

Pertussis (Whooping Cough)

1.5 Contact Hours - \$10

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Course Objectives

When you finish this course, you will be able to:

- Describe the clinical features and medical management of *Bordetella pertussis*.
- Outline the epidemiological features of pertussis including occurrence, transmission, and communicability.
- Describe current trends in the spread and surveillance of pertussis in the United States.
- Discuss major issues associated with pertussis vaccination in children, adolescents, and adults including recommendations, adverse reactions, and contraindications.

Introduction

Pertussis, or whooping cough, is an acute infectious disease caused by the bacterium *Bordetella pertussis*. Outbreaks of pertussis were first described in the 16th century, and the organism was first isolated in 1906. In the 20th century pertussis was one of the most common childhood diseases and a major cause of childhood mortality in the United States. Prior to the availability of pertussis vaccine in the 1940s, more than 200,000 cases of pertussis were reported annually.

Since widespread use of the vaccine began, incidence has decreased more than 98%, to an average of about 4,400 cases per year since 1980. Pertussis remains a major health problem among children in developing countries, with an estimated 285,000 deaths resulting from the disease in 2001.

Pertussis

- Highly contagious respiratory infection caused by *Bordetella pertussis*
- Outbreaks first described in 16th century
- *Bordetella pertussis* isolated in 1906
- Estimated 294,000 deaths worldwide in 2002

Bordetella Pertussis

B. pertussis is a small aerobic gram-negative rod. It is fastidious, and requires special media for isolation. *B. pertussis* produces multiple antigenic and biologically active products, including pertussis toxin, filamentous hemagglutinin, agglutinogens, adenylate cyclase, pertactin, and tracheal cytotoxin. These products are responsible for the clinical features of pertussis disease, and an immune response to one or more produces immunity to subsequent clinical illness. Recent evidence suggests that immunity from *B. pertussis* infection may not be permanent.

Features of *Bordetella pertussis*

- Fastidious gram-negative bacteria
- Antigenic and biologically-active components
 - Pertussis toxin (PT)
 - Filamentous hemagglutinin (FHA)
 - Agglutinogens
 - Adenylate cyclase
 - Pertactin
 - Tracheal cytotoxin

Pathogenesis

Pertussis is primarily a toxin-mediated disease. The bacteria attach to the respiratory cilia, produce toxins that paralyze the cilia, and cause inflammation of the respiratory tract, thus interfering with the clearing of pulmonary secretions. Pertussis antigens appear to allow the organism to evade host defenses, in that lymphocytosis is promoted, but chemotaxis is impaired. Until recently it was thought that *B. pertussis* did not invade the tissues. However, recent work has shown the bacteria in alveolar macrophages.

Clinical Features

The **incubation period** of pertussis is commonly 7 to 10 days, with a range of 4 to 21 days, and rarely may be as long as 42 days. The clinical course of the illness is divided into three stages.

The first stage, the **catarrhal stage**, is characterized by the insidious onset of coryza (runny nose), sneezing, low-grade fever, and a mild, occasional cough, similar to the common cold. The cough gradually becomes more severe, and after 1 to 2 weeks, the second, or paroxysmal stage, begins.

It is during the **paroxysmal stage** that the diagnosis of pertussis is usually suspected. Characteristically, the patient has bursts, or paroxysms of numerous, rapid coughs, apparently due to difficulty expelling thick mucus from the tracheobronchial tree. At the end of the paroxysm, a long inspiratory effort is usually accompanied by a characteristic high-pitched whoop. During such an attack, the patient may become cyanotic (turn blue). Children and young infants, especially, appear very ill and distressed. Vomiting and exhaustion commonly follow the episode. The patient usually appears normal between attacks.

Pertussis Clinical Features

- Incubation period 7 to 10 days (range 4 to 21 days)
- Insidious onset, similar to upper respiratory infection with nonspecific cough
- Fever usually minimal throughout course of illness

Paroxysmal attacks occur more frequently at night, with an average of 15 attacks per 24 hours. During the first 1 or 2 weeks of this stage the attacks increase in frequency, remain at the same level for 2 to 3 weeks, and then gradually decrease. The paroxysmal stage usually lasts 1 to 6 weeks, but may persist for up to 10 weeks.

Infants younger than 6 months of age may not have the strength to have a whoop, but they do have paroxysms of coughing. In the **convalescent stage**, recovery is gradual. The cough becomes less paroxysmal and disappears in 2 to 3 weeks. However, paroxysms often recur with subsequent respiratory infections for many months after the onset of pertussis. Fever is generally minimal throughout the course of pertussis.

Older persons (i.e., adolescents and adults), and those partially protected by the vaccine may become infected with *B. pertussis*, but usually have milder disease. Pertussis in these persons may present as a persistent (>7 days) cough, and may be indistinguishable from other upper respiratory infections. Inspiratory whoop is uncommon. *B. pertussis* is estimated to account for up to 7% of cough illnesses per year in older persons.

Even though the disease may be milder in older persons, these infected persons may transmit the disease to other susceptible persons, including un-immunized or under-immunized infants. Adults are often found to be the first case in a household with multiple pertussis cases.

Pertussis Among Adolescents and Adults

- Disease often milder than in infants and children
- Infection may be asymptomatic, or may present as classical pertussis
- Persons with mild disease may transmit the infection
- Older persons often source of infection for children

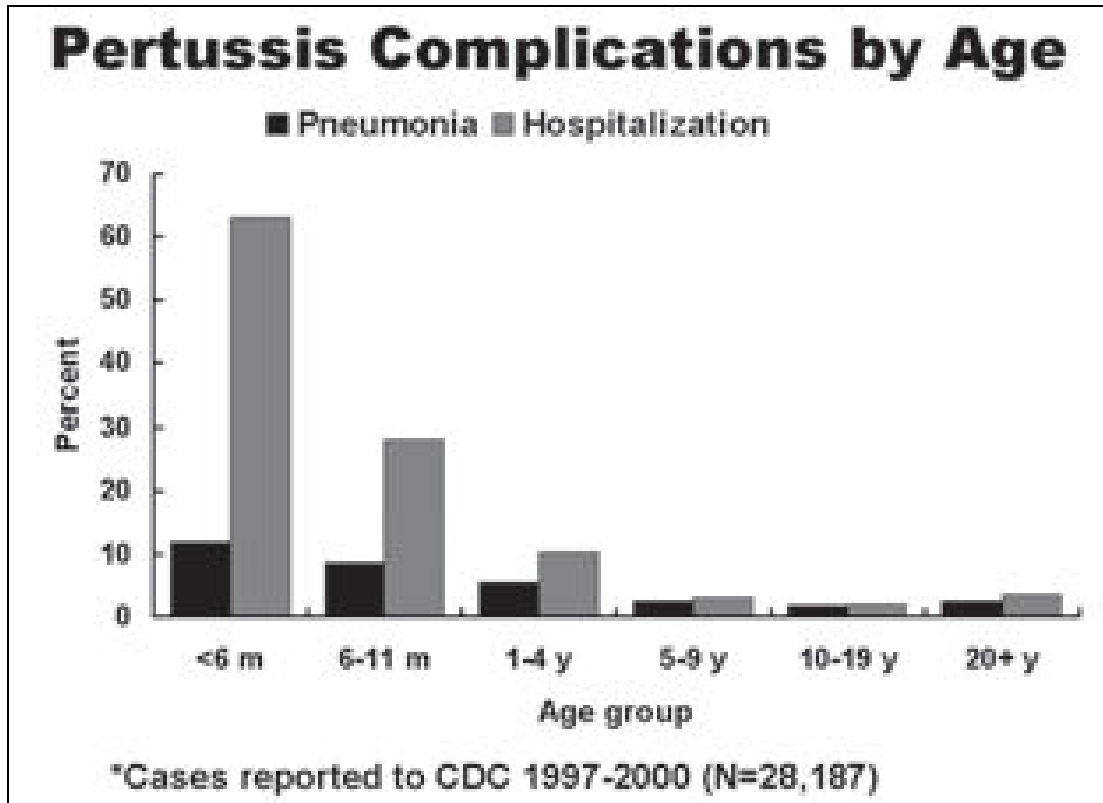
Complications

Young infants are at highest risk for acquiring clinical pertussis, and for pertussis-associated complications. The most common complication, and the cause of most pertussis-related deaths, is secondary bacterial pneumonia. Data from 1997 to 2000 indicate that pneumonia occurred among 5.2% of all reported pertussis cases, and among 11.8% of infants <6 months of age.

Pertussis Complications (cases reported to CDC 1997 to 2000, n=28, 187)	
Condition	Percent Reported
Pneumonia	5.2
Seizures	0.8
Encephalopathy	0.1
Hospitalization	20
Death	0.2

Neurologic complications such as seizures and encephalopathy may occur as a result of hypoxia from coughing, or possibly from toxin. Neurologic complications of pertussis are more common among infants. In 1997 to 2000, seizures and encephalopathy were reported among 0.8% and 0.1%, respectively, of all cases, and among 1.4% and 0.2%, respectively, of infants <6 months of age. Other less serious complications of pertussis include otitis media, anorexia, and dehydration. Complications resulting from pressure effects of severe paroxysms include pneumothorax, epistaxis, subdural hematomas, hernias, and rectal prolapse.

In 1997 to 2000, 20% of all reported pertussis cases required hospitalization, including 63% of all infants <6 months of age. In this 4 year period, 62 deaths were due to pertussis (case-fatality rate 0.2%); fifty-six (90%) of these deaths occurred in children <6 months of age.



Laboratory Diagnosis

The diagnosis of pertussis is based on a characteristic clinical history (cough for more than 2 weeks with whoop, paroxysms, or posttussive vomiting) as well as a variety of laboratory tests (culture, polymerase chain reaction [PCR], direct fluorescent antibody [DFA] and serology).

Culture is considered the gold standard laboratory test and is the most specific of the laboratory tests for pertussis. However, fastidious growth requirements make *B. pertussis* difficult to culture. The yield of culture can be affected by specimen collection, transportation, and isolation techniques. Specimens from the posterior nasopharynx, not the throat, should be obtained using Dacron® or calcium alginate (not cotton) swabs. Isolation rates are highest during the first 3 to 4 weeks of illness (catarrhal and early paroxysmal stages).

Cultures are variably positive (30% to 50%) and may take as long as 2 weeks, so results may be too late for clinical usefulness. Cultures are less likely to be positive if performed later in the course of illness (more than 2 weeks after cough onset) or on specimens from persons who have received antibiotics or have been vaccinated. Since adolescents and adults have often been coughing for several weeks before they seek medical attention, it is often too late for culture to be useful.

Because of the increased sensitivity and faster reporting of results of PCR, many laboratories are now using this method exclusively. PCR should be used in addition to, and not as a replacement for culture. No PCR product has been approved by the Food and Drug Administration (FDA), and there are no standardized protocols, reagents, or reporting formats for pertussis PCR testing. Consequently, PCR assays vary widely among laboratories. Specificity can be poor, with high rates of false-positive results in some laboratories.

Like culture, PCR is also affected by specimen collection. An inappropriately obtained nasopharyngeal swab will likely be negative by both culture and PCR. PCR is less affected by prior antibiotic therapy, since the organism does not need to be viable to be positive by PCR. Continued use of culture is essential for confirmation of PCR results. DFA testing of nasopharyngeal specimens may be useful as a rapid screening test for pertussis. Use of the monoclonal DFA test has improved the specificity, but DFA still has a low sensitivity and should not be relied upon as a criterion for laboratory confirmation.

Serologic testing could be useful for adults and adolescents who present late in the course of their illness, when both culture and PCR are likely to be negative. However, there is no FDA-approved diagnostic test. The currently available serologic tests measure antibodies that could result from either infection or vaccination, so a positive serologic response simply means that the person has been exposed to pertussis by either recent or remote infection or by recent or remote vaccination. Since vaccination can induce both IgM and IgA antibodies (in addition to IgG antibodies), use of such serologic assays cannot differentiate infection from vaccine response. At this time, serologic test results should not be relied upon for case confirmation of pertussis infection.

An elevated white blood cell count with a lymphocytosis is usually present in classical disease of infants. The absolute lymphocyte count often reaches 20,000 or greater. However, there may be no lymphocytosis in some infants and children or in persons with mild or modified cases of pertussis. More information on the laboratory diagnosis of pertussis is available at <http://www.cdc.gov/vaccines/pubs/surv-manual/default.pdf>.

Medical Management

The medical management of pertussis cases is primarily supportive, although antibiotics are of some value. Erythromycin is the drug of choice. This therapy eradicates the organism from secretions, thereby decreasing communicability and, if initiated early, may modify the course of the illness.

An antibiotic effective against pertussis (such as azithromycin, erythromycin or trimethoprim-sulfamethoxazole) should be administered to all close contacts of persons with pertussis, regardless of age and vaccination status. Revised treatment and postexposure prophylaxis recommendations were published in December 2005. All close contacts younger than 7 years of age who have not completed the four-dose primary series should complete the series with the minimal intervals. Close contacts who are 4–6 years of age and who have not yet received the second booster dose (usually the fifth dose of DTaP) should be vaccinated. The administration of Tdap to persons 10 through 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.

Epidemiology

Pertussis is a human disease that occurs worldwide; no animal or insect source or vector is known to exist. Adolescents and adults are an important reservoir for *B. pertussis* and are often the source of infection for infants. Pertussis has no distinct seasonal pattern, but may increase in the summer and fall.

Transmission

Transmission most commonly occurs by the respiratory route through contact with respiratory droplets, or by contact with airborne droplets of respiratory secretions. Transmission occurs less frequently by contact with freshly contaminated articles of an infected person.

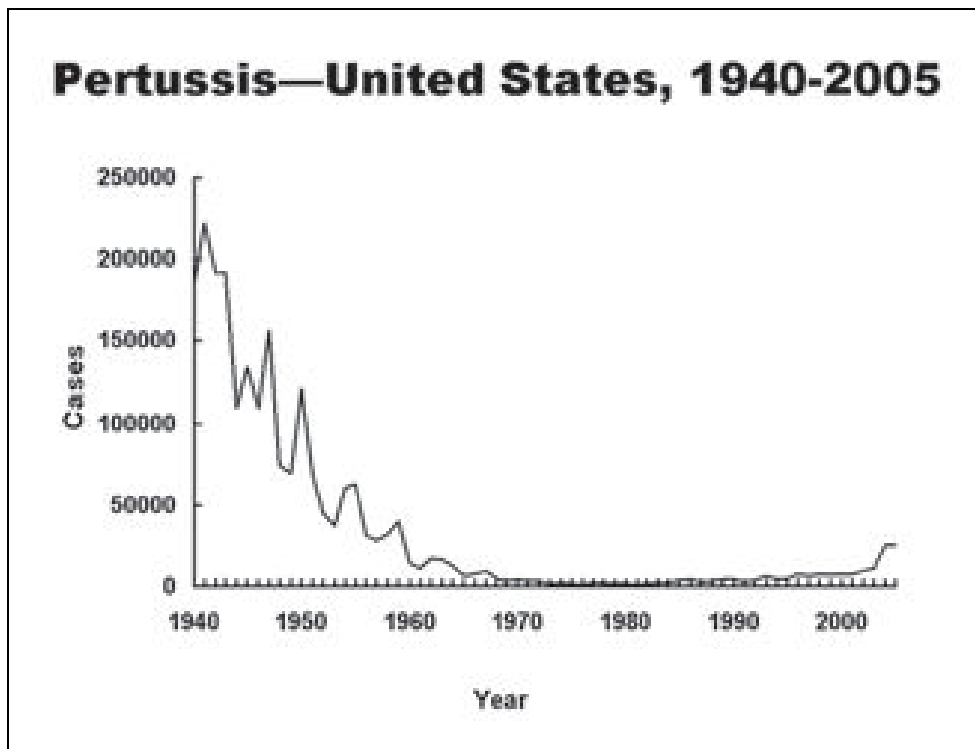
Communicability

Pertussis is highly communicable, as evidenced by secondary attack rates of 80% among susceptible household contacts. Persons with pertussis are most infectious during the catarrhal period and the first 2 weeks after cough onset (i.e., approximately 21 days).

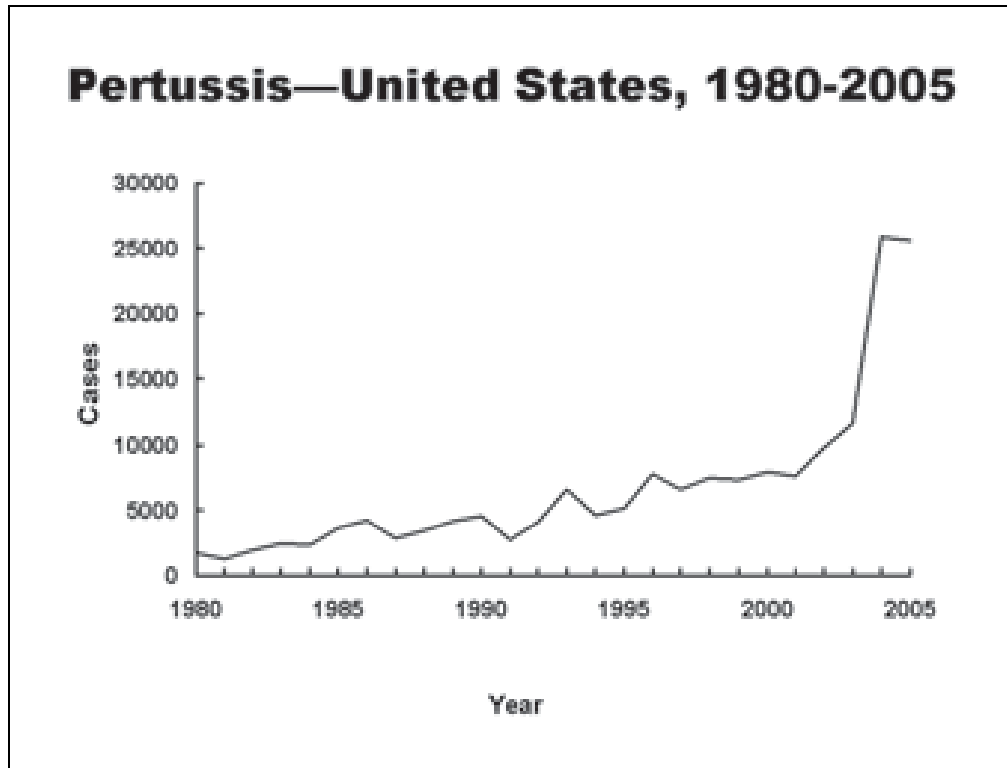
Trends in the United States

Before the availability of vaccine, pertussis was a common cause of morbidity and mortality among children. During the 6-year period from 1940 through 1945, more than 1 million cases of pertussis were reported, an average of 175,000 cases per year (incidence of approximately 150 cases per 100,000 population).

Following introduction of whole-cell pertussis vaccine in the 1940s, pertussis incidence gradually declined, reaching 15,000 reported cases in 1960 (approximately 8 per 100,000 population). By 1970, annual incidence was fewer than 5,000 cases per year, and during 1980 to 1990, an average of 2,900 cases per year were reported (approximately 1 per 100,000 population).



Pertussis incidence has been gradually **increasing** since the early 1980s. A total of 25,827 cases were reported in 2004, the largest number since 1959. The reasons for the increase are not clear.



Increased recognition and diagnosis of pertussis in older age groups probably contributed to this increase of reported cases among adolescents and adults. Of the 10,650 children 3 months to 4 years of age with reported pertussis during 1990 to 1996 and known vaccination status, 54% were not age-appropriately vaccinated with DTaP.

During 2001 to 2003, the highest average annual pertussis incidence was among infants younger than 1 year of age (55.2 cases per 100,000 population), and particularly among children younger than 6 months of age (98.2 per 100,000 population). In 2002, 24% of all reported cases were in this age group. However, in recent years, adolescents (11 to 18 years of age) and adults (19 years and older) have accounted for an increasing proportion of cases. During 2001 to 2003, the annual incidence of pertussis among persons aged 10 to 19 years increased from 5.5 per 100,000 in 2001, to 6.7 in 2002, and 10.9 in 2003. In 2004 and 2005, approximately 60% of reported cases were among persons 11 years of age and older.

Pertussis Surveillance

Pertussis cases are reported to CDC via two systems. States provide information about cases of pertussis, including demographic information, through the National Electronic Transmittal System for Surveillance. More detailed information is reported to CDC through the Supplementary Pertussis Surveillance System. Although many pertussis cases are not reported, the surveillance system is useful for monitoring epidemiologic trends. For instance, although the highest incidence of pertussis occurs in infancy, the age group at greatest risk for severe illness and complications, in recent years, the surveillance system has reflected an increase in the incidence of pertussis in all age groups, most notably among adolescents and adults.

Case Definition

The current case definition for pertussis was developed and adopted by the Council of State and Territorial Epidemiologists (CSTE) and the Centers for Disease Control and Prevention (CDC). It defines a clinical case of pertussis as an acute cough illness lasting at least 2 weeks with either paroxysms of coughing, inspiratory “whoop,” or post-tussive vomiting without other apparent cause (as reported by a health professional).

Case Classification

In outbreak settings, including household exposures, a case can be defined as an acute cough illness lasting at least 2 weeks without other symptoms. The clinical case definition below is appropriate for endemic or sporadic cases:

- Probable: Meets the clinical case definition, but is not laboratory confirmed and is not epidemiologically linked to a laboratory-confirmed case.
- Confirmed: A clinically compatible case that is laboratory-confirmed or epidemiologically linked to a laboratory-confirmed case.

Pertussis Vaccines

Whole-Cell Pertussis Vaccine

Whole-cell pertussis vaccine is composed of a suspension of formalin-inactivated *B. pertussis* cells. It was developed in the 1930s and used widely in clinical practice by the mid-1940s. Based on controlled efficacy trials conducted in the 1940s and on subsequent observational efficacy studies, a primary series of four doses of whole-cell DTP vaccine was 70% to 90% effective in preventing serious pertussis disease. Protection decreased with time, resulting in little or no protection 5 to 10 years following the last dose.

Local reactions such as redness, swelling, and pain at the injection site occurred following up to half of doses of whole-cell DTP vaccines. Fever and other mild systemic events were also common. Concerns about safety led to the development of more purified (acellular) pertussis vaccines that are associated with a lower frequency of adverse reactions. Whole-cell pertussis vaccines are no longer available in the United States but are still used in many other countries.

Whole-Cell Pertussis Vaccine

- Developed in mid-1930s and combined as DTP in mid-1940s
- 70% to 90% efficacy after 3 doses
- Protection for 5 to 10 years
- Local adverse reactions common

Acellular Pertussis Vaccine

Characteristics

Acellular pertussis vaccines are subunit vaccines that contain purified, inactivated components of *B. pertussis* cells. Several acellular pertussis vaccines have been developed for different age groups; these contain different pertussis components in varying concentrations. Acellular pertussis vaccines are available only as combinations with tetanus and diphtheria toxoids.

Pediatric Formulation (DTaP)

Three pediatric acellular pertussis vaccines are currently available for use in the United States. All three vaccines are combined with diphtheria and tetanus toxoids as DTaP and are approved for children 6 weeks through 6 years of age (to age 7 years). Infanrix (GlaxoSmithKline) contains three antigens, mostly pertussis toxin (PT) and FHA.

Tripedia (sanofi Pasteur) contains two components, FHA and PT, in equal amounts. Daptacel (sanofi Pasteur) contains five components, PT, FHA, pertactin, and fimbriae types 2 and 3. None of the available DTaP vaccines contains thimerosal as a preservative, although Infanrix and Daptacel contain 2-phenoxyethanol as a preservative. Tripedia does not contain a preservative. All three vaccines are supplied in single-dose vials or syringes.

Adolescent and Adult Formulation (Tdap)

Acellular pertussis-containing vaccines were first licensed for adolescents and adults in 2005. Two vaccines are currently available. Both vaccines are combined with tetanus toxoid and a reduced amount of diphtheria toxoid compared with pediatric DTaP (that is, similar quantities of tetanus and diphtheria toxoid to adult formulation Td).

Boostrix (GlaxoSmithKline) is approved for persons 10 through 18 years of age, and contains three pertussis antigens (PT, FHA, and pertactin) in a reduced quantity compared with the GlaxoSmithKline pediatric formulation. The vaccine contains aluminum hydroxide as an adjuvant and does not contain a preservative. Adacel (sanofi Pasteur) is approved for persons 11 through 64 years of age. It contains the same five pertussis components as Daptacel but with a reduced quantity of PT. Adacel contains aluminum phosphate as an adjuvant and does not contain a preservative. Both vaccines are supplied as single-dose vials or syringes.

Pertussis-Containing Vaccines

Vaccine	Age Group
DTaP (pediatric)	Approved for children 6 weeks through 6 years (to age 7 years)
Tdap (adolescent and adult)	Approved for persons 10 through 18 years (Boostrix) and 11 through 64 years (Adacel)

Immunogenicity and Vaccine Efficacy

DTaP

Since 1991, several studies conducted in Europe and Africa have evaluated the efficacy of DTaP vaccines administered to infants. These studies varied in type and number of vaccines, design, case definition, and laboratory method used to confirm the diagnosis of pertussis, so comparison among studies must be made with caution. Point estimates of vaccine efficacy ranged from 80% to 85% for vaccines currently licensed in the United States. Confidence intervals for vaccine efficacy overlap, suggesting that none of the vaccines is significantly more effective than the others.

When studied, the acellular pertussis vaccine was significantly more effective than whole-cell DTP. Mild local and systemic adverse reactions and more serious adverse reactions (such as high fever, persistent crying, hypotonic hyporesponsive episodes, and seizures) occurred less frequently among infants vaccinated with acellular pertussis vaccines than among those vaccinated with whole-cell DTP.

Tdap

Adolescent and adult formulation Tdap vaccines were licensed on the basis of noninferiority of the serologic response to the various components compared with each company's pediatric DTaP formulation (Infanrix and Daptacel) among persons who had received pediatric DTaP or DTP in childhood. For both vaccines, the antibody response to a single dose of Tdap was similar to that following three doses of DTaP in infants. This type of study is known as "bridging." The new vaccines are assumed to have similar clinical efficacy as DTaP vaccine since a similar level of antibody to the components was achieved.

Vaccination Schedule and Use

DTaP

The primary series of DTaP vaccine consists of four doses, the first three doses given at 4- to 8-week intervals (minimum of 4 weeks), beginning at 6 weeks to 2 months of age. The fourth dose is given 6 to 12 months after the third to maintain adequate immunity for the ensuing preschool years. DTaP should be administered simultaneously with all other indicated vaccines.

The fourth dose of all brands of DTaP is licensed, and recommended by ACIP, to be administered at 15 to 18 months of age (17 to 20 months for Daptacel). However, ACIP recommends that in certain circumstances the fourth dose be given earlier than 15 months of age. The fourth dose of DTaP may be given if the child is at least 12 months of age, and at least 6 months have elapsed since the third dose of pertussis vaccine was given, and, in the opinion of the immunization provider, the child is unlikely to return for an additional visit at 15 to 18 months of age. All three of these criteria should be met in order to administer the fourth dose of DTaP at 12 to 14 months of age.

Routine DTaP Primary Vaccination Schedule

Dose	Age	Minimum Interval
Primary 1	2 months	N/A
Primary 2	4 months	4 weeks
Primary 3	6 months	4 weeks
Primary 4	15 to 18 months	6 months

Children who received all four primary doses before the fourth birthday should receive a fifth (booster) dose of DTaP before entering school. This booster dose is not necessary (but may be given) if the fourth dose in the primary series was given on or after the fourth birthday. The booster dose increases antibody levels and may decrease the risk of school-age children transmitting the disease to younger siblings who are not fully vaccinated. *Infanrix* and *Tripedia* are approved for the fifth dose following a series of four doses of DTaP. For children who started the vaccination series with whole-cell DTP, DTaP should be substituted for any remaining doses of the pertussis series.

ACIP recommends that the series be completed with the same brand of DTaP vaccine if possible. However, limited data suggest that “mix and match” DTaP schedules do not adversely affect safety and immunogenicity. If the vaccine provider do not know or have available the type of DTaP vaccine previously administered to a child, any available DTaP vaccine should be used to continue or complete the vaccination series. Unavailability of the vaccine used for earlier doses is not a reason for missing the opportunity to administer a dose of acellular pertussis vaccine for which the child is eligible.

Interruption of the recommended schedule or delayed doses does not lead to a reduction in the level of immunity reached on completion of the primary series. There is no need to restart a series regardless of the time that has elapsed between doses.

Tdap

Both Tdap vaccines are approved by the Food and Drug Administration for a single (booster) dose for persons who have completed the recommended childhood DTP/DTaP vaccination series. The two vaccines are approved for use in different age groups: Boostrix is approved for persons 10–18 years of age; Adacel is approved for persons 11 to 64 years of age.

ACIP recommends that adolescents 11 to 12 years of age should receive a single dose of Tdap instead of Td. Adolescents 13 to 18 years who have not received Tdap should receive a single dose of Tdap as their catch-up booster instead of Td if they have completed the recommended childhood DTaP/DTP vaccination series, and have not yet received a Td booster.

A 5-year interval between Td and Tdap is encouraged to reduce the risk of local and systemic adverse reactions. However, ACIP did not define an absolute minimum interval between Td and Tdap. The interval between Td and Tdap may be shorter than 5 years if protection from pertussis needed. The decision whether to administer Tdap when less than 5 years has elapsed since the last dose of Td should be based on whether the benefit of pertussis immunity outweighs the risk of a local adverse reaction. An interval of less than 5 years can be considered in situations of increased risk of pertussis, such as during a pertussis outbreak, or if protection is needed because of household or other close contact with an infant younger than 12 months of age or a young child who has not been vaccinated against pertussis.

ACIP recommends that adults 19 through 64 years of age receive a single dose of Adacel to replace a single dose of Td for booster immunization against tetanus, diphtheria and pertussis. Adacel may be given at an interval less than 10 years since receipt of the last tetanus toxoid-containing vaccine to protect against pertussis. Special emphasis should be placed on Tdap vaccination of adults who have close contact with infants, such as childcare and healthcare personnel, and parents. Ideally, Tdap should be given at least 1 month before beginning close contact with the infant.

Any woman who might become pregnant is encouraged to receive a single dose of Tdap if she has not already received a dose. Women who have not received Tdap (including women who are breastfeeding) should receive a dose in the immediate postpartum period, before discharge from the hospital or birthing center, if 2 years or more have elapsed since the last Td. Shorter intervals since the last Td can be used if necessary. If Tdap cannot be administered before discharge, it should be given as soon as feasible. The dose of Tdap replaces the next routine dose of Td.

ACIP recommends Td when tetanus and diphtheria protection is required during pregnancy. However, pregnancy is not a contraindication for use of Tdap. A clinician may choose to administer Tdap to a pregnant woman in certain circumstances, such as during a community pertussis outbreak.

When Td or Tdap is administered during pregnancy, the second or third trimester is preferred to avoid coincidental association of vaccination and spontaneous termination of a pregnancy, which is more common in the first trimester. Clinicians can choose to administer Tdap instead of Td to pregnant adolescents for routine or “catch-up” vaccination because the incidence of pertussis is high among adolescents. Others for whom Tdap might be considered during pregnancy are pregnant healthcare personnel and child care providers (to prevent transmission to infants younger than 12 months of age and to other vulnerable persons) and pregnant women employed in an institution or living in a community with increased pertussis activity.

Healthcare personnel who work in hospitals or ambulatory care settings and have direct patient contact should receive a single dose of Tdap (Adacel only) as soon as feasible. Priority should be given to vaccination of healthcare personnel who have direct contact with infants 12 months of age and younger. An interval as short as 2 years (or less) from the last dose of Td is recommended for the Tdap dose. Tdap vaccine may be given at the same visit, or any time before or after any other vaccine. Immunity following pertussis is not permanent. Persons with a history of pertussis should receive a single dose of Tdap if it is otherwise indicated.

All adolescents and adults should have documentation of having received a primary series of at least three doses of tetanus and diphtheria toxoids during their lifetime. A person without such documentation should receive a series of three doses of tetanus- and diphtheria-containing vaccine.

One of these doses, preferably the first, should be Tdap if the person is at least 10 years of age (the minimum age approved for one of the two available Tdap products). The remaining two doses should be adult formulation Td. No pertussis vaccine is approved for children 7 to 9 years of age or for persons older than 64 years. ACIP does not recommend the use of Tdap in persons in these age groups.

Combination Vaccines Containing DTaP

TriHIBit

One combination DTaP-Hib (*Haemophilus influenzae* type b) vaccine is currently available in the United States (TriHIBit, sanofi Pasteur). The vaccines are provided in separate vials, and the DTaP component (Tripedia) is used to reconstitute the Hib component (ActHIB). No other brand of DTaP and Hib vaccine may be used to produce this combination (e.g., Infanrix must not be substituted for Tripedia). In addition, when supplied as TriHIBit, the DTaP and Hib components have a single lot number. Providers should generally use only the DTaP and Hib supplied together as TriHIBit. However, it is acceptable to combine Tripedia and ActHIB that have been supplied separately (i.e., not packaged as TriHIBit). In this situation, the lot numbers of both vaccines should be recorded in the child's chart.

Because of evidence of reduced immunogenicity of the Hib component when used as a combination, TriHIBit is not approved by the Food and Drug Administration for use as the primary series at 2, 4, or 6 months of age. It is approved only for the fourth dose of the DTaP and Hib series. If TriHIBit is administered as one or more doses of the primary series at 2, 4, or 6 months of age, the Hib doses should not be counted, and the child should be revaccinated as age-appropriate for Hib. The DTaP doses may be counted as valid and do not need to be repeated.

Although TriHIBit cannot be used in the primary series at 2, 4, or 6 months of age, it may be used as the booster (final) dose following a series of single-antigen Hib vaccine or combination hepatitis B–Hib vaccine (Comvax). TriHIBit can be used if the child is 12 months of age or older, has received at least one prior dose of Hib vaccine 2 or more months earlier, and TriHIBit will be the last dose in the Hib series. For example, TriHIBit can be used for the booster dose at 12 to 15 months of age in a child who has received Comvax or PedvaxHIB at 2 and 4 months of age, or three prior doses of HibTITER or ActHIB. TriHIBit can also be used at 15 to 59 months of age in a child who has received at least one prior dose of any Hib-containing vaccine. TriHIBit should not be used if the child has received no prior Hib doses.

Pediarix

In 2002, the FDA approved Pediarix (GlaxoSmithKline), the first pentavalent (5 component) combination vaccine licensed in the United States. Pediarix contains DTaP (Infanrix), hepatitis B (Engerix-B), and inactivated polio vaccines. In prelicensure studies, the proportion of children who developed a protective level of antibody and the titer of antibody were at least as high when the vaccine antigens were given together as Pediarix as when children received separate vaccines.

The minimum age for the first dose of Pediarix is 6 weeks, so it cannot be used for the birth dose of the hepatitis B series. Pediarix is approved for the first three doses of the DTaP and inactivated polio vaccine (IPV) series, which are usually given at about 2, 4, and 6 months of age; it is not approved for fourth or fifth (booster) doses of the DTaP or IPV series. However, Pediarix is approved for use through 6 years of age. A child who is behind schedule can receive Pediarix as long as it is given for doses 1, 2, or 3 of the series, and the child is younger than 7 years of age. A dose of Pediarix inadvertently administered as the fourth or fifth dose of the DTaP or IPV series does not need to be repeated.

Pediarix may be used interchangeably with other pertussis-containing vaccines if necessary (although ACIP prefers the use of the same brand of DTaP for all doses of the series, if possible). It can be given at 2, 4, and 6 months to infants who received a birth dose of hepatitis B vaccine (total of four doses of hepatitis B vaccine). Although not labeled for this indication by FDA, Pediarix may be used in infants whose mothers are HBsAg positive or whose HBsAg status is not known.

Other DTaP Issues

In certain circumstances, vaccination with DTaP vaccine should be delayed until a child with a known or suspected neurologic condition has been evaluated, treatment initiated, and the condition stabilized. These conditions include the presence of an evolving neurologic disorder (e.g., uncontrolled epilepsy, infantile spasms, and progressive encephalopathy), a history of seizures that has not been evaluated, or a neurologic event that occurs between doses of pertussis vaccine.

A family history of seizures or other neurologic diseases, or stable or resolved neurologic conditions such as controlled idiopathic epilepsy, cerebral palsy, or developmental delay are not contraindications to pertussis vaccination. Acetaminophen or ibuprofen may be administered to children with such histories or conditions at the time of DTaP vaccination and for 24 hours thereafter to reduce the possibility of postvaccination fever, which could cause a febrile seizure.

Reducing the dose of whole-cell DTP or DTaP vaccine or giving the full dose in multiple smaller doses may result in an altered immune response and inadequate protection.

Furthermore, there is no evidence that the chance of a significant vaccine reaction is likely to be reduced by this practice. The use of multiple reduced doses that together equal a full immunizing dose, or the use of smaller, divided doses is not endorsed or recommended. Any vaccination using less than the standard dose should not be counted, and the person should be revaccinated according to age.

Children who have recovered from documented pertussis do not need additional doses of pediatric pertussis vaccine. However, Tdap vaccine is recommended when the child becomes age eligible. Satisfactory documentation includes recovery of *B. pertussis* on culture or typical symptoms and clinical course when these are epidemiologically linked to a culture-confirmed case, as may occur during outbreaks. When such confirmation of diagnosis is lacking, vaccination should be completed because cough illness may be caused by other *Bordetella* species, other bacteria, or certain viruses.

Adverse Reactions Following Vaccination

DTaP

As with all injected vaccines, administration of DTaP may cause local reactions, such as pain, redness, or swelling. Local reactions have been reported in 20% to 40% of children after the first three doses. Local reactions appear to be more frequent after the fourth and/or fifth doses. Mild systemic reactions such as drowsiness, fretfulness, and low-grade fever may also occur. Temperature of 101°F or higher is reported in 3% to 5% of DTaP recipients. These reactions are self-limited and can be managed with symptomatic treatment with acetaminophen or ibuprofen. Moderate or severe systemic reactions (such as fever [105°F or higher], febrile seizures, persistent crying lasting 3 hours or longer, and hypotonic hypo-responsive episodes) have been reported after administration of DTaP but occur less frequently than among children who received whole-cell DTP. Rates of these less common reactions vary by symptom and vaccine but generally occur in fewer than 1 in 10,000 doses.

DTaP Adverse Reactions

- Local reactions such as pain, redness, and swelling occur in 20% to 40% of cases
- Temperature of 101°F or higher occurs in 3% to 5% of cases
- More severe adverse reactions are not common
- Local reactions more common following 4th and 5th doses
 - Local adverse reactions and fever
 - Reports of swelling of the entire limb
 - Extensive swelling after 4th dose is **not** a contraindication to 5th dose

Information on adverse reactions following a full series of DTaP is also limited. Available data suggest a substantial increase in the frequency and magnitude of local reactions after the fourth and fifth doses. For example, swelling at the site of injection occurred in 2% of patients after the first dose of Tripedia, and in 29% following the fourth dose. Increases in the frequency of fever after the fourth dose have also been reported, although the increased frequencies of other systemic reactions (e.g., fretfulness, drowsiness, or decreased appetite) have not been observed.

Swelling involving the entire thigh or upper arm has been reported after booster doses of certain acellular pertussis vaccines. The limb swelling may be accompanied by erythema, pain and fever. Although the swelling may interfere with walking, most children have no limitation of activity. The pathogenesis and frequency of substantial local reactions and limb swelling are not known, but these conditions appear to be self-limited and resolve without sequelae.

ACIP recommends that a fifth dose of DTaP be administered before a child enters school. It is not known whether children who experience entire limb swelling after a fourth dose of DTaP are at increased risk for this reaction after the fifth dose. Because of the importance of this dose in protecting a child during school years, ACIP recommends that a history of extensive swelling after the fourth dose should not be considered a contraindication to receipt of a fifth dose at school entry. Parents should be informed of the increase in reactogenicity that has been reported following the fourth and fifth doses of DTaP.

Tdap

The safety of Tdap vaccines was evaluated as part of prelicensure studies. The most common adverse reaction following both brands of Tdap vaccine is a local reaction, such as pain (66%), redness (25%) or swelling (21%) at the site of injection. Temperature of 100.4°F or higher was reported by 1.4% of Tdap recipients and 1.1% of Td recipients. Tdap recipients also reported a variety of nonspecific systemic events, such as headache, fatigue and gastrointestinal symptoms. Local reactions, fever, and nonspecific systemic symptoms occurred at approximately the same rate in recipients of Tdap and the comparison group that received Td without acellular pertussis vaccine. No serious adverse events have been attributed to Tdap.

Contraindications and Precautions to Vaccination

DTaP

Contraindications to further vaccination with DTaP are a severe allergic reaction to a vaccine component or following prior dose of vaccine, and encephalopathy not due to another identifiable cause occurring within 7 days after vaccination. Moderate or severe acute illness is a precaution to vaccination. Children with mild illness, such as otitis media or upper respiratory infection, should be vaccinated. Children for whom vaccination is deferred because of moderate or severe acute illness should be vaccinated when their condition improves.

Certain infrequent adverse reactions following DTaP vaccination are considered to be precautions for subsequent doses of pertussis vaccine. These adverse reactions are a temperature of 105°F (40.5°C) or higher within 48 hours that is not due to another identifiable cause; collapse or shock-like state (hypotonic hyporesponsive episode) within 48 hours; persistent, inconsolable crying lasting 3 hours or longer, occurring within 48 hours; and convulsions with or without fever occurring within 3 days.

There are circumstance—such as during a communitywide outbreak of pertussis—in which the benefit of vaccination outweighs the risk, even if one of the four precautionary adverse reactions occurred following a prior dose. In these circumstances, one or more additional doses of pertussis vaccine should be considered. DTaP should be used in these circumstances.

Tdap

Tdap is contraindicated for persons with a history of a severe allergic reaction to a vaccine component or following a prior dose of vaccine. Tdap is also contraindicated for persons with a history of encephalopathy not due to another identifiable cause occurring within 7 days after administration of a pertussis-containing vaccine.

Precautions to Tdap include a history of Guillain-Barré syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine and a progressive neurologic disorder (such as uncontrolled epilepsy or progressive encephalopathy) until the condition has stabilized. Persons with a history of a severe local reaction (Arthus reaction) following a prior dose of a tetanus and/or diphtheria toxoid-containing vaccine should generally not receive Tdap or Td vaccination until at least 10 years have elapsed after the last Td-containing vaccine. Moderate or severe acute illness is a precaution to vaccination. Persons for whom vaccination is deferred because of moderate or severe acute illness should be vaccinated when their condition improves.

As noted above, certain conditions following DTaP vaccine, such as temperature of 105°F or

higher, collapse or shock-like state, persistent crying, or convulsions with or without fever are a precaution to subsequent doses of DTaP. However, occurrence of one of these adverse reactions following DTaP vaccine in childhood is not a contraindication or precaution to administration of Tdap to an adolescent or adult. A history of extensive limb swelling following DTaP is not a contraindication to Tdap vaccination. A stable neurologic disorder (such as controlled seizures or cerebral palsy), pregnancy, breastfeeding, and immunosuppression are not contraindications or precautions to administration of Tdap.

Vaccine Storage and Handling

DTaP, Td and Tdap vaccines should be stored at 35° to 46°F (2° to 8°C) at all times. The vaccines must never be frozen. Vaccine exposed to freezing temperature must not be administered and should be discarded. DTaP, Td and Tdap should not be used after the expiration date printed on the box or label.

Reference

Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases. Chapter 7: Pertussis.* Atkinson W, Hamborsky J, McIntyre L, Wolfe S, eds. 10th ed. 2nd printing, Washington DC: Public Health Foundation, 2008.

(continued on next page)

Post Test

Circle one answer per question. (Passing grade is 80% or greater.)

1. Since the widespread use of the pertussis vaccine:
 - a) Pertussis has been declared “cured” worldwide.
 - b) More than 200,000 cases have been reported annually in the United States.
 - c) The disease remains a major health problem among children in developing countries.
 - d) The vaccine has been shown to cause more problems than the disease itself.
2. The incubation period of pertussis:
 - a) Is called the catarrhal stage and is characterized by runny nose, low-grade fever and mild, occasional cough.
 - b) Is the stage in which a diagnosis of pertussis is usually suspected.
 - c) Includes paroxysmal coughing attacks with long inspiratory effort accompanied by a high-pitched whoop.
 - d) Is commonly 7 to 10 days and rarely as long as 42 days.
3. The catarrhal stage of pertussis:
 - a) Is also called the convalescent stage.
 - b) Is characterized by runny nose, mild cough and low-grade fever similar to the common cold.
 - c) Is characterized by a gradual recovery.
 - d) Includes an average of 15 coughing attacks per 24 hours.
4. The paroxysmal stage of pertussis:
 - a) Is characterized by bursts of numerous rapid coughs followed by a long inspiratory effort with a high-pitched whoop.
 - b) Is characterized by a mild cough and runny nose similar to a common cold.
 - c) Is also called the incubation period.
 - d) Can last up to a year.
5. Adolescent and adults who have been immunized against pertussis as children:
 - a) Are immune for life.
 - b) May become infected and usually have more severe cases than un-immunized people.
 - c) May become infected with *B. pertussis*, but usually have milder disease.
 - d) May become infected, but are not contagious.
6. Older persons with milder pertussis are often the source of infection for un-immunized or under-immunized children.
 - a) True
 - b) False
7. Pertussis complications:
 - a) Are most often seen in adolescents whose immunity may have decreased.
 - b) Are most often seen in adults who have not been immunized.
 - c) Include neurologic complications such as seizures and encephalopathy in infants.
 - d) Are rarely seen in infants due to transferred immunity from the mother during breast feeding.

8. The most reliable test to confirm pertussis is a:
- Culture taken from the throat.
 - Culture taken from the posterior nasopharynx.
 - Culture performed more than 2 weeks after cough onset.
 - Serologic test that measures antibodies to pertussis.
9. Medical management of pertussis should include:
- Erythromycin and supportive care.
 - A 20 day course of penicillin.
 - Isolation of anyone with a lymphocyte count greater than 20,000.
 - An antibiotic effective against pertussis given to any close contacts who have not been vaccinated.
10. Pertussis:
- Occurs only in warm climates.
 - Can be spread by mosquitos.
 - Is rarely transmitted to household contacts unless direct contact with blood occurs.
 - Is most commonly transmitted by the respiratory route through droplets.
11. The incidence of pertussis has:
- Been gradually declining since the introduction of vaccine in the 1940's.
 - Remained the same since the 1960's when the vaccine took effect.
 - Been gradually increasing since the early 1980's.
 - Increased in recent years due to antibiotic resistant strains of pertussis.
12. Pediatric pertussis vaccines in the United States:
- Are combined only with the diphtheria toxoid.
 - Are approved for children 6 weeks to 14 years of age.
 - Contain thimerosal as a preservative.
 - Are combined with diphtheria and tetanus toxoids.
13. Studies have shown that acellular pertussis vaccine is significantly more effective with fewer adverse reactions than whole-cell DTP.
- True
 - False
14. Primary diphtheria, tetanus and pertussis (DTaP) vaccinations:
- Should be given at 2 months, 4 months, 6 months and 15 to 18 months of age.
 - Should be given at least 1 year apart.
 - Confer lifelong immunity.
 - Must be restarted if there is an interruption in the recommended schedule.
15. The Tdap vaccine:
- Is recommended for people over the age of 75 who have been exposed to pertussis.
 - Is recommended for adolescents 13 to 18 years of age as a catch-up booster only if they have not completed the childhood vaccination series.
 - Can only be given 5 years after a Td shot.
 - May be given less than 5 years after a Td shot if there is a pertussis outbreak.

16. Tdap (Adacel):

- a) May be given to an adolescent or adult without documentation of three doses of tetanus and diphtheria toxoids during their lifetime.
- b) Is not recommended during pregnancy.
- c) Is recommended to be given during the third trimester of pregnancy.
- d) Should not be given to people with a history of pertussis because they have permanent immunity.

17. Vaccination with DTaP:

- a) Should be delayed until a child with a neurologic condition has been treated and stabilized.
- b) Can be given to a child with epilepsy if used in multiple reduced doses that together equal a full immunizing dose.
- c) Has been shown to have decreased vaccine reaction when given in multiple reduced doses.
- d) Has been shown to give adequate immune response when given in multiple reduced doses.

18. Administration of the DTaP vaccine:

- a) Is not recommended if a child experiences extensive swelling after the fourth dose.
- b) May cause local adverse reactions such as fever and swelling of affected limb that are self-limited.
- c) Usually causes more severe reactions with the first dose than subsequent doses.
- d) Causes more adverse reactions than whole-cell DTP.

19. The DTaP vaccine should not be given if:

- a) There has been swelling at the injection site or mild fever with a prior vaccination.
- b) The child has a mild illness such as otitis media.
- c) There is a family history of autism.
- d) There was encephalopathy not due to another cause within 7 days of prior vaccination.

20. Tdap vaccine:

- a) Should be deferred until a moderate or severe illness improves.
- b) Can be safely given to persons with a progressive neurologic disorder.
- c) May be given within 5 years after a severe local reaction (Arthus reaction) following a prior tetanus shot.
- d) May be safely frozen for long periods of time.

(continued on next page)

Answer Sheet

Pertussis – 1.5 Units

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
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17. _____
18. _____
19. _____
20. _____

Course Evaluation

Please answer each of the following questions. Questions with an asterisk (*) are required.

* 1. This course met the goals and learning objectives.

Yes No

* 2. The author was well prepared to write about the content in a way that facilitated my learning.

Yes No

* 3. This course was free from commercial bias.

Yes No

* 4. The learning activity met my continuing education needs.

Yes No

* 5. The learning activity took me 60 minutes per contact hour.

(If you answer "No", please enter the total time it took to finish the course, test, and evaluation.)

Yes

No. How long did it take to finish the course, test, and evaluation? _____

6. My professional educational level is (check one):

Nursing

Nurse Aide LVN/LPN RN (diploma) RN (AD)

BSN MSN Nurse Practitioner / Advanced Practice Nurse

PhD / DNSc

Therapy

OT Aide COTA OT MOT OTD

PT Aide PTA PT MPT MSPT DPT PhD

Other (please specify): _____

(continued on next page)

7. I heard about ATrain Education from:

- Search engine
- Government or Board website
- Friend
- Advertisement
- Returning customer
- Other _____

8. I found the ATrainCEU.com website easy to use:

- Yes No_____

9. Comments or suggestions (optional): _____

Registration Information

Please answer all of the following questions (*required).

* Name: _____

* Address: _____

* City: _____ State: _____ Zip: _____

* Phone: _____

* Professional Designation: _____

* License Number and State: _____

Please e-mail my certificate: Yes No

Email (required if you want your certificate sent by email): _____

(Note: If you request an email certificate we will not send a copy of your certificate by US Mail.)

Payment Options

You may pay by credit card or by check. Fill out this section only if you are **paying by credit card**.

1.5 contact hours - \$10

Credit card information:

Name _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Card type: Visa MC American Express Discover

Card number _____ CVS # _____

Expiration date _____

Test Completion and Mailing Instructions

1. Complete all forms:

Answer Sheet

Evaluation Learning Activity

Registration Form (this page)

2. If you are **paying by check**, prepare a check for \$10 made out to ATrain Education, Inc.

3. Mail the completed forms and your payment to:

ATrain Education, Inc
5171 Ridgewood Rd
Willits, CA 95490

Once we receive your forms and payment, we will mail (or email, if you request it) your certificate of completion. If you have any questions or concerns, please call or contact us at Sharon@ATrainCEU.com. And thanks for taking the ATrain!