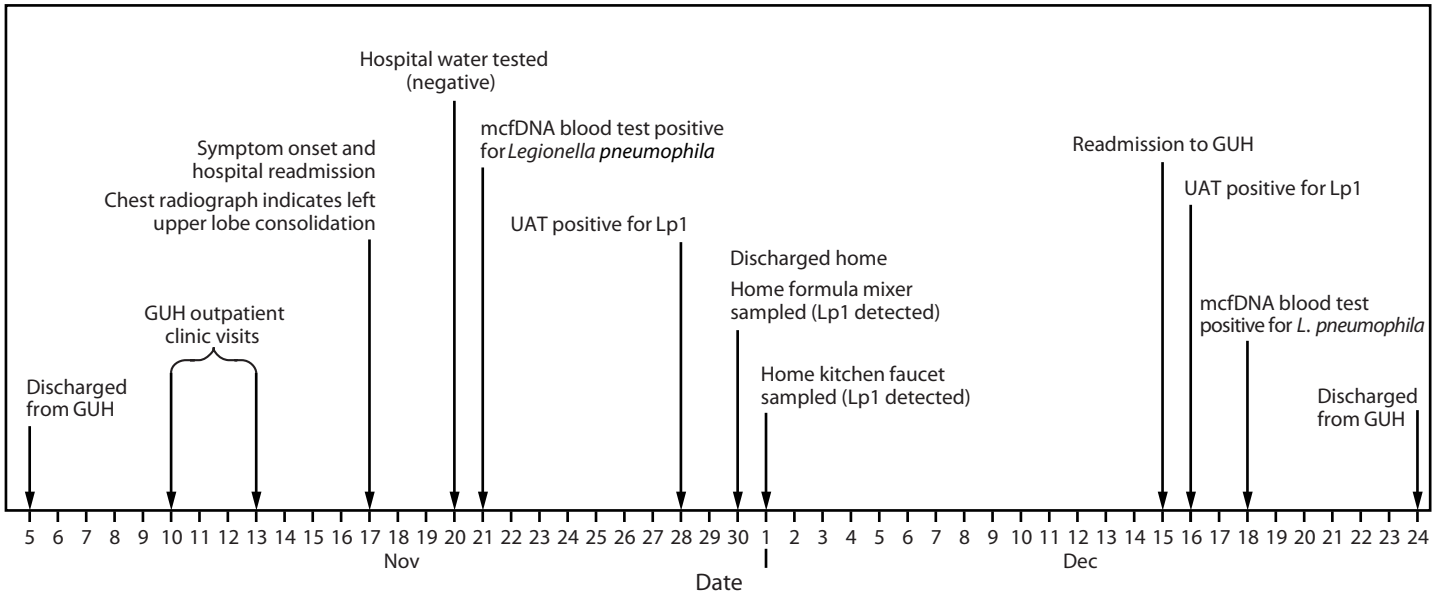
FIGURE. Timeline of Legionnaires disease diagnosis associated with a home device used to mix powdered infant formula — United States, November–December 2025



Abbreviations: GUH = Georgetown University Hospital; Lp1= *Legionella pneumophila* serogroup 1; mcfDNA = microbial cell–free DNA; UAT = urinary antigen test.

Assessment of Powdered Formula Mixing Device

Water from the powdered formula mixing device's internal reservoir collected on November 30 tested positive for *L. pneumophila* serogroup 1 (72.5 CFU/mL) using traditional spread-plate culture. Water collected the next day from the kitchen faucet used to fill the device was also positive for *L. pneumophila* serogroup 1 (0.7–3.0 CFU/mL). This faucet had an under-sink filtration system that removed chlorine. The internal device reservoir contained water at 106°F (41°C); the parents reported they had not fully emptied and drained the device in >30 days, conditions conducive to *Legionella* species amplification (*1*).

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Summary

What is already known about this topic?

Legionnaires disease is a serious pneumonia caused by inhalation or aspiration of *Legionella* bacteria. Stagnant, warm water (77°F–113°F [25°C–45°C]) increases the risk for *Legionella* growth.

What is added by this report?

Legionnaires disease was identified in an infant with an immunocompromising condition who had recently consumed formula prepared using filtered tap water and mixed by a home powdered formula preparation device. *Legionella pneumophila* serogroup 1 was detected in the household water and in higher concentrations in the formula preparation device.

What are the implications for public health practice?

Ready-to-feed formula may be used for formula-fed infants who have immunocompromising conditions; if powdered formula is used, it should be prepared with water heated to ≥158°F (≥70°C) and cooled before feeding. Infant formula mixing device manufacturers might consider revising their device instructions and designs to minimize the risk for *Legionella* bacteria growth.

Hospitalization

On admission, the infant required oxygen via nasal canula and received cefepime, a broad-spectrum fourth-generation cephalosporin and vancomycin. After receipt of the mcfDNA *Legionella* test results on November 21, treatment was changed to azithromycin and meropenem. Her condition improved after a 5-day course, and she was discharged on November 30 on a 21-day course of oral levofloxacin. However, she was readmitted on December 15 with poor oral intake and chest radiograph findings showing new left lung cavitations. The family reported that they had discontinued use of the formula mixing device and had only used boiled tap water for formula preparation after November 30. Repeat UAT (December 16) and blood mcfDNA (December 18) tests were again positive for *L. pneumophila* serogroup 1 and *L. pneumophila*, respectively. Given the absence of new exposures and consistent detection of the same organism, these findings were interpreted as persistence of the initial infection. The infant recovered after a 6-day course of azithromycin and placement of a nasogastric tube and was discharged on December 24 to complete additional intravenous antibiotics at home (ceftriaxone for 20 days and clindamycin for 7 days). The health care provider submitted a Consumer Product Safety Commission report regarding this device on February 15, 2026.

Preliminary Conclusions and Actions

A confirmed case of Legionnaires disease was diagnosed in an infant with an immunocompromising condition based on positive UAT results. Investigation identified *Legionella* bacteria in an infant formula mixing device and in the filtered household water used to fill the device as plausible contributors to infection via aspiration. The household water filter was not tested, although these devices might contribute to the growth of organisms if not properly maintained (*3*); removal of chlorine by the filter could have contributed to the growth of *Legionella* organisms. Limitations included lack of clinical and environmental isolates for comparison, the occurrence of possible health care exposures during the incubation period, and environmental sampling occurring approximately 2 weeks after illness onset.

The device manufacturer recommends using distilled or boiled water but does not specifically recommend routine internal reservoir draining. Storing water at 77°F–113°F (25°C–45°C) can promote *Legionella* bacteria growth (*2*). The device's internal reservoir temperature (106°F [41°C]) and prolonged water storage likely facilitated bacterial amplification.

Household devices that retain warm water are possible *Legionella* bacteria sources and might pose a health risk, especially for persons with immunocompromising conditions. For infants with immunocompromising conditions who are fed reconstituted powdered formula, water should be heated to ≥158°F (≥70°C) before mixing to reduce risk for exposure to or infection with other bacteria in the formula (e.g., *Cronoboacter*). Prepared formula should be cooled before feeding to prevent scalding (*4*). Boiling water will kill *Legionella* organisms if they are present. Manufacturers might consider revising their device design and instructions to reduce the risk for bacteria growth by recommending additional routine reservoir maintenance and emphasizing risks associated with use of unboiled tap water to prepare infant formula, especially for infants with immunocompromising conditions.

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Notes from the Field

Initial Public Health Response to a Measles Outbreak in a Close-Knit West Texas Community — January–February 2025

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Introduction

On January 29, 2025, the South Plains Public Health District (SPPHD) alerted the Texas Department of State Health Services (DSHS) Public Health Region 1 of an unvaccinated school-aged child with measles in Gaines County, a rural county in west Texas bordering New Mexico. Investigations during January 29–February 28, 2025, identified 207 confirmed cases[†] (144 laboratory confirmed and 63 epidemiologically linked), predominately in a multilingual, close-knit community in Gaines County and eight nearby counties. This report describes barriers to implementing public health interventions during the initial phase of the outbreak. This activity was reviewed by CDC, deemed not research, and conducted consistent with applicable federal law and CDC policy.[§]

Investigation and Outcomes

Characteristics of Persons with Measles

Among 207 measles cases in Texas residents reported during January 29–February 28, approximately two thirds (143; 69%) were reported in Gaines County; the remaining 64 (31%) occurred in eight nearby counties (Table). The median age of persons with measles was 7 years (range = 0 days–57 years), and 115 (56%) cases occurred in females. Among 22 females of childbearing age (15–44 years) with measles, two (10%) were pregnant. Among reported cases during this time, 38 (18%) patients were hospitalized (*1*). On February 26, 2025, an unvaccinated school-aged child with measles died. Overall, 348 clinical specimens were collected for confirmatory testing and viral genotype analysis; among 106 (30%) that were successfully genotyped, all were genotype D8 (*2*).

Vaccination Status of Persons with Measles and Local Vaccination Coverage

Among 207 persons with confirmed measles, 201 (97%) had no documentation of receipt of measles, mumps, and rubella (MMR) vaccine or their vaccination status was unknown; six (3%) had received ≥1 vaccine dose. In the outbreak area, county

TABLE. Number and percentage of persons with measles, by demographic characteristics, hospitalization status, and vaccination status — west Texas measles outbreak, January 29–February 28, 2025

Characteristic	No. (%)
Total	**207 (100)**
County of residence	
Gaines	143 (69)
Terry	35 (17)
Yoakum	9 (4)
Dawson	9 (4)
Dallam, Martin, Ector, Lubbock, and Lynn*	11 (5)
Age group, yrs	
0–4	68 (33)
5–17	105 (51)
≥18	33 (16)
Unknown	1 (<1)
Sex	
Female	115 (56)
Pregnant, aged 15–44 yrs (n = 22)	2[†] (9)
Male	92 (44)
Hospitalization status	
Hospitalized	38 (18)
Not hospitalized	169 (82)
No. of MMR vaccine doses received	
None or unknown[§]	201 (97)
1[¶]	2 (1)
≥2[¶]	4 (2)

Abbreviation: MMR = measles, mumps, and rubella.

* Because each of these counties reported fewer than five cases, they were combined to avoid potential identification of persons.

† Gestational ages were 29 weeks and 35 weeks.

§ Disaggregating unvaccinated persons from those with unknown vaccination status was not possible because the Texas Immunization Registry requires explicit consent by law (i.e., is an opt-in registry) to enroll. Unknown vaccination status includes persons who reported having received MMR vaccine but whose vaccination status could not be verified and those who could not recall if they had received MMR vaccine. Unvaccinated status includes persons with no documented doses of MMR vaccine >14 days before symptom onset.

¶ Review of the available information indicated that these persons received ≥1 age-appropriate dose of MMR vaccine >14 days before symptom onset or best available proxy date (if the date of rash was not available, one of the following dates was used, in this order: symptom onset date, specimen collection date, hospital admission date, or date reported to the region). Measles Outbreak – August 12, 2025 | Texas DSHS

* These authors contributed equally to this report.

† A confirmed measles case was defined as an acute, febrile rash illness (temperature can be <101°F [38.3 °C] or subjective and rash of <3 days' duration) that is laboratory confirmed or epidemiologically linked to a laboratory-confirmed case, or a febrile rash illness in a person living in or visiting (within the past 21 days) any of the following outbreak counties as of February 28, 2025: Dawson, Gaines, Lynn, Martin, Terry, and Yoakum (Measles Outbreak Case Definition | Texas DSHS). Laboratory-confirmed cases were those among persons who received a positive wild-type measles test result using one of the methods described in the 2025 Texas DSHS Epi Case Criteria Guide.

§ 45 C.F.R. part 46, 21 C.F.R. part 56; 42 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq.

MMR vaccination coverage among kindergarteners during the 2024–25 school year ranged from 77.3% to 94.6%, compared with 93.2% in Texas overall. To prevent in-school transmission (and be consistent with Texas law), public health professionals recommended that school administrators ask students not to return to school for 21 days after a measles exposure if they did not have documented evidence of immunity (receipt of ≥2 valid MMR vaccine doses, documented prior infection, or positive antimeasles immunoglobulin G titers). Children attending unaccredited private schools or those who were homeschooled would not be included in this policy, potentially leading to ongoing school-based transmission.

Response to Distribution of Measles Information and Prevention Materials

SPPHD and DSHS developed and distributed culturally appropriate and community-informed resources describing measles disease and prevention strategies, including school guidance, information for school nurses and parents, and vaccination and testing clinic locations. CDC helped translate materials into relevant languages. During January 29–February 28, public health education focused on the importance of vaccination and symptom recognition. In counties with evidence of ongoing measles transmission, an early dose of MMR vaccine for infants aged 6–11 months and a second MMR vaccine dose for adults who had received only 1 dose were recommended. Thirty-three MMR vaccination clinics for persons aged ≥6 months and 16 measles testing clinics were held in DSHS Public Health Region 1. Despite these measures, vaccine acceptance was low; approximately 275 MMR vaccine doses were administered. Understanding transmission dynamics in the affected community was difficult because many persons interviewed during case investigations declined to provide enough information to enable follow-up and an exposure assessment (e.g., names of household members [often in large household units], contacts, or exposures).

Preliminary Conclusions and Actions

Low rates of MMR vaccination and measles testing and reluctance among community members while being interviewed during case investigations presented substantial challenges during the initial weeks of this measles outbreak. SPPHD and DSHS contacted trusted community members to better understand perspectives of the community. Many community members described their lack of trust in outside institutions and their reluctance to engage with public health and health care systems overall, based on an ethos within the community that prioritized maintaining independence from outside institutions and seeking solutions from within the community. This perspective complicated implementation of standard measles control measures and hampered epidemiologic investigations. Therefore, many measles cases likely remained unreported.

Decreases in measles vaccination coverage worldwide have increased the risk for larger measles outbreaks, especially in undervaccinated communities (About Measles | CDC). On August 18, 2025, the Texas measles outbreak was declared over, having comprised 762 confirmed cases, 99 hospitalizations, and a second measles-associated death. Although the source of this outbreak remains unknown, internationally imported cases have been associated with outbreaks among other close-knit U.S. communities with low vaccination coverage (*3*,*4*). High population coverage with 2 MMR vaccine doses is the most effective public health intervention for preventing measles (Measles Vaccination | CDC).

This outbreak highlights several challenges associated with encouraging vaccination, testing, education, and other interventions to limit disease severity and spread in certain communities. Early in a measles outbreak response, public health partnerships with trusted community members might help guide the development of culturally appropriate educational materials to support public health interventions. In challenging community contexts, public health messaging intended to limit viral transmission and severe health outcomes could supplement standard control measures, including advising persons with suspected measles to avoid contact with others to prevent transmission and to seek medical care promptly.

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Summary

What is already known about this topic?

Measles is a highly contagious respiratory virus that can cause serious illness. A measles outbreak occurred in Texas during January–August 2025.

What is added by this report?

During January 29–February 28, 2025, Texas reported 207 confirmed measles cases, primarily among members of a close-knit west Texas community. Most cases occurred among unvaccinated persons or those with unknown vaccination status. Measles, mumps, and rubella (MMR) vaccine and measles testing clinics were offered; however, community members were hesitant to interact with public health and health care systems, and MMR vaccine acceptance was low. Educational materials on measles and measles prevention were developed and distributed.

What are the implications for public health practice?

In challenging community contexts, public health messaging intended to limit viral transmission and severe health outcomes could supplement standard control measures, including advising persons with suspected measles to avoid contact with other persons to prevent transmission and to seek medical care promptly.

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