Pertussis

Disease Category: Vaccine Preventable and Respiratory Disease

Timeframe to follow-up: Same day

Signs and Symptoms	Early (Catarrhal Stage): Runny nose, mild fever (<100.4 F), mild occasional cough, sneezing, fatigue. Later (Paroxysmal Stage): Severe prolonged coughing fits, "whooping" sound when inhaling after a cough, vomiting after coughing, exhaustion following coughing episodes, apnea (in infants). Recovery: Gradual decrease in coughing frequency and severity, symptoms may persist for weeks ("100-day cough).
Incubation	Usually 5 to 10 days after exposure; range 5 to 21 days.[1]

Case Classification[2]	Probable:
	• In the absence of a more likely diagnosis, illness meeting the clinical criteria
	
	OR
	
	• Illness with cough of any duration, with
	  ○ At least one of the following signs or symptoms:
	  ▪ Paroxysms of coughing; or
	  ▪ Inspiratory whoop; or
	  ▪ Post-tussive vomiting; or
	  ▪ Apnea (with or without cyanosis)
	
	AND
	
	  ○ Contact with a laboratory confirmed case (epidemiologic linkage)
	
	Confirmed:
	
	Acute cough illness of any duration, with
	• Isolation of *B. pertussis* from a clinical specimen, OR
	• PCR positive for B. pertussis.

Differential Diagnosis	Viral Upper Respiratory Infections (URIs), viral bronchitis, pneumonia, asthma, Gastroesophageal Reflux Disease (GERD), Tuberculosis (TB), other Bordetella Species
Treatment	Azithromycin is the first line of choice for both treatment and for post-exposure prophylaxis (PEP). Antimicrobial agents are not effective once a paroxysmal cough is established but can limit the spread of illness.
Duration	• Catarrhal Stage – may last 1-2 weeks • Paroxysmal Stage - may last 2-6 weeks (can extend to 10 weeks in some cases) • Convalescent Stage – may last 2-3 weeks, may be longer

Exposure	Respiratory droplets, direct contact, environmental persistence.
Laboratory Testing	Nevada State Public Health Laboratory (NSPHL) can test for *Bordetella pertussis* (*B. pertussis*) through PCR assay or culture using a nasopharyngeal swab. https://med.unr.edu/public-health-lab/disease-characteristics/clinical-analysis/bordetella-pertussis
Control of Contacts	• Post-exposure prophylaxis (PEP) is recommended for all household contacts and any high-risk close contacts of case. • All contacts should be monitored for signs and symptoms for 21 days after last exposure. • Provide education and recommend prevention, including "stay up to date on DTaP."
Key areas of focus during investigation	Immunization status, contact investigation and determine any exposure source from group settings.
Public Health Actions	Reports on Pertussis cases must be made to the Local Health Authority during the regular business hours of the health authority on the first working day following the identification of the case. Local Health Authority to notify Office of State Epidemiology (dpbhepi@health.nv.gov) or call 775-684-5911/775-400-0333 (after hours) if outbreak suspected. For individual confirmed or probable cases: • Confirm diagnosis, if possible • Identify potential exposures • Manage any case exclusions • Identify close contacts, manage any contact exclusion, and PEP recommendations • Provide education about how to prevent transmission To the best of the local health authority's ability, each step of the investigation should be completed within one working day or in alignment with NAC 441A.

Key Partner Agencies	• Local Health Authorities
	• Nevada State Public Health Laboratory (NSPHL)
	• Nevada Immunization Program
	  ○ nviz@health.nv.gov or (775) 684-5900.
	• Centers for Disease Control and Prevention
	  ○ E-mail or 800-232-4636

TABLE OF CONTENTS

PERTUSSIS

I. DISEASE REPORTING

A. Legal Reporting Requirements

A report to the health authority may be made by telephone; telecopy (in the form prescribed by the health authority); or any form of electronic communication identified by the health authority, following the specified format and procedure (see Appendix A for contact information).[3]

1. Health Care Providers and Health Care Facilities

Health providers and facilities must notify the health authority where provider is located within the first working day after identifying the case.[4–6]

2. *Laboratories*

Laboratories must notify the health authority within the first working day after identifying the case.[7] If the lab is located outside of Nevada, notify the Nevada Chief Medical Officer through the Office of State Epidemiology (OSE) within the same timeframe.[7,8]

3. Local Health Authority (LHA)[6]

LHA's must notify the Office of State Epidemiology (OSE) by preparing a case report form for each case of pertussis reported in its jurisdiction. This should be completed within 7 days after completing the case investigation.

II. THE DISEASE AND ITS EPIDEMIOLOGY

A. Background[9,10]

Pertussis, or whooping cough, is an acute infectious disease caused by the bacterium *Bordetella pertussis*. In the 20th century, it was one of the most common childhood diseases and a leading cause of childhood mortality in the United States. Before vaccines became widely available, more than 200,000 cases were reported annually. However, since the widespread use of the vaccine began, the incidence of pertussis has dropped by more than 75% compared to the pre-vaccine era. Despite this progress, pertussis remains a significant global health concern. Cases occur year-round, typically with peaks in late summer-autumn. Neither previous infection nor immunization provide life-long immunity.

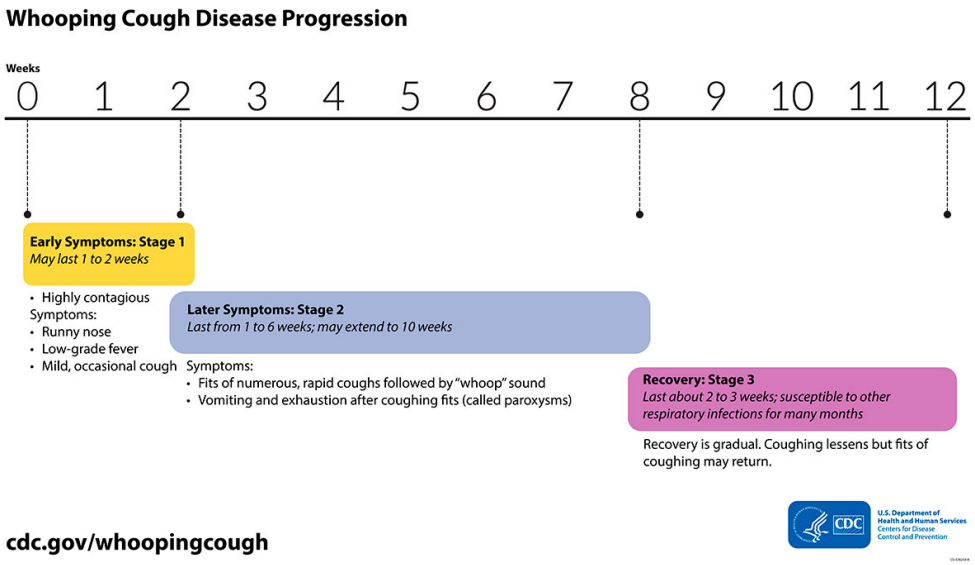
B. Etiologic Agent[11]

Pertussis or whooping cough is a respiratory illness caused by bacteria called *Bordetella pertussis.* This disease is only found in humans.

The whooping cough bacteria attach to the cilia (tiny, hair-like extensions) that line part of the upper respiratory system. The bacteria then release toxins, which damage the cilia and cause the airways to swell.

C. Description of Illness[12]

Pertussis progresses through three stages: catarrhal, paroxysmal, and convalescent, typically lasting 6–12 weeks or more. The catarrhal stage (1–2 weeks) mimics a mild upper respiratory infection with symptoms like runny nose, low-grade fever, and fatigue; despite being a mild stage, it is highly contagious. The paroxysmal stage (2–6 weeks) features intense coughing fits, often ending in a "whoop," and may include vomiting, exhaustion, or apnea in infants. Severe coughing can lead to complications like rib fractures or pneumonia, even as bacterial load declines. The convalescent stage (2–3 weeks or longer) marks gradual recovery, though a residual "100-day cough" may persist. Early diagnosis, especially in the catarrhal stage, is crucial to prevent further transmission. Patients are no longer contagious during the convalescent stage.



D. Disease Burden in Nevada[10,13]

Pertussis is an endemic disease to Nevada and worldwide. Children everywhere, regardless of ethnicity, climate, or geographic region can be at risk for being exposed to and contract pertussis. The CDC tracks pertussis cases across the United States. While cases have increased nationally in recent years, the number remains relatively low in Nevada. As of October 3, 2025, most pertussis cases in the state occurred in Clark County, which reported 42 cases. Nevada reported a total of 59 pertussis cases in 2025, equating to 1.7 cases per 100,000 people. In the United States, cases have been increasing since the 1990s until the start of the pandemic in 2020, mostly due to waning immunity.

See the Nevada Office of State Epidemiology Communicable Disease Dashboard for Nevada specific data on Pertussis (Current Status – Vaccine Preventable section).

E. Reservoirs[9]

Humans are believed to be the only host for pertussis. Unlike other infectious diseases with environmental or animal reservoirs, pertussis relies entirely on human hosts for survival, replication, and transmission. Adolescents and adults with waning immunity (immunity

typically starts to wane 4-6 years after vaccination or natural infection) serve as significant reservoirs. These individuals often experience mild or atypical symptoms, which can lead to delayed diagnosis and unintentional transmission, particularly to infants and young children who are at the highest risk for severe disease. Unvaccinated and under-vaccinated populations also contribute to the persistence of pertussis in communities, creating opportunities for outbreaks.

F. Modes of Transmission[9]

Bordetella pertussis is transmitted exclusively between humans through respiratory droplets. This highly contagious pathogen spreads primarily during close person-to-person contact, such as coughing, sneezing, or talking which releases infectious droplets into the air. The risk of transmission is highest in crowded or enclosed environments, such as households, schools, and daycare centers. Symptoms can resemble a common cold, making undiagnosed cases a significant driver of transmission.

G. Incubation Period[1]

The incubation period of pertussis typically ranges from 5 to 10 days but can extend from 5 to 21 days. The length of the incubation period can vary based on factors such as the host's immune response, age, and vaccination status. Individuals are not infectious during this period.

H. Period of Communicability

The period of communicability for pertussis begins with the onset of symptoms in the catarrhal stage, typically 1-2 weeks after exposure. Individuals are most contagious during this early stage when symptoms resemble a mild cold, including runny nose, sneezing, and mild cough, as high bacterial loads are present in respiratory secretions. The period of communicability peaks just before the characteristic severe coughing episodes of paroxysmal stage develop, which can further facilitate the spread through respiratory droplets. Without treatment, individuals can remain contagious for up to 21 days after the onset of paroxysmal coughing. After completing five days of appropriate antibiotic treatment, the risk of transmission is significantly reduced.

I. Testing[14]

Appropriate, timely diagnostic testing is important for diagnosis. Bacterial cultures are most useful during the first 2 weeks of cough and prior to antibiotic use. Polymerase Chain Reaction (PCR) is the most useful 2-4 weeks after cough onset. Serologic testing is not recommended.

Specimens may be sent to the Nevada State Public Health Laboratory (NSPHL) for testing through PCR assay and culture: https://med.unr.edu/public-health-lab/disease-characteristics/clinical-analysis/bordetella-pertussis. Pertussis testing is also available through commercial labs, but if culture is positive labs must submit isolates of pertussis (Bordetella pertussis or Bordetella parapertussis) species to NSPHL for shipment to CDC for further testing.

J. Treatment & Post-exposure Prophylaxis[10,15]

Receiving treatment for pertussis within the first 1-2 weeks is most effective for reducing symptom severity. It is important to begin treatment before the coughing paroxysms occur, to lessen the symptoms. Beginning treatment more than 3 weeks after cough onset is unlikely to be beneficial. Antibiotics used for treatment and postexposure prophylaxis (PEP) are the same. Azithromycin prescribed for 5 days is an appropriate first-line choice for both treatment and PEP. See table 1 for recommendation based on age and recommended alternate agent to macrolide therapy.

Table 1: Recommended Antimicrobial Therapy and Postexposure Prophylaxis for Pertussis[10]

	Recommended Drugs			Alternative
Age	Azithromycin	Erythromycin	Clarithromycin	TMP-SMX*
<1 month	10 mg/kg/day as single dose for 5 days	40 mg/kg/day in 4 divided doses for 14 days	Not recommended	Contraindicated at younger than 2 months
1-5 months	10 mg/kg/day as single dose for 5 days	40 mg/kg/day in 4 divided doses for 14 days	15 mg/kg/day in 2 divided doses for 7 days	2 months or older: TMP, 8 mg/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 through 5 (maximum 250 mg/day)	40 mg/kg/day in 4 divided doses for 7-14 days (maximum 2 g/day)	15 mg/kg/day in 2 divided doses for 7 days (maximum 1 g/day)	2 months or older: TMP, 8 mg/kg/day; SMX, 40 mg/kg/day in 2 doses for 14 days
Adolescents and adults	500 mg as a single dose on day 1, then 250 mg as single dose on days 2 through 5	2 g/day in 4 divided doses for 7-14 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

*TMP: trimethoprim; SMX: sulfamethoxazole

III. EPIDEMIOLOGIC CASE INVESTIGATION

The public health authority should begin investigating the case of Pertussis, step by step, within one working day of notification or in alignment with NAC 441A.

A. Step 1: Review relevant information about the disease.

1. Review scientific information in Control of Communicable Diseases Manual, most current edition.

2. Review Pertussis case definition (Pertussis (Whooping Cough) (Bordetella pertussis) 2020 Case Definition | CDC).[2]

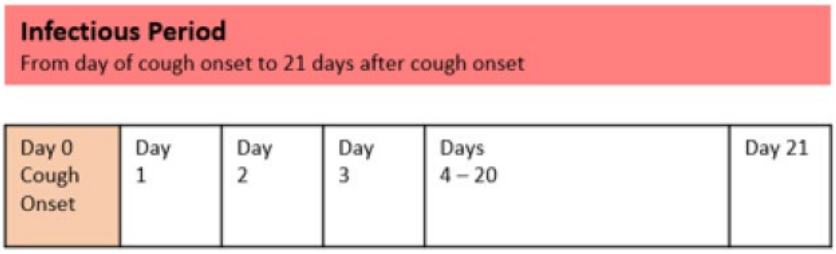
B. Step 2: Begin investigating the case.

1. Contact Reporting Source and/or Reported Case

Upon receiving an initial case report, review lab test results and available clinical details and epidemiologic factors. Please make three attempts to contact the case (text and phone calls) on separate days, at different times of the day (morning, afternoon, late afternoon). Document all attempts to contact a reporting source and/or reported case, preferably in the "Encounters" tab of EpiTrax. Please use case report forms (CRF) to gather accurate information about the case. Focus on the key data elements listed below and in the summary table at the beginning of this protocol. Filling out an electronic version of the CRF in EpiTrax is preferred. If used, the completed PDF version should be attached to the CMR in EpiTrax. The CRF should be completed within 7 days of completing the investigation of the case.

A. Review labs and medical records. Ensure that labs identify *Bordetella pertussis* and not *Bordetella parapertussis*. Case may still meet case definition even with a negative test base on clinical symptoms.

B. Identify cough onset date to determine infectious period. Cough onset is considered day zero and the infectious period goes through 21 days after symptoms began.



C. Ensure case has been recommended to receive antibiotic treatment (if it is <21 days since cough onset)

D. Identify household contacts, close contacts, and high-risk close contacts and evaluate contacts for postexposure prophylaxis (PEP) indication.

E. Recommend pertussis vaccine for unvaccinated or under vaccinated persons.

C. Step 3: Identify potential source of infection[14]

The investigation focuses on potential exposures in the 5 – 10 days (rare cases up to 21 days) before onset, including:

A. Exposure to others that may have been sick

B. Any exposure to large groups (i.e., schools/daycares, church gatherings, parties, family events, etc.).

D. Step 4: Initiate control measures for case and/or for contacts (see Section IV – Section VI below).

E. Step 5: Provide Education and Prevention messaging to the case and/or contacts (see Section IX below).

IV. CONTROL OF CASE[10,16]

1. Management/Exclusions for Specific Groups or Settings

It is essential that data be used to determine the scope of the epidemiologic investigation and the potential for spread and that any intervention/control measures be based on those determinations and public health judgement.

A. *General Population*

1. Per NAC 441A.630, a case having pertussis must be excluded from childcare facilities, schools, sporting events sponsored by schools, sensitive occupations, public gatherings, and from contact with susceptible persons not residing in the same household as the case for 21 days after the date of onset of illness or for 5 days after the initiation of medical treatment specific for pertussis.
    a. If antimicrobial therapy is prescribed, verify treatment with the provider's office.

B. *Case in childcare or school setting*

1. Exclude case from childcare/school setting for 21 days following cough onset OR until case has completed 5 days of antibiotic treatment. If antibiotics are prescribed, verify treatment with provider's office.

Outside of the childcare/school setting, confirmed/suspected cases should also be removed from the presence of younger children and infants (e.g., siblings), until patients have received 5 days of antibiotics.

2. If case attended childcare/school setting during infectious period, advise parents of case that the facility will be notified of potential pertussis exposure. . Assure them that HIPAA protocols will be followed when doing this.
3. Contact childcare/school nurse to notify of case; initiate contact identification and implement any control measures such as cough monitoring.

C. *Case works in a medical facility or is a patient in a medical facility*

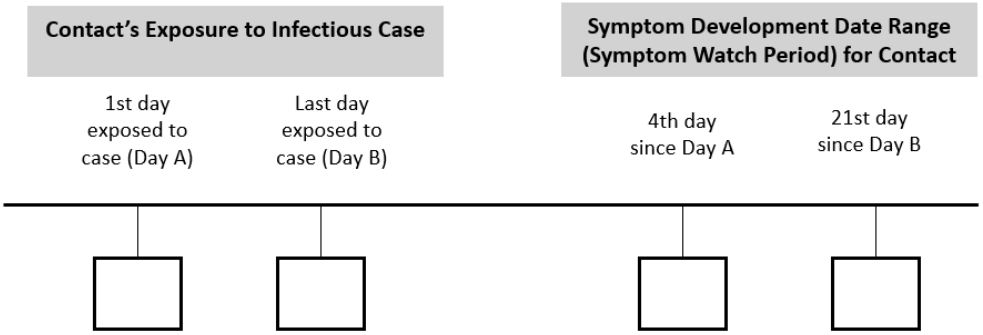
1. Notify infection prevention staff about cases; they will determine appropriate precautions and restrictions for both patients and staff.
2. Recommended to exclude positive staff from health facility for 21 days following cough onset OR until case has completed 5 days of antibiotic treatment.
3. The medical facility shall provide care to the case in accordance with respiratory isolation and droplet precautions when examining patient.

V. CONTROL OF CONTACTS[16]

Close contacts often include household members and immediate family members, significant others, and childcare contacts. A close contact is someone who potentially had direct contact with the respiratory secretions (e.g., a cough, sneeze in the face) of a confirmed/probable case within 21 days of cough onset or between cough onset and completion of 5-days of antimicrobial therapy.

High-risk contacts are discussed below. Lower-risk contacts are those who potentially had direct contact with a confirmed/probable case within 21 days of cough onset but who do not meet any of the high-risk criteria.

A. Use the infectious period to determine the first and last day of exposure to case.



A. To calculate the symptom development period for contacts, add 4 days to the first exposure date and 21 days to the last exposure date (this is based on the incubation period).[9]
B. <u>All contacts</u> should monitor for symptoms that begin within 21 days of last exposure, even if they receive postexposure prophylaxis (PEP). If symptoms develop, the individual should contact their healthcare provider and the health department. Investigator shall provide education.
C. <u>Any symptomatic contacts</u> with a cough illness should be investigated to determine if they meet probable case definition. Investigate and implement control measures for symptomatic contacts immediately. Refer to healthcare provider for evaluation. Have contact call ahead to make arrangements for isolation to limit potential exposure of others to pertussis. Symptomatic contacts should isolate at home until they have received 5 days of appropriate antimicrobial therapy, or 21 days have passed since symptom onset with no antimicrobial therapy or received a negative pertussis result.

1. Management/Exclusions for Specific Groups or Settings[10]

Per Red Book, a 5-day course of azithromycin is an appropriate first-line choice for post-exposure prophylaxis (PEP). PEP is not recommended >21 days after last exposure, however, it can be recommended beyond the initial 21 days for household contacts or situations with high-risk contacts who have been exposed.

A. *Close Contacts*

PEP is usually not required for healthy close contacts. However, PEP is recommended for all high-risk close contacts of the index patient. PEP may be given regardless of immunization status.

B. *High-risk Contacts*[17]

PEP is recommended within 21 days of exposure for those at higher risk of more severe disease (regardless of immunization status), including:

- Infants and women in their third trimester of pregnancy: infants under the age of 12 months, especially among infants <2 months, have a higher risk of severe or fatal pertussis-related complications; women in their third trimester could possibly pass pertussis to their newborn infant.
- All persons with pre-existing health conditions: Pertussis may exacerbate conditions (e.g., persons who are immunocompromised or have moderate to severe asthma).
- Contacts who are likely to be in close proximity with infant <12 months of age, pregnant women, or individuals with pre-existing health conditions at risk for severe illness.
- All contacts in high-risk settings that may include infants <12 months of age or women in the third trimester of pregnancy (ex. Neonatal intensive care units, childcare settings, and maternity wards)

C. *Childcare/School Contacts*

PEP is only recommended for those at higher risk of severe infection (see subsection B immediately above).

- Provide pertussis disease control and information to the childcare/school nurse or administration
- Work with childcare/school nurse or administration to notify parents and teachers of possible exposure to pertussis.
- Observe any employees and exposed children, especially under-immunized children for 21 days after last contact with case while infectious.
    - Consider excluding any exposed contact that develops a cough within 21 days of last exposure and recommend evaluation by a physician.
    - An excluded contact may return either after 5 days of appropriate pertussis treatment, after 21 days since cough onset, or after a negative test result for pertussis (assuming no other condition requiring exclusion is identified)
- Determine immunization status of contacts and recommend appropriate vaccines to be administered when indicated.

D. *Inadequately immunized children <7 years of age*

Per NAC 441A.630, contact who is less than 7 years of age and inadequately immunized against pertussis and who resides in the same household as a case having pertussis must be excluded from schools, child care facilities, sporting events sponsored by schools, public gatherings, and from contact with susceptible persons not residing in

the household for 21 days after last exposure or until the case and the contact receive at least 5 days of appropriate antimicrobial therapy or prophylaxis specific to pertussis.

E. *Healthcare Contacts*[18]
- Exclude symptomatic healthcare personnel with known or suspected pertussis from work for 21 days from the onset of cough, or until 5 days after the start of effective antimicrobial therapy.
- Work restrictions are not necessary for asymptomatic healthcare personnel who have an exposure to pertussis and receive postexposure prophylaxis, regardless of their risk for interaction with persons at increased risk for severe pertussis.
- For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and are likely to interact with persons at increased risk for severe pertussis: Administer postexposure prophylaxis or if not receiving postexposure prophylaxis, restrict from contact (e.g., furlough, duty restriction, or reassignment) with patients and other persons at increased risk for severe pertussis for 21 days after the last exposure.
- For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and are not likely to interact with persons at increased risk for severe pertussis: Administer postexposure prophylaxis, OR
- Implement daily monitoring for 21 days after the last exposure for development of signs and symptoms of pertussis.
- For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and who have preexisting health conditions that may be exacerbated by a pertussis infection: Administer postexposure prophylaxis.

VI. CONTROL OF CARRIERS

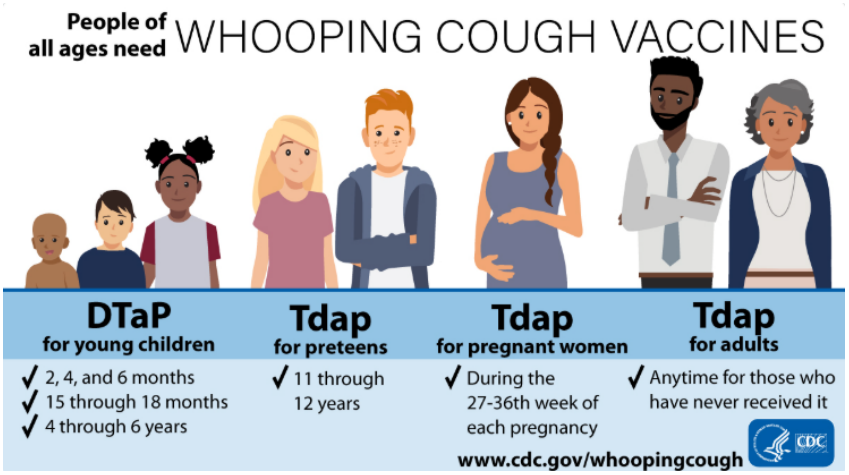
There is no documented chronic carrier state for pertussis. Disease response does not require any carrier-specific control measures. Transmission only happens during the acute infection period, especially early on. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL

Coordinate with senior epidemiology staff to determine if an outbreak is occurring. If so, notify local health authorities or infection control, as appropriate.

Note: According to NAC 441A.630, if the health authority determines that there is an outbreak of pertussis, the health authority may exclude children who are susceptible to pertussis from attending a school or childcare facility in an effort to control the outbreak.

VII. PREVENTION[19,20]

- Staying up to date on pertussis-containing vaccines is the most effective method to prevent pertussis.



- Practice good respiratory etiquette:
  - Covering the mouth and nose with a tissue or elbow when coughing or sneezing helps minimize the spread of respiratory droplets.
  - Regularly handwashing with soap and water or using alcohol-based hand sanitizers can prevent the transmission of bacteria.
  - Staying home while sick.
  - Using face masks when out in public.
- Encourage cocooning strategies, where close contacts (parents, caregivers) are vaccinated transmission to the infant.
- Wash hands before eating or before touching eyes, mouth, or nose.
- Wash hands after touching anyone who is coughing, sneezing, blowing their nose, or has a runny nose.
- Do not share things like cigarettes, towels, lipsticks, toys or anything else that may be contaminated with respiratory droplets.
- Do not share food, utensils, or beverage containers. The Nevada OSE website also provides information about Pertussis.

VIII. REPORTING

When a suspected pertussis-related death occurs, please notify the State Epidemiologist. They will work with the Vaccine-Preventable Disease Coordinator to notify the CDC via email or through the NNDSS system, in accordance with CDC guidelines regarding suspected pertussis-related deaths.

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X. ACKNOWLEDGEMENTS

This document was developed based on the content and format of the disease investigation guidelines of several state and local health jurisdictions:

- Oregon Health Authority Investigative Guidelines
- Washington State Department of Health Reporting and Surveillance Guidelines
- Washoe County Health District Epidemiology and Communicable Disease Program Investigation of Communicable Disease Manual

The Nevada Office of State Epidemiology would like to acknowledge the work of these great partners.

XI. UPDATE LOG

12/02/2025

Ihsan Azzam, Ph.D., M.D.
Medical Officer

Chief Medical Officer Approval DateChief