



Recommended Pertussis Control Measures (July 2012)

Clinical symptoms

Catarrhal stage: Cold-like symptoms (runny nose, sneezing, mild cough). Fever is absent or minimal. Stage lasts 1-2 weeks and cough gradually becomes more severe.

Paroxysmal stage: Cough worsens and progresses to spasms (paroxysms) of cough, followed by sudden inspiration (may result in “whoop” noise). Cough may be followed by post-tussive vomiting. Those with pertussis may appear well between bouts of coughing.

Convalescent stage: Cough gradually becomes less severe and spasms decrease in frequency. Pertussis cough can last 6-10 weeks, or longer.

Note: Pertussis in children < 6 months is most severe, and can be atypical (short catarrhal stage, poor feeding, cyanosis or apneic spells, no whoop, longer convalescent stage).

Clinical Case Definition

In the absence of a more likely diagnosis, a diagnosis of pertussis can be made in patients with a cough illness lasting ≥ 2 weeks, with at least one of the following symptoms:

- paroxysms of coughing;
- inspiratory “whoop”; or
- post-tussive vomiting

Transmission

Inhalation of aerosolized droplets from an infected person. Contact with contaminated surfaces rarely (if ever) transmits infection.

Infectious period

From the onset of cold-like symptoms to 3 weeks after cough onset. Persons are considered non-infectious after 5 days of appropriate antibiotic treatment.

Incubation period

Typically 7-10 days with a range of 4-21 days.

Reporting

Per Indiana law (410 IAC 1-2.3), suspected and confirmed cases of pertussis should be reported immediately to your local health department.

Timely reporting is critical to the interruption of pertussis transmission. If you cannot contact your local health department staff, call ISDH at:

- (317) 233-7112 during business hours
- (317) 233-1325 on weekends, holidays, or other non-working hours

Diagnostic Testing

Suspect cases of pertussis should be tested using polymerase chain reaction (PCR) and/or culture.

Only symptomatic patients should be tested.

- PCR testing can be a rapid, specific, and sensitive method for diagnosing pertussis. It is best to collect the specimen in the first 4 weeks of illness. For PCR best practices, please see: www.cdc.gov/pertussis/clinical/diagnostic-testing/diagnosis-pcr-bestpractices.html
- Although culture is considered the “gold standard” for lab diagnosis of pertussis, results may take as long as two weeks to obtain. Specimens should be collected during the first 2 weeks of illness, prior to the start of antibiotics. A negative culture does not rule out pertussis.
- Direct fluorescent antibody (DFA) testing and serology are not recommended.

DO NOT WAIT FOR LAB RESULTS TO TREAT SUSPECTED CASES.

There is no charge for pertussis testing performed by the ISDH Laboratory. Test kits (for culture and PCR testing) may be obtained by contacting the lab at (317) 921-5875 or containers@isdh.in.gov.

Treatment

Erythromycin, clarithromycin, or azithromycin are the preferred antimicrobial agents for treatment and prophylaxis of pertussis. Please see Table 1 (page 3) of this document for prescribing information by age group. Patients are considered non-infectious after completing the 5th day of appropriate treatment.

Close Contacts

Anyone who has had direct contact with respiratory, oral, or nasal secretions from a symptomatic case is considered a close contact. These include:

- Household members
- Daycare contacts in the same home daycare or in the same classroom within a daycare center
- People who have had direct face-to-face contact with an infectious pertussis case during coughing or sneezing
- Medical providers who performed a medical examination of the mouth, nose, or throat
- Anyone who shared a confined space with an infectious person for >1 hour

Post Exposure Prophylaxis

Antimicrobial prophylaxis (same regimen as treatment for cases) may be recommended for patients who are close contacts of pertussis cases.

Prophylaxis is recommended for close contacts regardless of vaccination status.

- Prophylaxis is recommended if exposure to an infectious case occurred within the previous 21 days (the maximum incubation period for pertussis)
- Asymptomatic contacts receiving prophylaxis should **not** be excluded from their usual activities.
- Symptomatic contacts should be evaluated as suspect pertussis cases.

Vaccination of Contacts

In addition to providing antimicrobial prophylaxis, providers should assess the pertussis vaccination status of close contacts. The use of vaccine to catch-up or boost contacts of pertussis cases is recommended. Tdap is licensed for persons aged 10 years and older (Boostrix) or 11 through 64 years (Adacel). ACIP recommends off-label use of Tdap,

such as giving Tdap to under-vaccinated children age 7-10 years. Vaccination recommendations are as follows:

- Give DTaP to children under 7 years of age who are due or overdue for DTaP vaccination.
- Give one dose of Tdap to children 7-10 years old who are not fully vaccinated against pertussis. If additional doses are needed, use Td vaccine.
- Do not wait for the pre-adolescent check-up to provide Tdap to household contacts; give it as early as 10 years old.
- Give Tdap to adolescents and adults ages 13 and older who have not yet received a Tdap. Give the dose regardless of the interval since the last Td.
- Give Tdap to all adults who have or will have contact with children under the age of 1 year.
- ACIP recommends that women receive a dose of Tdap during pregnancy, preferably after 20 weeks gestation. If not administered during pregnancy, Tdap should be given immediately postpartum.
- **Tdap is currently only recommended as a one-time booster.**

Precautions for Medical/Hospital Exposure

- Cases isolated by droplet precautions:
Surveillance for additional cases is recommended
- Cases not isolated by droplet precautions:
 - a. Provide prophylaxis for staff (whether vaccinated with Tdap or not) who had direct contact with respiratory secretions without wearing respiratory protection
 - b. Case should be in droplet isolation
 - c. Surveillance of staff and patients for respiratory symptoms for 42 days
 - d. Encourage staff who have not previously received a dose of Tdap to get the vaccine

Precautions for Day Care and School

Children with pertussis may return after completion of 5 days of appropriate antibiotic therapy or after 21 days of cough. Symptomatic children should be excluded from day care/school pending a physician's evaluation.

**Table 1: Recommended Antimicrobial Therapy and Postexposure Prophylaxis for Pertussis
In Infants, Children Adolescents, and Adults¹**

| Age Group | Recommended Drugs | | | Alternate agent ² |
|------------------------|---|--|--|---|
| | Azithromycin | Erythromycin | Clarithromycin | TMP-SMX |
| <1 month | 10 mg/kg/day as a single dose for 5 days ³ | 40-50 mg/kg/day in 4 divided doses for 14 days | Not recommended | Contraindicated at <2 months |
| 1-5 months | See above | See above | 15 mg/kg per day in 2 divided doses for 7 days | ≥2 mo of age: TMP, 8mg/kg/day; SMX, 40 mg/kg/day in 2 doses for 14 days |
| ≥6 months and children | 10 mg/kg as a single dose on day 1 (maximum 500 mg), then 5 mg/kg/day as a single dose on days 2-5 (maximum 250 mg/day) | 40-50 mg/kg/day in 4 divided doses for 14 days (maximum 2 g/day) | 15 mg/kg per day in 2 divided doses for 7 days (maximum 1 g/day) | See above |
| Adolescents and Adults | 500 mg as a single dose on day 1, then 250 mg as a single dose on days 2-5 | 2 g/day in 4 divided doses for 14 days | 1 g/day in 2 divided doses for 7 days | TMP, 320 mg/day; SMX, 1600 mg/day in 2 divided doses for 14 days |

¹ Adopted from American Academy of Pediatrics Red Book, 2009 and Centers for Disease Control and Prevention's "Recommended antimicrobial agents for the treatment and postexposure prophylaxis of pertussis: 2005 CDC guidelines"

² TMP=trimethoprim; SMX=sulfamethoxazole. This drug can be used as an alternative in patients >2 months of age who cannot tolerate macrolides or who are infected with a rare macrolide resistant strain of *B. pertussis*

³ Preferred macrolide for this age group because of the risk of idiopathic hypertrophic pyloric stenosis associated with erythromycin