

## **Pertussis (*Bordetella pertussis*)** (Whooping Cough)

### **REPORTING INFORMATION**

- **Class B:** Report by the close of the next business day after the case or suspected case presents and/or a positive laboratory result to the local public health department where the patient resides. If patient residence is unknown, report to the local public health department in which the reporting health care provider or laboratory is located.
- Reporting Form(s) and/or Mechanism: [Ohio Confidential Reportable Disease Form](#) (HEA 3334, rev. 1/09), [Positive Laboratory Findings for Reportable Disease Form](#) (HEA 3333, rev. 8/05), the local health department via the Ohio Disease Reporting System (ODRS), or telephone.
- [CDC Pertussis Surveillance Worksheet](#) is available for use to assist in local health department disease investigation and contact tracing activities. Information collected from the form should be entered into ODRS and not sent to the Ohio Department of Health (ODH), unless otherwise requested.

### **AGENT**

*Bordetella pertussis*, a Gram-negative coccobacillus; a pertussis-like syndrome can also be caused by *B. parapertussis*; parapertussis is not reportable in Ohio.

### **CASE DEFINITION**

#### **Clinical case definition**

In the absence of a more likely diagnosis, a cough illness lasting  $\geq 2$  weeks with at least one of the following: paroxysms of coughing, inspiratory "whoop," or posttussive vomiting, and apnea (with or without cyanosis) (FOR INFANTS <1 YEAR ONLY).

#### **Laboratory criteria for diagnosis**

- Isolation of *Bordetella pertussis* from a clinical specimen, or
- Positive polymerase chain reaction [PCR] for *B. pertussis*.

#### **Case Classification**

Suspect\*: A case not fully meeting the clinical case definition (e.g. cough illness <14 days) and/or is not laboratory confirmed by culture or PCR (e.g. positive DFA and/or IgM but no positive culture or PCR).

Probable: A case that meets the clinical case definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory-confirmed case of pertussis; or (FOR INFANTS <1 YEAR ONLY) a case of acute cough illness of any duration with at least one of the following symptoms: paroxysms of coughing, inspiratory "whoop", post-tussive vomiting, or apnea (with or without cyanosis) and is laboratory confirmed by PCR or epidemiologically linked to a case confirmed by either culture or PCR.

Confirmed: A case of acute cough illness of any duration with a positive culture for *B. pertussis*; or a case that meets the clinical case definition and is laboratory confirmed by either culture or PCR; or a case that meets the clinical definition and is epidemiologically linked directly to a case confirmed by either culture or PCR.

Not a Case: This status will not generally be used when reporting a case, but may be used to reclassify a report if investigation revealed that it was not a case.

#### **Comment**

An institutional outbreak of pertussis is defined as two or more cases clustered in time and space where transmission is suspected to have occurred in that setting. An outbreak is community-related when the number of reported cases is higher than

what is expected on the basis of previous reports during a non-epidemic period for a given population in a defined time. Two or more large outbreaks within the same community setting at the same time should be combined to one outbreak. Household outbreaks are defined as three or more cases in two or more households.

The clinical case definition is appropriate for endemic or sporadic cases. In outbreak settings, one or more cases should be confirmed to be pertussis by positive culture results. Active surveillance should be maintained for 42 days after cough onset of most recent case in the outbreak.

The outbreak definition should be used for epidemiologic investigation and not for implementing control measures.

Because some studies have documented that *direct fluorescent antibody [DFA] testing of nasopharyngeal secretions has low sensitivity and variable specificity, it should be not relied on as a criterion for laboratory confirmation*. Serologic testing for pertussis is available in some areas but is not standardized and, therefore, should not be relied on as a criterion for laboratory confirmation. Both probable and confirmed cases are reported nationally.

Note: An illness meeting the clinical case definition should be classified as "probable" rather than "confirmed" if it occurs in a patient who has contact with an infant aged <1 year who is Polymerase Chain Reaction (PCR) positive for pertussis and has  $\geq 1$  sign or symptom and cough duration <14 days (classified as "probable" case).

\* This case classification can be used for initial reporting purposes to ODH as CDC has not developed a classification.

## **SIGNS AND SYMPTOMS**

The clinical course is divided into three stages: catarrhal, paroxysmal, and convalescent. The catarrhal stage has a gradual onset and initially resembles the common cold (i.e. coryza, sneezing, low grade fever, mild cough); this stage lasts from one to two weeks. Usually, whooping cough is not suspected until the cough gradually becomes more severe and paroxysms occur. These are characterized by repeated violent coughs without intervening inhalation, followed by a gasp for air that produces a characteristic high-pitched whoop. The patient becomes red or cyanotic, the eyes bulge, and the tongue protrudes. Thick mucus is dislodged and vomiting often follows. There is no fever and the patient appears normal between attacks.

The paroxysmal stage generally lasts from four to six weeks but might last as long as 10 weeks. Paroxysmal attacks occur more frequently at night. Adults, infants less than six months of age, and partially immunized persons may lack the whoop and have few paroxysms. In infants, the cough may be minimal or absent, and apnea may be the only symptom. In convalescence the whoop and vomiting stop and the cough becomes less paroxysmal, disappearing over two to three weeks. Some patients have recurrent bouts of all symptoms, including whoop, during viral upper respiratory infections for many months after pertussis.

## **DIAGNOSIS**

Culture or PCR is the diagnostic procedure of choice. Cultures should be collected from a nasopharyngeal (NP) specimen during the first two weeks of cough. Cultures are less likely to be positive if the patient has received prior antibiotic therapy, if the specimen collection is beyond the first two weeks of cough, or the patient has been vaccinated. Isolates should be sent to the Ohio Department of Health Laboratory for strain identification and antimicrobial resistance testing. PCR should be tested from NP swabs during the first three weeks following cough onset. False-negative results may occur if

PCR testing is performed after antibiotic therapy.

Please notify the ODH Bureau of Infectious Diseases VPD Epidemiology Program at (614) 995-5599 before shipping a specimen to the Ohio Department of Health Laboratory.

## **EPIDEMIOLOGY**

### **Source**

Humans are the only reservoir.

### **Occurrence**

The disease is common to children worldwide. Since the 1940's, there has been a marked decline in the United States and other countries where immunization levels are high. The disease might be more common in adults than previously thought, but it is often not considered in the differential diagnosis.

### **Transmission**

Through direct contact with discharges from an infected person, usually by the airborne route. Communicability is greatest in the catarrhal stage and the first two weeks after cough onset (i.e. approximately 21 days).

### **Period of Communicability**

Communicability gradually decreases and becomes negligible for ordinary nonfamilial contacts in about three weeks, despite spasmodic cough with whoop. For control purposes communicability extends from seven days after exposure to three weeks after the paroxysmal stage in patients not treated with effective antibiotics. In treated patients, infectiousness extends for five days after onset of therapy.

### **Incubation Period**

Commonly 5-10 days, with an upper limit of 21 days.

## **PUBLIC HEALTH MANAGEMENT**

### **Case**

#### Treatment

Spread of pertussis can be limited by decreasing infectivity of the patient and by protecting close contacts of that patient. Antimicrobials given in the catarrhal stage may ameliorate the disease. After paroxysms are established, however, antimicrobials have no discernible effect on the course of the illness and are given primarily to limit the spread of the organisms to others. The macrolide agents azithromycin, erythromycin and clarithromycin are preferred for treatment of pertussis in persons aged  $\geq 1$  month (see table for dosing recommendations). For infants  $< 1$  month azithromycin is preferred, erythromycin and clarithromycin are not recommended. For persons  $\geq 2$  months old who cannot tolerate macrolides, an alternative agent is trimethoprim-sulfamethoxazole [TMP-SMX]. The choice of antibiotic for treatment or prophylaxis should take into account effectiveness, safety, tolerability, ease of adherence to the regimen prescribed and cost.

#### Isolation

The Ohio Administrative Code (OAC 3701-3-13, (R)) states that "a person with pertussis who is not treated with effective antimicrobial therapy, shall be isolated, including exclusion from school or child care center, until three weeks after the onset of paroxysms. If effective antimicrobial therapy is given, the person shall be isolated for five days after initiation of antimicrobial therapy".

### **Contacts**

#### Prophylaxis

The primary objective of postexposure antimicrobial prophylaxis (PEP) is to prevent

death and serious complications from pertussis in individuals at increased risk of severe disease. CDC supports **targeting postexposure antibiotic use to persons at high risk of developing severe pertussis and to persons who will have close contact with those at high risk of developing severe pertussis**. For more information, please visit CDC's Postexposure Antimicrobial Prophylaxis for pertussis website at: <http://www.cdc.gov/pertussis/outbreaks/PEP.html>.

Postexposure prophylaxis with an effective antimicrobial agent can be administered to contacts prior to illness onset. The decision to prophylax is made after considering the infectiousness of the patient and the intensity of the exposure, the potential consequences of severe pertussis in the contact, and the possibilities for secondary exposure of persons at high risk from the contact. CDC supports providing PEP to the following:

- Infants and women in their third trimester of pregnancy;
- All persons with pre-existing health conditions that may be exacerbated by a pertussis infection (for example, but not limited to immunocompromised persons and patients with moderate to severe medically treated asthma);
- Contacts who themselves have close contact with either infants under 12 months, pregnant women or individuals with pre-existing health conditions at risk of severe illness or complications;
- All contacts in high risk settings that include infants aged <12 months or women in the third trimester of pregnancy. These include, but are not limited to neonatal intensive care units, childcare settings, and maternity wards.

Prophylaxis of asymptomatic household contacts within 21 days of onset of cough in the index patient is recommended by CDC and can prevent symptomatic infection. Symptomatic (coughing) household members of a pertussis patient should be treated as if they have pertussis. The recommended antimicrobial agents and dosing regimens for postexposure prophylaxis are the same as those for treatment of pertussis (see table). All persons should be watched closely for respiratory symptoms for 14-21 days after last contact.

A broader use of PEP is supported in limited closed settings when the number of identified cases is small and when community-wide outbreaks are not ongoing; however, when continued transmission of pertussis is evident, multiple rounds of antibiotics would not be recommended. Rather than repeating a course of antibiotics, contacts should be monitored for onset of signs and symptoms of pertussis for 21 days.

#### Flight Exposures

Pertussis cases on flights lasting less than eight hours should be investigated to see if any contacts were infants that sat on either side of the case. If an infant did sit on either side of a suspected or confirmed case, then contact the Immunization Program at the Ohio Department of Health with the airline flight and seat number. No further follow-up is needed if no infants were present beside the case. Contact the Ohio Department of Health with the airline flight and seat number for pertussis cases on a flight greater than eight hours. Verify if there was any other air travel or international travel history. The Ohio Department of Health will work with CDC to notify contacts.

#### Vaccine (in addition to antimicrobials)

All close contacts younger than 7 years of age who have not completed the four-dose primary series should complete the series with the minimum intervals. Close contacts who are 4-6 years of age and who have not yet received the second booster (usually the 5th dose of DTaP) should be vaccinated.

The administration of Tdap to persons 10-64 years of age who have been exposed to a person with pertussis is not contraindicated, but the efficacy of postexposure use of

Tdap is unknown.

### Prevention and Control

Immunization with pertussis vaccine is the most important measure for the control of pertussis. See the ODH Vaccine Protocol Manual for details. Human pertussis immune globulin is no longer available in the United States. Reducing the dose of pertussis vaccine or giving the full dose in multiple small doses may result in an altered immune response and is not recommended. Furthermore, there is no evidence that the frequency of significant vaccine reactions is likely to be reduced by this practice. Interrupting the recommended primary and booster immunization schedule or delaying doses probably does not lead to a reduction in the level of immunity reached on completion of the primary series. Therefore there is no need to restart a series, regardless of the time elapsed between doses.

Ohio School Requirement: All students entering school should have received a minimum of 4 doses of DTaP with the last dose being received on or after 4 years of age. In addition, in 2011, a progressive requirement was added for seventh graders that they receive a booster Tdap dose. (In 2009, Ohio added a progressive requirement for tetanus vaccination, but both Td and Tdap were allowed. In 2011, the requirement emphasized Tdap.)

Recommended antimicrobial treatment and postexposure prophylaxis for pertussis, by age group:

Age Group	Primary agents			*Alternate
	Azithromycin	Erythromycin	Clarithromycin	*TMP-SMZ
< 1 month	Recommended agent - 10 mg/kg/day in a single dose for 5 days (only limited safety data available)	Not preferred - Erythromycin is associated with infantile hypertrophic stenosis. Use if azithromycin is unavailable; 40-50 mg/kg/day in 4 divided doses for 14 days	Not recommended (safety data not available)	Contraindicated for infants aged < 2 mos. (risk for kernicterus)
1-5 months	10 mg/kg/day in a single dose for 5 days	40-50 mg/kg/day in 4 divided doses for 14 days	15 mg/kg/day in 2 divided doses for 7 days	Contraindicated at age < 2 mos. For infants ≥2 mos. TMP 8 mg/kg/day, SMZ 40 mg/kg/day in 2 divided doses for 14 days
Infants ≥6 months and children	10 mg/kg as a single dose on day 1 (maximum: 500 mg) then 5 mg/kg per day as a single dose on days 2 through 5 (maximum: 250 mg)	40-50 mg/kg/day (maximum: 2 g per day) in 4 divided doses for 14 days	15 mg/kg/day in 2 divided doses (maximum: 1g per day) for 7 days	TMP 8 mg/kg/day, SMZ 40mg/kg/day in 2 divided doses for 14 days

Adults	500 mg in a single dose on day 1 then 250 mg per day on days 2-5	2 g per day in 4 divided doses for 14 days	1 g per day in 2 divided doses for 7 days	TMP 320 mg per day, SMZ 1,600 mg per day in 2 divided doses for 14 days
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\* Trimethoprim sulfamethoxazole (TMP-SMZ) can be used as an alternative agent to macrolides in patients aged  $\geq 2$  months that are allergic to macrolides, who cannot tolerate macrolides, or who are infected with a rare macrolide-resistant strain of *Bordetella pertussis*.

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**What is pertussis?**

Pertussis, or whooping cough, is a highly contagious respiratory infection caused by the bacteria *Bordetella pertussis*.

**Who gets pertussis?**

Pertussis can occur at any age. Although most of the reported cases occur in children under five years, the number of cases in adolescents and adults is increasing, probably due to waning of vaccine immunity. Adolescents and adults and those partially protected by the vaccine may have milder disease which is not diagnosed as pertussis. Pertussis is thought to account for up to 7% of cough illnesses per year in adults.

**How is pertussis spread?**

Pertussis is primarily spread by direct contact with the discharges from the nose and throat of infected individuals. Frequently, older siblings or other adult household members who may be harboring the bacteria in their nose and throat can bring the disease home and infect an infant in the household.

**What are the symptoms of pertussis?**

Pertussis begins as a mild upper respiratory infection. Initially, symptoms resemble those of a common cold, including sneezing, runny nose, low-grade fever and a mild cough. Within two weeks, the cough becomes more severe and is characterized by episodes of numerous rapid coughs followed by a crowing or high-pitched whoop. A thick, clear mucous may be discharged with the coughing. These episodes may recur for one to two months, and are more frequent at night. Young infants, adolescents, and adults do not have these typical coughing spells. Older people or partially immunized children may have milder symptoms.

**How soon after infection do symptoms appear?**

The incubation period is usually 7 to 10 days, with a range of 4 to 21 days.

**When and for how long is a person able to spread pertussis?**

A person can transmit pertussis from the onset of symptoms to three weeks after the onset of coughing episodes. The period of communicability can be reduced to five days after appropriate antibiotic therapy is begun.

**Does past infection with pertussis make a person immune?**

One attack usually confers immunity comparable to that provided by vaccine.

**What are the complications associated with pertussis?**

Young infants are at the greatest risk for complications. Serious complications of pertussis include pneumonia, seizures, encephalopathy (disorders of the brain), and death. Less serious complications include ear infections, loss of appetite, and dehydration.

**What is the vaccine for pertussis?**

Children should be immunized with the DTaP (diphtheria toxoid in combination with tetanus toxoid and acellular pertussis) vaccine at 2, 4, 6 and 15 to 18 months of age and between 4 and 6 years of age. Older children and adults who have completed the primary series should receive Td (tetanus/diphtheria) boosters every 10 years. It is recommended that for both adolescents (11-18 years of age) and adults <65 years of age, Tdap (tetanus/diphtheria/acellular pertussis) be used for one of those boosters to

provide protection against pertussis. See the Centers for Disease Control and Prevention (CDC) for the most current Advisory Committee on Immunization Practices (ACIP) recommendations on vaccination and control measures.

**What can be done to prevent the spread of pertussis?**

The single most effective control measure is maintaining the highest possible level of immunization in the community. The treatment of cases of pertussis with the appropriate antibiotic is important, as is the treatment of close contacts of cases. In addition, medical professionals should consider the diagnosis of pertussis in adolescents and adults with persistent coughs. People who have or may have pertussis (including those with a persistent cough) should stay away from young children and infants until properly evaluated by a physician.