The California Department of Public Health (CDPH) issued a Health Advisory on April 25, 2018 entitled "Multistate Outbreak of Serratia Marcescens Bloodstream Infections" to alert the health care community of Serratia marcescens bloodstream infections potentially associated with BD PosiFlush™ Heparin Lock Flush and BD™ Pre-Filled Normal Saline Flush syringes. To date, no products have tested positive for S. marcescens. BD has issued a voluntary recall of certain lots of BD PosiFlush™ Heparin Lock Flush and BD™ Pre-Filled Normal Saline Flush syringes due to potential contamination with S. marcescens. See the notice below for additional product recall information and a call for cases.

In Los Angeles County, providers should notify the Los Angeles County Department of Public Health of cases by calling the Acute Communicable Disease Control Program, Monday to Friday 8:30am-5pm at 213-240-7941, and asking for the liaison public health nurse.

To view this and other communications or to sign-up to receive LAHANs, please visit http://publichealth.lacounty.gov/lahan
The CDPH Healthcare-Associated Infections (HAI) Program is working with multiple state and local health departments, the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA) to investigate cases of *Serratia marcescens* bloodstream infection in patients with central venous catheters or implantable medical ports. The investigation has identified a potential association with BD PosiFlush™ Heparin Lock Flush and BD™ Pre-Filled Normal Saline Flush syringes. To date, no products have tested positive for *S. marcescens*. **BD has issued a voluntary recall of certain lots of BD PosiFlush™ Heparin Lock Flush and BD™ Pre-Filled Normal Saline Flush syringes due to potential contamination with *S. marcescens*.**

Healthcare facilities, home health agencies, and healthcare providers in outpatient practices that use BD PosiFlush™ Heparin Lock Flush and BD™ Pre-Filled Normal Saline Flush syringes should refer to the link provided for additional details and a list of recall products and lot numbers:

The investigation is ongoing. Healthcare facilities and providers should save any available bacterial isolates and notify their local public health department and the CDPH HAI Program at HAIprogram@cdph.ca.gov if they identify either:

- Clusters (i.e., ≥2 cases) of *S. marcescens* bloodstream infections in patients who have central venous catheters or implantable medical ports occurring at a single healthcare facility since April 1, 2018, or
- Cases (i.e., one or more cases) of *S. marcescens* bloodstream infections among outpatients who have central venous catheters or ports in place since April 1, 2018.