

ORIGINAL RESEARCH

Clinical Diagnosis of *Bordetella Pertussis* Infection: A Systematic Review

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Background: *Bordetella pertussis* (BP) is a common cause of prolonged cough. Our objective was to perform an updated systematic review of the clinical diagnosis of BP without restriction by patient age.

Methods: We identified prospective cohort studies of patients with cough or suspected pertussis and assessed study quality using QUADAS-2. We performed bivariate meta-analysis to calculate summary estimates of accuracy and created summary receiver operating characteristic curves to explore heterogeneity by vaccination status and age.

Results: Of 381 studies initially identified, 22 met our inclusion criteria, of which 14 had a low risk of bias. The overall clinical impression was the most accurate predictor of BP (positive likelihood ratio [LR+], 3.3; negative likelihood ratio [LR−], 0.63). The presence of whooping cough (LR+, 2.1) and posttussive vomiting (LR+, 1.7) somewhat increased the likelihood of BP, whereas the absence of paroxysmal cough (LR−, 0.58) and the absence of sputum (LR−, 0.63) decreased it. Whooping cough and posttussive vomiting have lower sensitivity in adults. Clinical criteria defined by the Centers for Disease Control and Prevention were sensitive (0.90) but nonspecific. Typical signs and symptoms of BP may be more sensitive but less specific in vaccinated patients.

Conclusions: The clinician's overall impression was the most accurate way to determine the likelihood of BP infection when a patient initially presented. Clinical decision rules that combine signs, symptoms, and point-of-care tests have not yet been developed or validated. (J Am Board Fam Med 2017;30:308–319.)

Keywords: *Bordetella Pertussis*, Vaccination, Vomiting, Whooping Cough

Pertussis is an acute respiratory illness caused by the *Bordetella pertussis* (BP) bacterium. Initial symptoms are usually relatively mild, and can include cough, sneezing, coryza, and slight fever. The disease then progresses to produce more severe, paroxysmal coughing fits. During these episodes, the characteristic “whooping” may be heard as the patient tries to inhale through narrowed upper airways and the larynx. Posttussive vomiting, cyanosis, and apnea can occur as a result of the severity of these episodes.¹ A recent systematic review of the

prevalence of BP infection in patients with prolonged cough found that the overall prevalence of BP infection among primary care patients with prolonged cough (typically >1 week) was 12.4%; it was 18% in studies of children—much higher than suggested by laboratory-based surveillance reports.² The recent large increase in pertussis cases in the United States has been described by the Centers for Disease Control and Prevention (CDC) as an epidemic.³

For infants and young children, complications from pertussis may be life-threatening, and hospitalization may be warranted. Vaccination against BP is effective at preventing the spread of infection and is recommended for infants, children, and adults.^{4,5} Though older children and adults are unlikely to experience severe complications from pertussis, they can act as vectors of infection when in contact with those who are more vulnerable, including unvaccinated or incompletely vaccinated infants and children.^{6,7}

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CDC guidelines recommend a macrolide antibiotic (azithromycin, clarithromycin, or erythromycin), or, as an alternative, trimethoprim-sulfamethoxazole, for patients diagnosed with pertussis. Ideally, treatment should begin within 1 to 2 weeks of the onset of symptoms.⁸ However, recognition of patients with pertussis is challenging, as many of their symptoms overlap with those of viral acute respiratory tract infections, and the recommended diagnostic test (polymerase chain reaction [PCR]) typically takes several days. Thus, signs and symptoms may be able to help identify patients at high risk for pertussis, for whom testing should be prioritized. We identified only a single previous systematic review of clinical diagnosis, which excluded studies of young children and studies using culture as a reference standard.¹ A number of potentially relevant studies have also been published since its search was completed in 2010. The purpose of this meta-analysis is to perform a comprehensive systematic review and meta-analysis of the accuracy of signs and symptoms for the diagnosis of pertussis in patients of all ages.

Methods

Literature Search

We systematically reviewed studies published in MEDLINE using the following search strategy:

“pertussis”[tiab] OR “whooping cough”[tiab]
AND (“medical history taking”[MeSH Terms]
OR “physical examination”[MeSH Terms] OR
“signs and symptoms” OR “symptoms and signs”
OR “symptom”[Title/Abstract] OR “history and
physical” OR “physical examination” OR “phys-
ical examination” OR “clinical diagnosis” OR
“clinical examination” OR “post-tussive” OR
“posttussive” OR “vomiting” OR “c-reactive
protein” OR “CRP” OR “sedimentation rate”
OR “sed rate” or “WESR” or “procalcitonin”
OR “white blood cell count” OR “complete
blood count” OR “WBC” OR “CBC”

We did not restrict the search by language or date of publication. In addition, we searched the reference lists of included studies for additional studies not initially identified in our MEDLINE search.

Inclusion and Exclusion Criteria

We included prospective cohort studies of patients presenting with acute cough, prolonged cough, or

clinically suspected pertussis if all patients received a reference standard test consisting of PCR, culture, or serology, and if studies provided adequate data to calculate either the sensitivity or specificity of the examined symptoms. We excluded studies if they used a case-control design (which overestimates treatment accuracy)⁹; if sign and symptom data were collected retrospectively or after the initial patient contact; if the study was performed in a specialized population (eg, immunocompromised patients); if data were gathered only after a positive test had been obtained; or if the study had fewer than 25 patients.^{10,11} Since outbreak investigations typically gather symptom data retrospectively, and often by telephone, they were not included. Our goal was to identify high-quality studies that gathered clinical data at the time the patient presented, masked to the results of the reference standard test. No age restriction or restriction by immunization status was used.

Data Abstraction

Each abstract was reviewed by 2 investigators (MC and CM) for possible inclusion, and the full text of any study that potentially fit the inclusion criteria was reviewed in detail. Two investigators (MC and CM), working in parallel, abstracted data on study characteristics, study quality, and the accuracy of signs and symptoms. Any discrepancies were resolved by consensus after discussion, involving the third investigator (ME) if necessary.

Quality Assessment

The studies were evaluated for potential bias using the QUADAS-2 framework, which assesses patient selection, index test, reference standard used, and patient flow.¹² The reference standard was considered to be at low risk of bias if PCR, culture, paired serology, or some combination of those was used to evaluate all patients in the study, whereas single serology was considered to have a high risk of bias. Assessments were conducted in parallel, such that each study was examined by at least 2 of the investigators, and disagreements were resolved by consensus after discussion.

Statistical Analysis

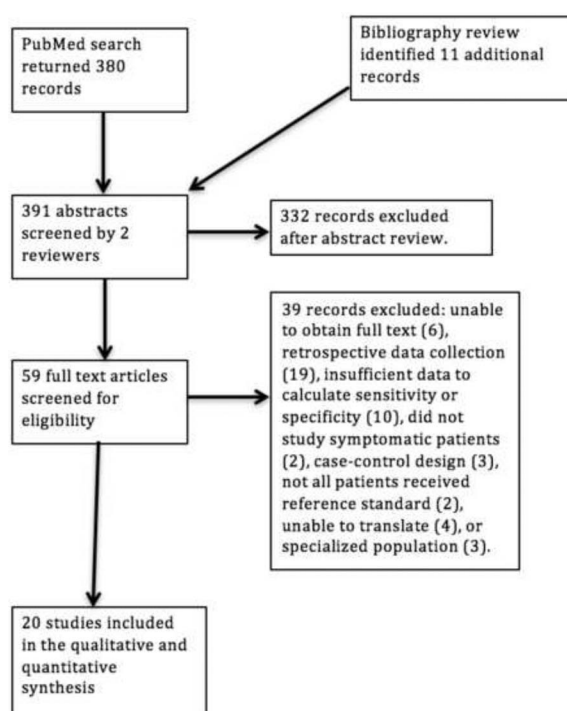
We performed bivariate meta-analysis using the meta and metafor procedures in R, version 3.2.2. We calculated summary estimates and 95% confidence intervals for sensitivity, specificity, positive

likelihood ratios (LR+), negative likelihood ratios (LR-), and diagnostic odds ratios (DORs) using the Reitsma method from the meta procedure. This method can only calculate summary estimates when both sensitivity and specificity are available. Some of the included studies did not report specificity. In these situations, the summary estimates of sensitivity were calculated using a random effects model of raw proportions using the metafor procedure. The raw proportion was the sensitivity for each symptom, calculated by the number of true positives divided by true positive plus false negative (TP/[TP + FN]). Two variables (headache and wheezing) had positive likelihood ratios <1.0, so we report the accuracy of the absence of these signs or symptoms. We used summary receiver operating characteristic (ROC) curves to explore heterogeneity and plot 95% confidence intervals for the summary estimates of accuracy.

Results

The results of the search process are summarized in the Preferred Reporting Items for Systematic Re-

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-analyses flow diagram. Only the first identified reason for excluding an article is listed. In some cases > 1 reason was identified.



views and Meta-analyses diagram (Figure 1). The initial MEDLINE search identified 381 studies, of which 17 were included; a review of the reference lists of included studies identified 5 more. Overall, 22 studies with a total of 15,909 patients met the inclusion and exclusion criteria. Their characteristics are summarized in Table 1. Twelve were set in Europe, 2 in Korea, and the remainder each in 1 of 8 countries in Australasia, Africa, or the Americas. Study size ranged from 32 to 3,629 patients. Nineteen studies used PCR, culture, or paired serology as the reference standard; only 3 studies used a single serology as the reference standard. Four studied adults only, 8 studied children only, and 10 studied both adults and children.

Quality Assessment

The quality assessment is summarized in Table 2, using the QUADAS-2 framework. Overall, we judged 14 studies to be at low risk of bias, 4 at moderate risk of bias, and 4 at high risk of bias.

Accuracy of Signs and Symptoms

The accuracy of individual signs and symptoms (reported by at least 3 studies) is summarized in Table 3 (full results by individual study are available in the online Appendix). The overall clinical assessment by the physician was the most helpful single piece of information at ruling in pertussis when positive, with an LR+ of 3.3, an LR- of 0.63, and a DOR of 5.3. While the overall impression of a physician was quite specific (0.85), it lacked sensitivity (0.47) and would therefore fail to identify more than half of patients with pertussis.

The following individual signs and symptoms were significantly associated with pertussis (LR+ and LR- both were significantly different from 1.0): whooping cough (overall and in children only), posttussive vomiting, paroxysmal cough, sputum, sleep disturbed by cough, and absence of headache. However, the likelihood ratios were all between 2.1 and 0.58, indicating little diagnostic value.

While paroxysmal cough was the most sensitive single finding, it lacked specificity (0.35) because it occurs in many other respiratory infections. The 3 signs or symptoms that were best at ruling out pertussis when absent or negative were the overall clinical assessment by a physician (LR-, 0.57), the absence of paroxysmal cough (LR-, 0.58), and the absence of sputum production (LR-, 0.63). Still,

Table 1. Characteristics of Included Studies

Studies	Patient Population	Patients (n)	Age	Adult or Child	Reference Standard	Country	Year(s) Recruited
Teepe et al, ¹³ 2015	Adults presenting with cough of <28 days' duration	3074	Mean, 50 years	Adult	PCR	12 European countries	2007–2010
Karagul, et al, ¹⁴ 2015	Consecutive patients between ages 10 and 39 years admitted to a hospital with at least 2 weeks of cough illness	214	Mean, 26.6 years; range, 10–39 years	Both	PCR*	Turkey	2010–2011
Park et al, ¹⁵ 2014	Patients with cough of <30 days' duration presenting to a hospital or outpatient clinic	490	Mean, 44.3 years	Both	PCR or culture	South Korea	2011–2012
Gentile et al, ¹⁶ 2014	Consecutive children with clinically suspected pertussis based on typical symptoms, prolonged cough (older children), or apnea (infants)	620	Median, 3 months; range, 15 days to 8 years	Child	PCR	Argentina	2003–2011
Philipson et al, ¹⁷ 2013	Consecutive patients aged 5–49 years with at least 2 weeks of cough	222	5–16 years (n = 70); 17–49 years (n = 156)	Child	Single IgG in oral fluid samples	New Zealand	2011
Miyashita et al, ¹⁸ 2013	Consecutive adolescents and adults with cough	1315	Mean, 37.5 years; range, 16–79 years	Adult	PCR and paired serology	Japan	2005–2012
Ghanaie et al, ¹⁹ 2010	Population-based sample of children with at least 2 weeks of cough	328	Mean, 11 years; range, 6–14 years	Child	PCR or culture	Iran	2007–2008
Harnden et al, ²⁰ 2006	Children presenting to a primary care physician with at least 2 weeks of cough	172	Mean, 9.4 years; range, 5–16 years	Child	Single or paired IgG serology†	England	2001–2005
Park et al, ²¹ 2005	Persons aged ≥16 years presenting to an outpatient clinic with cough of 1–12 weeks' duration	102	Mean, 30 years; range, 19–83 years	Adult	PCR and culture	Korea	2002–2003
Narkeviciute et al, ²² 2005	Immunized children with prolonged cough referred for evaluation in a hospital	32	Median, 11; range, 4–15 years	Child	Single IgM or IgA serology	Lithuania	2001
Liese et al, ²³ 2003	Children with cough for at least 7 days	116	Mean, 4.2 years; range, 2.2–6.0 years	Child	PCR or culture‡	Germany	1997–1999
Preziosi and Halloran, ²⁴ 2003	Children aged 6 months to 8 years with cough of >7 days' duration	989	Range, 6 months to 8 years	Child	Culture or serology	Senegal	1993

Continued

Table 1. Continued

Studies	Patient Population	Patients (n)	Age	Adult or Child	Reference Standard	Country	Year(s) Recruited
Gilberg et al, ²⁵ 2002	Adults with cough of 7–31 days' duration, without fever or other clear cause	123	Median, 49 years; range, 18–88 years	Both	≥2-fold anti-PT IgG, PCR, or culture	France	1999
Senzilet et al, ²⁶ 2001	Adults and adolescents with cough from 1–8 weeks' duration referred from a primary care sentinel surveillance network	442	Mean, 37.2 years; range, 12–90 years	Both	PCR, culture, and/or serology	Canada	1996–1997
Streibel et al, ²⁷ 2001	Persons aged 10–49 years with acute paroxysmal cough or persistent cough 7–34 days' duration	212	Median, 35 years; range, 10–49 years	Both	PCR, culture, or serology	United States	1995–1996
Heininger et al, ²⁸ 2000	Patients enrolled in a vaccine trial or family members with at least 7 days of cough	392	NR	Both	PCR, culture, and/or serology	Germany	1991–1994
Heininger et al, ²⁹ 1997	All children presenting to a pediatrician with cough of ≥7 days' duration	2045	Mean, 4.3 years; range, 6 days to 41 years	Both	Culture	Germany	1990–1991
Schlapfer et al, ³⁰ 1995	Patients enrolled in a vaccine trial or family members with at least 7 days of cough	546	Mean, 4.7 years; range, child up to 47 years	Both	PCR or culture	Germany	1993–1994
Postels-Multani et al, ³¹ 1995	Adult members in a family with a child who has confirmed pertussis and who have a respiratory symptom	79	Mean, 36 years; median, 33 years; range, 19–83 years	Adult	Culture or serology [§]	Germany	1992–1994
Granstrom et al, ³² 1991	Consecutive patients with suspected pertussis seen at the outpatient clinic of a hospital	285	Median, 3.7 years; range, 0.3–63.2 years	Both	Culture or serology	Sweden	1986–1987
He et al, ³³ 1998	Adults and children with a complaint of paroxysmal cough of any duration	584	Median, 9 years; range, 7 days to 74 years	Both	PCR or culture	Finland	1994–1997
Heininger et al, ³⁴ 1993	Children and household contacts with cough illness	3629	Almost all (98%) aged ≤15 years	Child	Culture	Germany	1991–1992

*Pertussis positive: positive for insertion sequence 481(IS481) and pertussis toxin promoter (ptxA-Pr); Bordetella spp: positive for IS481 with a cycle threshold (Ct) value <35 and negative for ptxA-Pr; indeterminate: positive for IS481 with a Ct between 35 and 40, and negative for ptxA-Pr; negative: cycle threshold >=40.

†>100 Enzyme-linked immunosorbent assay units in a single sample, or a 4-fold change in titers.

‡Polymerase chain reaction (PCR) or culture from nasopharyngeal swab (cough >7 days) or serology (cough >21 days).

§Culture, >=100% increase in immunoglobulin (Ig) G or IgA antibodies to pertussis toxin (PT), filamentous hemagglutinin (FHA), and/or pertactin, or IgA antibody levels to PT, FHA, and/or pertactin at least 2 standard deviations above normal. NR, not reported.

Table 2. Assessment of Study Quality Using the QUADAS-2 Framework

Study	Concerns That Exist That Included Patients and That Index Test Results Were Interpreted Without Knowledge of Reference Standard (Y/N/U)				Likelihood That Conduct or Interpretation of Index Test Results Was Influenced by Knowledge of Reference Standard (H/L/U)		Applicability: Concerns That Exist That the Index Test Differs from the Review Question (Y/N/U)		Reference Standard Is Likely to Correctly Classify Patients as Having Pertussis (Y/N/U)		Reference Standard Was Interpreted without Knowledge of Index Test (Y/N/U)		Likelihood That Conduct or Interpretation of Reference Standard Introduced Bias (H/L/U)		Applicability: Concerns That Exist That the Reference Standard Do Not Match the Review Question (Y/N/U)		All Patients Received a Reference Standard (Y/N/U)		All Patients Received the Same Reference Standard (Y/N/U)		All Patients Included in the Analysis (Y/N/U)		Patient Flow Could Have Introduced Bias (H/L/U)		Overall Assessment of Risk of Bias (L/M/H)
	Consecutive or Random Sample Enrolled (Y/N/U)	Avoided Case-Control Design (Y/N/U)	Avoided Inappropriate Exclusion Criteria (Y/N/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	Likelihood That Patient Selection Could Have Introduced Bias (H/L/U)	
Teepe, 2015	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	Y	Y	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Karagul, 2015	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Park, 2014	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Gentile, 2014	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Miyashita, 2013	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Ghanie RM, 2010	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Park, 2005	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Heininger, 2000	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Heininger, 1997	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Granstrom, 1991	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Strehel, 2001	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	N	Y	Y	Y	Y	L	L	L
Gilberg, 2002	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
He, 1998	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Heininger, 1993	Y	Y	Y	L	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	L	L
Schapler, 1995	N	Y	Y	H	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	M	M
Philipson K, 2013	Y	Y	Y	L	Y	Y	L	N	N	N	N	U	U	H	Y	N	Y	Y	Y	Y	Y	Y	L	M	M
Hamden, 2006	Y	Y	Y	L	Y	Y	L	N	N	N	N	U	U	H	Y	N	Y	Y	Y	Y	Y	Y	L	M	M
Senzilet, 2001	U	Y	Y	U	Y	Y	L	N	N	Y	Y	U	U	L	Y	N	Y	Y	Y	Y	Y	Y	L	M	M
Narkeviciute I, 2005	Y	Y	Y	L	Y	Y	H	N	N	N	N	U	U	H	Y	N	Y	Y	Y	Y	Y	H	H	H	H
Liese JG, 2003	Y	Y	Y	L	Y	Y	L	N	N	N	N	U	U	H	Y	N	Y	N	Y	Y	Y	H	H	H	H
Postels-Multani, 1995	N	Y	Y	H	Y	Y	L	N	N	N	N	U	U	H	Y	N	Y	N	Y	Y	Y	H	H	H	H
Preziosi and Halloran, 2003	Y	Y	Y	L	Y	Y	L	N	N	N	N	U	U	H	Y	N	Y	N	Y	Y	Y	H	H	H	H

H, high; L, low; M, medium; N, no; U, unknown; Y, yes.

Table 3. Summary Estimates of the Diagnostic Accuracy of Signs and Symptoms for *Bordetella pertussis* Infection*

Sign or Symptom	Studies*	Sensitivity (95% CI)					Specificity (95% CI)	LR+ (95% CI) [‡]	LR− (95% CI) [‡]	DOR (95% CI) [‡]	AUROCC [‡]
		Studies Reporting Sensitivity and Specificity	All Studies [†]								
Overall clinical impression	4/5	0.47 (0.36–0.59)	0.48 (0.39–0.58)				0.85 (0.71–0.93)	3.3 (1.9–5.5) [§]	0.63 (0.56–0.70) [§]	5.3 (3.3–8.1) [§]	0.659
Whooping cough											
All	12/17	0.31 (0.23–0.41)	0.31 (0.24–0.40)				0.84 (0.74–0.91)	1.9 (1.2–3.1) [§]	0.83 (0.73–0.95) [§]	2.5 (1.4–4.2) [§]	0.545
Children	5/6	0.41 (0.24–0.61)	0.43 (0.29–0.57)				0.84 (0.52–0.96)	2.9 (1.2–7.3)	0.72 (0.60–0.84)	4.1 (1.4–9.8)	0.593
Adults	7/8	0.21 (0.16–0.28)	0.17 (0.11–0.23)				0.82 (0.70–0.90)	1.2 (0.81–1.8)	0.97 (0.81–1.8)	1.3 (0.75–2.0)	0.349
Posttussive vomiting											
All	14/19	0.42 (0.33–0.52)	0.45 (0.35–0.54)				0.75 (0.68–0.80)	1.7 (1.4–1.9) [§]	0.77 (0.68–0.86) [§]	2.2 (1.7–2.7) [§]	0.646
Children	5/7	0.56 (0.39–0.72)	0.55 (0.41–0.68)				0.66 (0.52–0.78)	1.7 (1.3–2.2)	0.67 (0.49–0.84)	2.6 (1.6–3.9)	0.650
Adults	7/8	0.34 (0.26–0.43)	0.35 (0.27–0.42)				0.80 (0.74–0.84)	1.7 (1.3–2.3)	0.83 (0.73–0.93)	2.0 (1.3–3.0)	0.602
Paroxysmal cough											
All	13/16	0.80 (0.71–0.86)	0.79 (0.73–0.86)				0.35 (0.24–0.49)	1.2 (1.1–1.4) [§]	0.58 (0.49–0.68) [§]	2.2 (1.7–2.7) [§]	0.653
Children	5/7	0.72 (0.60–0.81)	0.75 (0.65–0.84)				0.47 (0.32–0.62)	1.4 (1.2–1.7)	0.61 (0.52–0.72)	2.3 (1.6–3.1)	0.644
Adults	6/6	0.88 (0.80–0.92)	=				0.26 (0.12–0.47)	1.2 (1.04–1.6)	0.50 (0.33–0.75)	2.6 (1.4–4.4)	0.774
Sputum production	4/4	0.79 (0.52–0.93)	—				0.34 (0.18–0.56)	1.2 (1.1–1.3) [§]	0.63 (0.39–0.89) [§]	2.0 (1.3–3.0) [§]	0.555
Wheezing absent	4/4	0.75 (0.34–0.95)	—				0.36 (0.17–0.62)	1.1 (0.90–1.3)	0.69 (0.31–1.1)	1.9 (0.83–3.8)	0.514
CDC clinical criteria	3/3	0.90 (0.82–0.95)	—				0.16 (0.13–0.19)	1.07 (0.97–1.1)	0.66 (0.33–1.1)	1.8 (0.86–3.4)	0.19
Headache absent	3/3	0.60 (0.38–0.85)	—				0.54 (0.24–0.81)	1.3 (1.05–1.8) [§]	0.76 (0.51–0.95) [§]	1.8 (1.1–2.7) [§]	0.588
Sleep disturbed by cough	5/6	0.55 (0.21–0.85)	0.56 (0.31–0.80)				0.54 (0.19–0.85)	1.2 (1.0–1.5) [§]	0.83 (0.69–0.95) [§]	1.5 (1.1–1.9) [§]	0.557
Dyspnea	4/4	0.21 (0.09–0.42)	—				0.84 (0.57–0.95)	1.3 (0.92–1.9)	0.96 (0.90–1.05)	1.4 (0.89–2.1)	0.467
Sneezing	4/4	0.78 (0.58–0.90)	—				0.23 (0.13–0.36)	1.00 (0.87–1.09)	0.97 (0.63–1.4)	1.1 (0.65–1.7)	0.423
Apnea	5/6	0.07 (0.02–0.22)	0.10 (0.03–0.17)				0.93 (0.83–0.97)	1.0 (0.64–1.5)	0.99 (0.94–1.02)	1.0 (0.64–1.5)	0.606
Cyanosis	4/4	0.05 (0.01–0.24)	—				0.95 (0.79–0.99)	0.99 (0.66–1.4)	1.0 (0.96–1.02)	1.0 (0.67–1.4)	0.545
Chest pain	3/3	0.25 (0.16–0.37)	—				0.74 (0.67–0.80)	0.96 (0.72–1.2)	1.01 (0.92–1.1)	0.95 (0.67–1.3)	0.55
Fever	7/8	0.13 (0.05–0.29)	0.17 (0.05–0.29)				0.82 (0.71–0.90)	0.76 (0.45–1.2)	1.0 (0.95–1.1)	0.73 (0.41–1.2)	0.549

The estimates presented here include only signs and symptoms for which at least 3 studies reported both sensitivity and specificity. Entries are sorted by diagnostic odds ratios.

*Data are the number of studies with reported values for both sensitivity and specificity among the total studies found.

†When studies reported sensitivity only, sensitivity was calculated using a random effects model.

‡These values were calculated using only data from studies that were able to calculate both sensitivity and specificity.

§Value is significantly different from 1.0.

CDC, Centers for Disease Control and Prevention; CI, confidence interval; DOR, diagnostic odds ratio; LR+, positive likelihood ratio; LR−, negative likelihood ratio; AUROCC, area under the receiver operating characteristic curve (also known as the c-statistic).

these LR– values are quite close to 1.0 and are therefore only minimally helpful.

Because prolonged cough was often part of the inclusion criteria, it was not reported by most studies as a clinical variable. When it was reported, studies generally indicated the overall duration of cough for the episode of illness, rather than the duration of cough at the time the patient initially presented to a clinician. Two studies did report the likelihood of pertussis for patients with cough for >2 weeks at presentation, compared with a shorter duration. One was a large, contemporary European multicenter study that enrolled 3074 patients, of whom 93 had pertussis by PCR. Pertussis was more likely among patients with cough for >2 weeks, but the sensitivity was only 27% and specificity 82% (LR+, 1.5; LR–, 0.89).¹³ An older study also reported data for this variable, but similarly did not find it to be a helpful predictor of pertussis (LR+, 1.1; LR–, 0.98).³⁰

We were able to evaluate separately for adults and children the accuracy for 3 key symptoms: whooping cough, posttussive vomiting, and paroxysmal cough. Both whooping cough (41% vs 20%) and posttussive vomiting (56% vs 34%) were more sensitive in children, although the specificity was similar. The LR+ for whooping cough was 4.1 in children and only 1.4 in adults.

No studies of a clinical decision rule (CDR) combining data for several signs and symptoms met our inclusion criteria. One study used the combination of symptoms and the local prevalence of pertussis for the week in which a sample was drawn to predict the likelihood of infection. However, it gathered data retrospectively and has not been prospectively or externally validated.³⁵ The CDC has defined the clinical case for pertussis as cough for ≥ 14 days plus at least 1 other typical symptom (paroxysms of cough, inspiratory whoop, or posttussive vomiting). Three studies reported the accuracy of the CDC criteria, with summary estimates of accuracy at 90% sensitivity, only 16% specificity, LR+ of 1.1, and LR– of 0.66.^{19,25,27}

Summary ROC Curves

Summary ROC curves for key signs and symptoms are shown in Figure 2A through D, stratified by age, where possible. The ROC curve for the overall clinical impression (Figure 2A) shows good consistency and a fairly narrow confidence interval around the summary estimate of accuracy. As noted

earlier, whooping cough (Figure 2B) and posttussive vomiting (Figure 2C) were both more sensitive in children than in adults. Apnea and cyanosis (Figure 2D) are plotted together because they had very similar sensitivity and specificity values. Of 4 studies reporting data for cyanosis, 3 found that it was highly specific (>0.95) but lacked sensitivity.

Vaccination Status

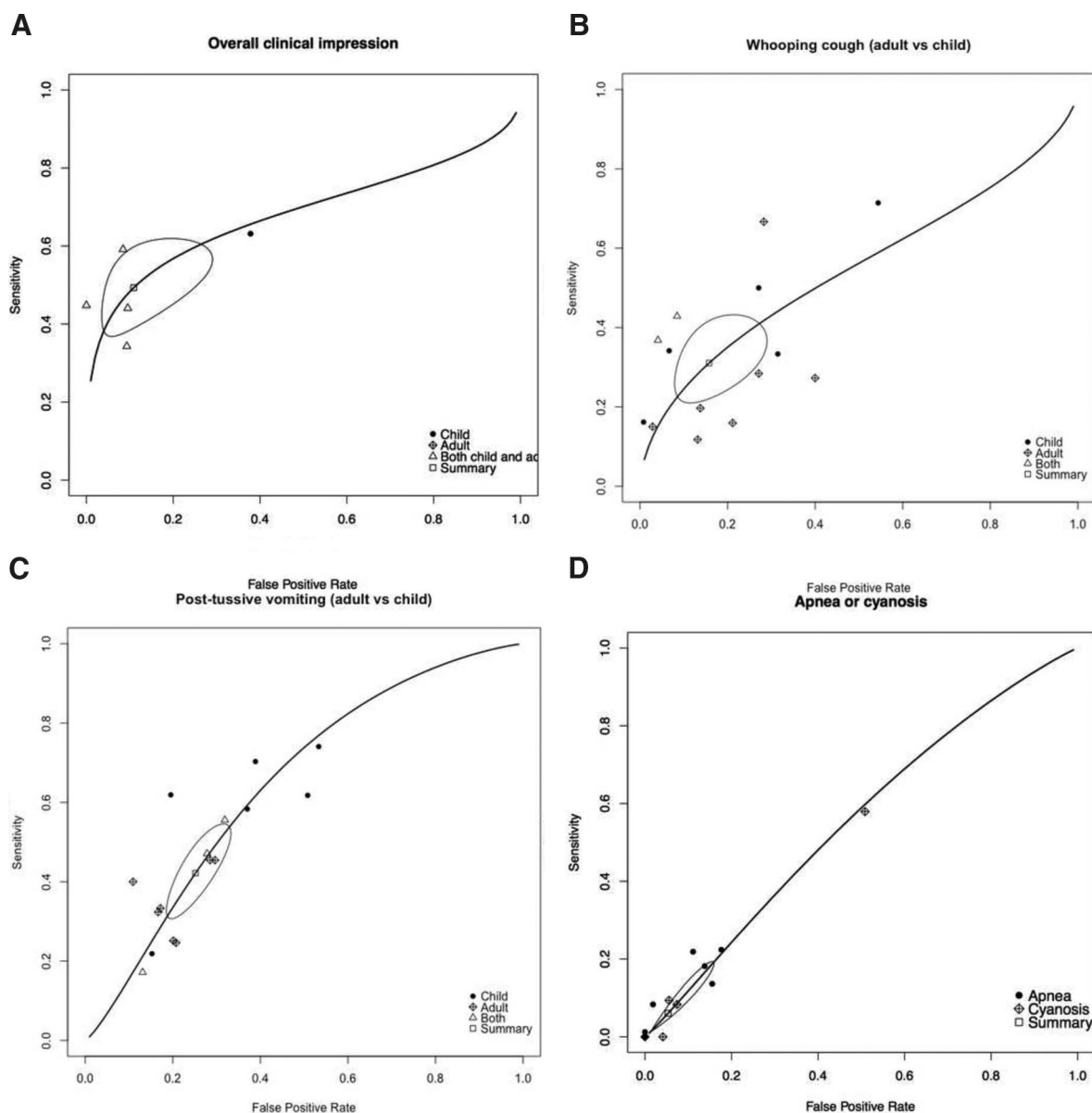
Summary ROC curves comparing populations that have high rates of vaccination with those that have low rates are shown in Figure 3A through D. Given the small number of studies in these comparisons, the ability to draw inferences is limited, and the data should be interpreted cautiously. The observed pattern based on these limited data is that in a vaccinated population, typical signs and symptoms of pertussis are more sensitive but less specific than those in an unvaccinated population.

Discussion

We have reviewed the best available evidence regarding the clinical diagnosis of BP infection in adults and children. The overall quality of the included studies, aided by the strict inclusion criteria of our systematic review, was good, with over half at low risk of bias. Unfortunately, we must conclude that individual signs and symptoms are of limited value, with none having an LR+ >2.1 or an LR– <0.5 . The exception is the overall clinical impression, which had an LR+ of 3.3 and an LR– of 0.63. While the overall clinical impression has excellent specificity, it lacks sensitivity and would fail to identify half of the patients with pertussis. However, it clearly suggests that when a clinician has a strong clinical suspicion for pertussis, he or she should trust that suspicion and order confirmatory testing. Of course, the positive predictive value depends on the prevalence of pertussis. For example, it is 15% when the prevalence is 5%, 27% when the prevalence is 10%, and 45% when the prevalence is 20%.

Our overall summary estimates of accuracy were similar to those of a previous systematic review.¹ However, we identified a number of additional studies, including 7 published since that review, and were able to stratify our results by adult versus child and vaccinated versus unvaccinated populations. Two symptoms, whooping cough and posttussive vomiting, were more sensitive in children

Figure 2. Summary receiver operating characteristic curves for overall impression (A), whooping cough (B), posttussive vomiting (C), and apnea or cyanosis (D), stratified by age.

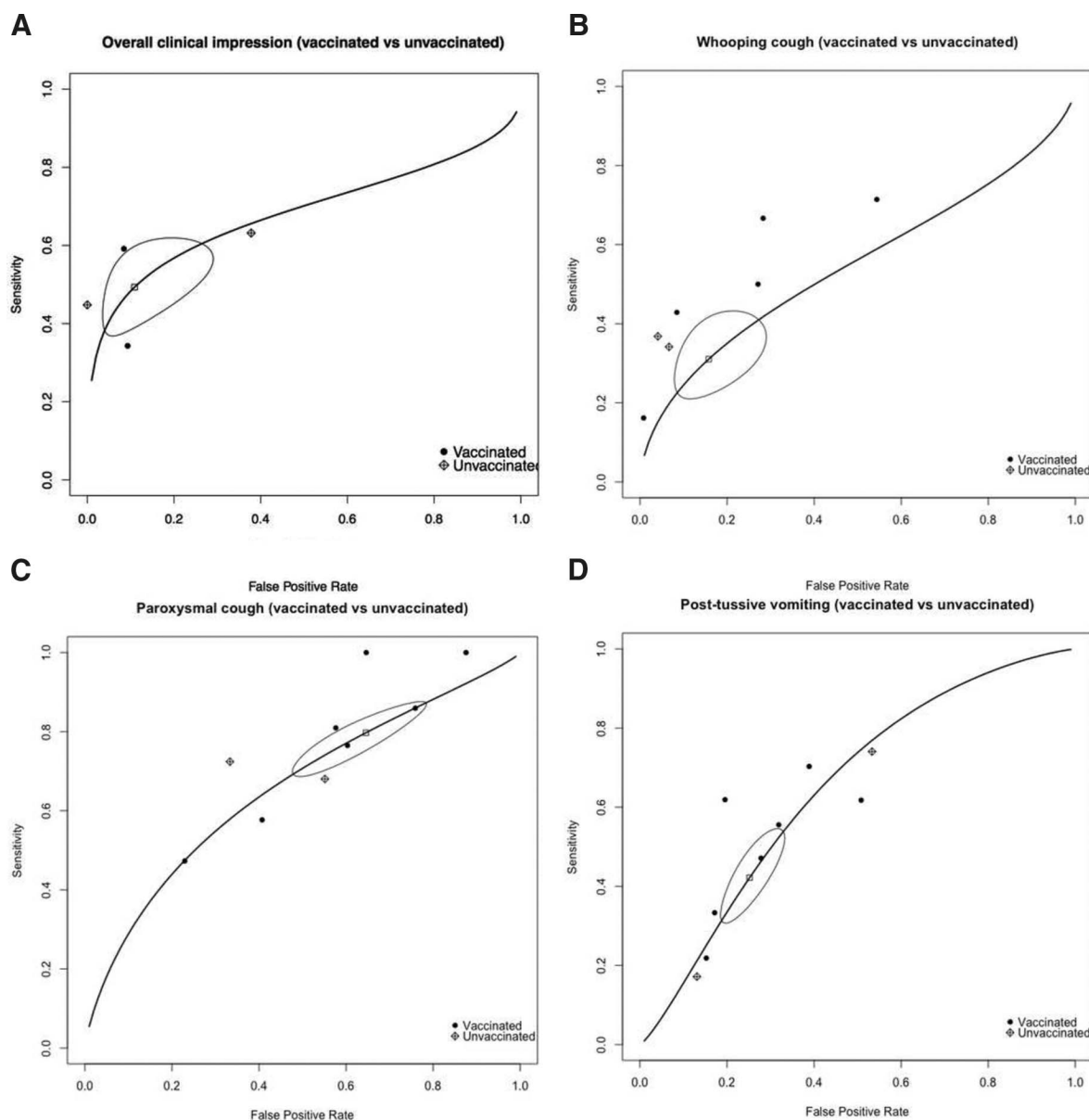


than in adults. This may be because of physiologic differences in airway size in children versus in adults; aerophagia, which is more common in children than in adults; and possibly a lower threshold for vomiting in children than in adults. Whooping and posttussive vomiting are therefore less diagnostically useful in adults, and the absence of these symptoms does not rule out pertussis in this group.

Based on a review of the ROC curves, it seems that typical signs and symptoms of pertussis are more sensitive but less specific in a vaccinated pop-

ulation than in an unvaccinated population. More sensitive signs and symptoms may have their greatest value in ruling out pertussis when negative. However, the small number of studies makes it difficult to draw conclusions, highlighting the need for studies of clinical diagnoses among contemporary vaccinated populations. These possible differences in the presentation between vaccinated and unvaccinated populations makes it important that we perform contemporary, well-designed, and adequately powered studies of signs, symptoms, and CDRs, as older data may no longer apply to the

Figure 3. Summary receiver operating characteristic curves for overall impression (A), whooping cough (B), paroxysmal cough (C), and posttussive vomiting (D), stratified by vaccination status.



many parts of the world where >95% of the population is vaccinated.

Our systematic review had several limitations. Data regarding the duration of a symptom or combination of symptoms and their association with the diagnosis were limited. The area under the summary ROC curves calculated by the mada procedure were somewhat unreliable because of sparse data and clustering of data in 1 part of many of the curves. The small number of studies for comparing vaccinated with unvaccinated populations limited our ability to draw conclusions, and some studies

were quite old. Finally, considerable heterogeneity exists for common symptoms of pertussis, such as whooping cough and paroxysmal cough. This could be a result of differences in how the question was asked or differences in the population (adult vs child, vaccinated vs unvaccinated).

An important gap in the literature is the lack of validated CDRs. CDRs have been useful in other acute respiratory infections such as pharyngitis³⁶ and pneumonia.³⁷ They typically classify patients as low, moderate, and high risk; these categories correspond to patients in whom disease is ruled out,

further testing is needed, or disease is ruled in.^{38,39} We identified only 1 CDR for pertussis; it is for infants and incorporates surveillance data but has not been prospectively validated.³⁵ The CDC's definition of a clinical case could be considered a kind of CDR; however, it is sensitive but very nonspecific (16%). This reflects the fact that it is a clinical case definition intended for use in outbreaks, with the knowledge that more specific confirmatory testing with culture or PCR would be available.

CDRs for other conditions have sometimes incorporated point-of-care tests such as C-reactive protein or procalcitonin^{40,41}; this is a promising area for further research in the diagnosis of pertussis. Another, as demonstrated by Fine and colleagues,^{35,42} is the incorporation of surveillance data or novel approaches like using Google searches to predict the prevalence of pertussis.

To see this article online, please go to: <http://jabfm.org/content/30/3/308.full>.

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