MEDICAL HEALTH OFFICERS ALERT

APRIL 8, 2026

IN THIS ISSUE:

- PERTUSSIS INCREASE WITHIN IH
- CLINICAL AWARENESS
- TREATMENT AND CHEMOPROPHYLAXIS
- IMMUNIZATION

MEDICAL HEALTH OFFICERS:

Dr. Sue Pollock

Dr. Silvina Mema

Dr. Sanaz Vaseghi

Dr. Fatemeh Sabet

Dr. Andy Delli Pizzi

Dr. Muhammad Mukarram

Dr. Marisa Webster

CONTACT INFO:
DUTY MHO LINE (24/7)
1-866-457-5648

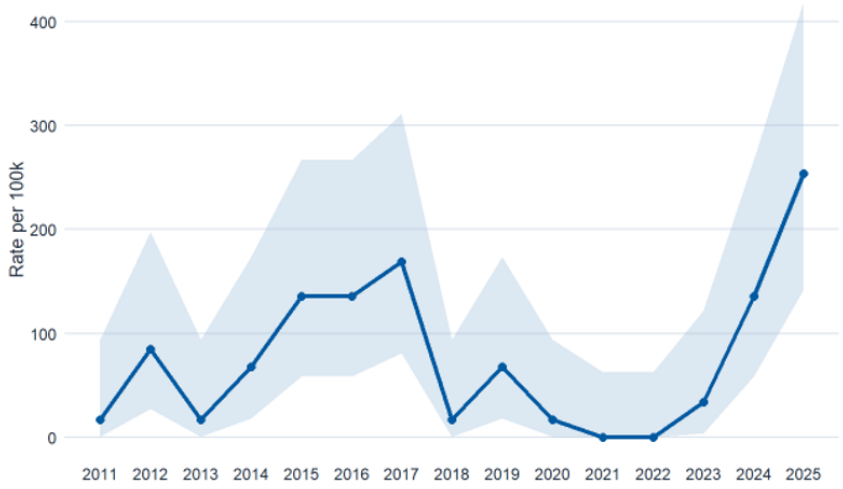
Increase in Pertussis Cases

Pertussis, or whooping cough, is a highly contagious disease of the respiratory tract caused by the bacteria Bordetella pertussis. Vaccination is the most effective prevention for severe disease and the protection of infants, who are the most vulnerable population. However, pertussis immunity from either vaccination or prior infection wanes over time, and a previously immunized person can still become sick, though the illness is milder.

Epidemiology

1. **Pertussis (whooping cough) activity in Interior Health has been elevated since 2024 and remained high in 2025**, with 169 cases reported, roughly twice the provincial rate. Activity has been lower in early 2026, but the expected peak season is in the summer.
2. **Pertussis activity is cyclical, with peaks of activity expected every 2 to 5 years.** The most recent cyclical peak was observed in 2017 within Interior Health.
3. **Infants under one year bear a disproportionate burden of pertussis.** This age group is at the highest risk for severe outcomes, including hospitalization and death. In 2025, 15 infants were diagnosed in Interior Health, the highest rate of any age group at 254 cases per 100k population, and nearly half required hospitalization.
4. **Most cases are among young persons, with more than 70% occurring among those 0-19 years of age.** The majority of these cases were unimmunized.

Fifteen-year trend of infant (<1 year) pertussis incidence in Interior Health.



TO VIEW PREVIOUS MHO UPDATES:
https://www.interiorhealth.ca/information-for/medical-staff/tools-and-resources/mho-updates

Actions requested of all clinicians

- **Be alert for cases of pertussis.** Consider pertussis in any patient with paroxysmal cough, cough with an inspiratory whoop, or cough ending with vomiting, gagging, or apnea. Also consider pertussis in patients with a prolonged cough with no other known cause, or persons with a recent exposure (incubation period is between 5 and 21 days), and have compatible symptoms.
- **Test** patients with suspected pertussis using a nasopharyngeal swab for pertussis culture and PCR.
- **Report** suspect, probable, and confirmed cases to the CD Unit @ 1-866-778-7736.
- **Treat** and offer **chemoprophylaxis** to contacts, particularly the high-risk contacts outlined below.
- Encourage your patients to update their **immunizations.**

Clinical presentation

During the initial two weeks of infection, symptoms may be indistinguishable from minor respiratory tract infections (catarrhal phase). Afterwards, the cough develops into the classic paroxysms followed by an inspiratory whoop and may include post-tussive vomiting (paroxysmal phase). The whoop is usually absent in older children and adults. Consider pertussis in a patient who has a paroxysmal cough of any duration, a cough with an inspiratory whoop, or cough ending in vomiting or gagging or associated with apnea. Pertussis should also be considered in patients with prolonged cough with no other known cause, or among those with compatible symptoms and a recent exposure (incubation period averages 7-10 days).

Patients with pertussis should avoid settings with children less than 1 year of age or pregnant women in their third trimester. This includes daycares, schools, and certain workplaces, until five days of treatment has occurred or three weeks after onset of paroxysmal cough.

Test

If you suspect pertussis, test the patient with **Nasopharyngeal swab with COPAN green-top eSwab** for PCR and culture that go to BCCDC for testing.

Instructions for use of the appropriate swab and collection of nasopharyngeal specimens is provided at:

eLab Handbook

Treatment and chemoprophylaxis

Dosages and duration are identical for treatment and chemoprophylaxis. See chart below.

Antibiotic treatment administered in the catarrhal phase can decrease duration of illness and severity of symptoms. Antibiotics given after the onset of paroxysmal cough will decrease the infectious period but not the duration of symptoms.

Chemoprophylaxis may be recommended by public health for high-risk contacts within three weeks of the first exposure.

High risk contacts of a pertussis case:

- Infants less than one year of age
- Women in 3rd trimester pregnancy
- Household/close group contacts (e.g., family, daycare) if there is an infant or 3rd trimester pregnancy in the group

Immunization

The pertussis vaccine is part of the normal childhood vaccine schedule **which is given at 2 months, 4 months, 6 months, and 18 months old, and again at age 4 to 6 years (before Kindergarten). A pertussis vaccine is also given to teens at 14 to 16 years of age (Grade 9) in British Columbia.** A client's immunization status is available in Care Connect and clients can book an appointment to get up to date through Interior Health's public health program.

Suggested resources

BC Centre for Disease Control. Pertussis. Accessible from BCCDC - Management of Specific Diseases - Pertussis

HealthLink BC. BC Routine Immunization Schedule. Accessible from: Immunization schedules | HealthLink BC

Interior Health

Pertussis Treatment and Chemoprophylactic Agents – Dosage Summary

AGE	AZITHROMYCIN	ERYTHROMYCIN	CLARITHROMYCIN	TRIMETHOPRIM - SULFAMETHOXAZOLE (alternative agent)
< 1 month	**Recommended agent.** 10 mg/kg per day in a single dose for 5 days	**Not preferred.** Erythromycin is associated with infantile hypertrophic pyloric stenosis. Use if azithromycin is unavailable: 40 mg/kg/day po (maximum 1 gm/day) divided in 3 doses for 7 days	**Not recommended** (safety data unavailable).	**Contraindicated for infants aged < 2 months** (risk for kernicterus).
1 – 5 months	10 mg/kg per day in a single dose for 5 days	40 mg/kg/day po (maximum 1 gm/day) divided in 3 doses for 7 days	15 mg/kg/day po (maximum 1 gm/day) divided in 2 doses for 7 days	**Contraindicated for infants aged < 2 months** (risk for kernicterus) **Children 2 months to ≤ 12 years of age:** Trimethoprim 4 mg/kg and Sulfamethoxazole 20 mg/kg po twice a day for 14 days (maximum Trimethorprim 160mg and Sulfamethoxazole 800mg twice daily)
≥ 6 months to ≤ 12 years	10 mg/kg/day po (maximum 500 mg) once for 1 day, **then** 5 mg/kg/day po (maximum 250 mg/day) once daily for 4 days	40 mg/kg/day po (maximum 1 gm/day) divided in 3 doses for 7 days	15 mg/kg/day po (maximum 1 gm/day) divided in 2 doses for 7 days	**Children 2 months to ≤ 12 years of age:** Trimethoprim 4 mg/kg and Sulfamethoxazole 20 mg/kg po twice a day for 14 days (maximum Trimethoprim 160mg and Sulfamethoxazole 800mg twice daily)
> 12 years	500mg po once for one day then 250mg po once daily for 4 days	40 mg/kg/day po (maximum 1 gm/day) divided in 3 doses for 7 days	1 gm/day divided in 2 doses for 7 days. **Not recommended in pregnancy**	**Adults and children over 12 years of age:** Trimethoprim 160 mg and Sulfamethoxazole 800 mg po twice a day for 14 days. **Not recommended in pregnancy**