VCHIP CHAMP VDH COVID-19

December 14, 2020 | 12:15-12:45pm Call Questions and Answers*

Wendy Davis, MD, FAAP, Vermont Child Health Improvement Program, UVM
Breena Holmes, MD, FAAP, Physician Advisor, Maternal & Child Health, Vermont Department of Health (VDH), VCHIP Senior Faculty

Vermont in the News

Wendy Davis, MD, VCHIP: Thanks to Dr. Buzz Land for sharing the map showing how we compare in terms of the current state of things across the country. This graphic (see slides) is showing the 50 places that are at the highest COVID-19 risk level and wonderful Vermont is at the lower risk level.

VDH Update: Testing

Breena Holmes, MD, VCHIP & VDH: We continue to be feeling that this capacity for testing in Vermont is good. If that's not accurate or not your experience at a local level, then I want to hear from you. In terms of turnaround time, people were getting results within 2-3 days IF they used hospital sites or on-demand sites. If you're not getting test results within a couple of days or you don't have good community access, then I would like to know that today. I know you've been very patient. At this point, if you're waiting more than three days, let me know, and I'm going to try to navigate this. The infectious disease doctors were feeling there was some risk to using dual rapid tests for flu and COVID-19. We should have something definitive to tell you by Wednesday. We are experiencing a low level of flu in Vermont, and that makes the rapid test for flu less accurate due to low prevalence.

VDH Update: Schools

Breena Holmes, MD, VCHIP & VDH: VDH has not recommended that any schools go remote. We have only recommended that certain pods go remote due to cases. The Winooski community is experiencing an outbreak. We are back to having daily conversations with Winooski about contact tracing, access to testing, and communications with families. The Winooski school district is now deciding to go remote until January. The consistent, persistent ongoing communication among us has to be the same. It's still safe to be in schools. Most schools only have one case. As we've said from the beginning, as goes the community, so goes the schools, and that's been our experience since September.

VDH Update: Schools and COVID-19 Stigma

Wendy Davis, MD, VCHIP: I should have pointed out on this slide and I will add it for the final that what I'm showing you all in terms of cases is actually from a public news source, WCAX. We try to not be too Chittenden County centric on these calls, but I do know this may perhaps impact more of you in our catchment area. So, this is this is gleaned both from WCAX and communications from Superintendent Tom Flanagan, who has been a very consistent communicator.

Breena Holmes, MD, VCHIP & VDH: The standard template letter from schools about positive cases in schools will have a stigma paragraph. When classes go remote, the students know which student is the positive. The kids hate learning remotely, and there's been some very direct bullying when pods have to go remote because of a positive student case. It's somewhat unbearable to be a person with COVID, especially when it comes to the care of children.

*Note: This is a paraphrased synopsis of the call and is not a word-for-word transcription.

CDC Update: COVID-19 Vaccine Calls/Information

Wendy Davis, MD, VCHIP: We thought we would defer a little bit more information on the vaccine to Wednesday's call because there another CDC outreach call for physicians today. We will try to have a team member listen to that and will wrap some of those recommendations into the information we include on Wednesday's call. We are hoping Chris Finley and Martha Plumpton can be on our call on Wednesday with more information. The most we've heard about delivery time is sometime this week.

Practice Issues – Asthma Update 2020: NAEPPCC Expert Panel Recommendations *by Thomas Lahiri, MD FAAP – Director, Pediatric Pulmonology, UVM Children's Hospital*

Thomas Lahiri, MD, UVMCH: For the purposes of this brief talk, these abbreviations are what are going to appear in some of the slides for short acting, long acting, bronchodilators, inhaled corticosteroids, long acting muscarinic antagonists in leukotriene receptor antagonists. These guidelines have not been updated since 2007. It's been 13 years since we've had updated guidelines. The guidelines break up the management of asthma by age group (ages 0-4, 5-11 and 12+). There have been a couple of important changes noted. For young children ages 0-4 diagnosed with intermittent asthma, having two or three isolated episodes of wheezing, there is a recommendation for possibly considering a short course of daily inhaled corticosteroid for 7-10 days and using combination inhaled corticosteroid, long acting bronchodilators for step three and above as maintenance treatment.

It has been somewhat controversial over the past decade whether or not a short course of inhaled corticosteroid will help or not. I think most infants and young children we follow don't cleanly fall into this category of being truly intermittent. Most kids in a daycare or child care setting will have more frequent symptoms, and are probably still best served by using daily inhaled corticosteroids throughout the fall and winter months, at least by using concomitant inhaled corticosteroids for 7-10 days. In short, acting bronchodilators at the onset of symptoms was a recommendation of the panel. This is based on studies using very high doses of budesonide 1 milligram twice daily, which is two to four times the usual maintenance dose, so this is not low dose Flovent we're talking about.

For children ages 5-11, steps 3 and 4 indicate using combination inhaled corticosteroids both daily and as needed. Furthermore, formoterol is now recommended. This is called SMART therapy. If a patient is adherent to daily corticosteroid treatment, it's not necessarily recommended to increase inhaled corticosteroid dose for acute symptoms. In a transient manner, there's no clear benefit of increasing inhaled corticosteroid dose for kids who are over 12 years of age. If you suspect they're adherent, using daily inhaled corticosteroids and as needed short acting bronchodilator is still the mainstay. However, if you feel the patient is not adherent, you can also consider using inhaled corticosteroids for youth ages 12 and up as needed. There's also recommendations about it for patients that are over 16 years old, considering quadrupling the dose of inhaled corticosteroid for those who are experiencing exacerbation of symptoms with questionable or poor adherence, so adherence plays a huge role here. Using the previous guidelines in terms of your maintenance treatment may be completely adequate if you have adherent patients. However, in situations where you suspect adherence is suboptimal, using as needed inhaled corticosteroid is another option.

The suggested maximum daily inhaled corticosteroid dose for intermittent use are 36 mcg (8 puffs) for ages 4-11 and 54 mcg (12 puffs) for ages 12 and up. There aren't very good recommendations in the document aside from referring to the one milligram twice daily budesonide, so these are dose equivalents grouped in

pediatric terminology. If patients are receiving frequent, intermittent high doses of inhaled corticosteroids, then you should really go to combination therapy with LABA on a daily basis and not just do this intermittent stuff if their symptoms are not well controlled.

For the 12 and up category, you can see even beginning at step 2 the traditional guidelines for using low dose inhaled corticosteroids and as needed bronchodilator. Now the recommendation also exists for the concomitant PRN inhaled corticosteroid and short acting bronchodilator. Then, at step 3 and above, using combination therapy with inhaled corticosteroids and formoterol, both for daily and as needed therapy.

There is a growing body of evidence that single maintenance and reliever therapy, called smart therapy, with inhaled corticosteroids and formoterol may be more effective. Thus, it should be considered for step 3 and above, especially in those ages 12 and up. It is not necessary to go to this route if you're doing well on your usual inhaled corticosteroid and as needed short acting bronchodilator. However, for those with more difficult to control symptoms, you can use the same combination inhaler for rescue therapy or reliever therapy in addition to maintenance therapy. I certainly have evidence for those ages 12 and up. The certainty is a little bit lower for those ages 4 to 11. It should be noted this is really only referring to combination inhalers that use formoterol, including both Symbicort and Dulera, but not Advair, which has salmeterol all as a long acting bronchodilator.

Formoterol has a rapid onset of action similar to that of albuterol and a good safety profile. The maintenance dose mcg should be 1-2 puffs once or twice daily, but you can go up to 8 puffs daily for 4-11 year olds and 12 puffs daily based on the formoterol dosing for those 12 and up so you can use this just like you would use albuterol. For reliever therapy during acute exacerbations, this may have big implications in terms of how inhalers are covered through Medicaid or insurance. Right now, you can only get one inhaler a month, and if you're using single maintenance and reliever therapy, you need to be able to get more than one inhaler at a time. So, using SMART therapy may have less impact on linear growth compared to high dose inhaled corticosteroids, better asthma control measures, and reduction of exacerbations. So, SMART therapy is now the preferred regiment for Step 4 in children 12 years and up. However, it’s not to be used with Salmeterol.

Long acting muscarinic agents like Tiotropium (Spiriva) can be used in children 12 years and over. It is not the preferred therapy. With inhaled corticosteroids, the ICS-LABA is preferred, but a LAMA (muscarinic agent) can be added if asthma control is suboptimal on that combination ICS-LABA. It can be considered as an add-on therapy to inhaled corticosteroids if a patient can't take a LABA for whatever reason. Also, if you have a patient with glaucoma or at risk for urinary retention, you should use LAMAs with extreme caution.

Leukotriene receptor antagonists (LTRA) were not specifically addressed in these guidelines. The new guidelines suggest continuing to offer LTRA as an alternative for monotherapy (step 2) and as adjunct therapy for higher steps. Most of you are aware there is a black box warning for Montelukast regarding behavioral and mood side effects that we do see at significant frequencies. So, there should be cautionary use in children and adolescents, especially for those with a history of depression or mood disorders.

Finally, there was some discussion about the use of fractional exhaled nitric oxide (FeNO) testing for the diagnosis of asthma, as a marker of T2 bronchial/eosinophilic inflammation. It can be a useful adjunct test and we do perform this at the University of Vermont Children's Hospital. It is mostly used in conjunction with spirometry.

*Note: This is a paraphrased synopsis of the call and is not a word-for-word transcription.

Questions/Discussion:

Q: The availability of testing is great at the CIC site at BMH afterhours and we have found the turn-around time is terrific - sometimes back in under 24hr.
A: Breena Holmes, MD, VCHIP & VDH: Yes, those CIC sites go to Broad and they've really become quite efficient.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: That is good news.

Q: I've been trying to register for an account for the asymptomatic testing but am not receiving an email with registration info. I have tried several addresses and checked spam folders. Is something up with the system?
A: Breena Holmes, MD, VCHIP & VDH: Not to my knowledge but if you want to email me directly, I can get you to someone who can help you with that.

Q: Is there any specific recommendation for a specific time interval between COVID illness and COVID vaccine? Or can patients get the vaccine no matter how long since illness (as long as isolation period completed)?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: No. There is some subtlety not to give vaccine to those currently infected and to consider waiting 3 months in those currently infected. Otherwise, for the most part, we do not take into account previous COVID infection.
A: Wendy Davis, MD, VCHIP: We thought we would defer a little bit more information on the vaccine to Wednesday's call because there is another clinician outreach call by the CDC today and that is entitled "What Every Clinician Should Know about COVID-19 Vaccine Safety" and that immediately follows our call. It's from 1:00 to 2:00 PM Eastern. The link is on this slide, but we will try to have our team member listen to that and then we'll wrap some of the most relevant recommendations into some of the information that we present on Wednesday. I'm also hoping that either Chris Finley or Meredith Plumpton might be able to be on with us on Wednesday to answer further questions. We've been in touch with them through the weekend and they're certainly following this story. I think the best we've heard about delivery time here is sometime this week. Others may know more specifics about that. I will say based on my listening to the call yesterday that I took away that post COVID-19 patients should still be offered the vaccine and that regardless of whether they were symptomatic or not, that appears to be safe. Don't recommend antibody testing and certainly defer if they're still symptomatic or within their own isolation period. So, in part, that's to not expose the health care personnel who may be administering the vaccine, but no waiting interval is required after disease recovery. And it was also noted, and I think this is some of the subtleties that Dr. Raszka is talking about, that because reinfection we now are thinking is somewhat uncommon within 90 days of recovery, and you may recall that was part of our discussion last week that patients who wish to delay for three months could be accommodated.

Q: Was there anything new about treatment of cough variant asthma?
A: Thomas Lahiri, MD, UVMCH: No, I don't think we distinguish between cough variant and non-cough variant and asthma. I think if the symptoms are consistent with asthma you would use the same treatment algorithm that exists in these guidelines. These guidelines are very dense, 322 pages. So it's almost impossible to get through in its entirety, but know that the classification scheme you can call cough as the respiratory symptom that you're following. It doesn't necessarily have to be wheezing if it's bronchodilator responsive or corticosteroid responsive in the past, I think using the algorithm that in place would be what I would use for both cough variant or non-cough variant and wheezing associated asthma.

*Note: This is a paraphrased synopsis of the call and is not a word-for-word transcription.

Q: Do you run into difficulties with insurance covering Symbicort and Dulera? I tried switching a kid and the inhaler was too expensive for the family to afford so we stuck with daily ICS.
A: Thomas Lahiri, MD, UVMCH: These inhalers are ridiculously expensive, all of them, the inhaled corticosteroids and the combination inhalers. We are having difficulties being able to prescribe more than one Symbicort® or Dulera at a time. Now that the guidelines have been published just very recently, we hope that insurance carriers will recognize the need for giving more than one inhaler. I've heard that the adults have been able to do this, but I haven't. I know my partners and I were having this discussion about whether we're going to be able to get multiple Symbicorts dispensed in a month if a patient needs them. That is recommendation for guidelines, so hopefully the insurances, including Medicaid, will follow suit. But in terms of the cost, if you're on Medicaid, it usually shouldn't be an issue once this is understood on formulary, but for other insurances, if you have a big copay, this is a huge cost and so it might be a reason where you don't go to combination therapy because of cost.

Q: And for maintenance (not SMART), is Advair still considered equally recommended as Symbicort?
A: Thomas Lahiri, MD, UVMCH: I view all three of the available combination inhalers as equal. So there's no reason, if you have somebody who is well controlled on Advair, to not keep them on Advair. That's totally acceptable. If you have to increase the dose to four to six times a day, I would not use Advair for that purpose.

Q: If you have any comments specific to our current context of both COVID-19 illness and influenza, although we're not seeing significant influence at the moment as we've been sporadic as a state, but anything to add there?
A: Thomas Lahiri, MD, UVMCH: No, I think even our children with chronic respiratory disease have not been significantly affected, at least in Vermont and our catchment area by COVID per say. We still have a lot of concern about respiratory patients due to neuromuscular diseases being the highest risk category. Asthmatics, if you look across the country, have been doing pretty well overall, especially young asthmatics. We are seeing rhinovirus triggered exacerbations, so rhinovirus is alive and well in the community and making its rounds and that's probably what we're seeing in terms of exacerbations that are out there right now.