

VCHIP CHAMP VDH COVID-19

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Wendy Davis, MD, FAAP, Vermont Child Health Improvement Program, UVM

Breana Holmes, MD, FAAP, Director of Maternal & Child Health, Vermont Department of Health (VDH)

Pediatric SARS-CoV-2 Studies

Wendy Davis, MD, VCHIP: Many of us were taken aback by the publication in the last 24 hours from a group at Massachusetts General Hospital (MGH) titled “Pediatric SARS-CoV-2: Clinical Presentation, Infectivity, and Immune Responses.” The AAP daily briefing headline this morning indicated this research suggests children have higher levels of SARS-CoV-2 in their airways than the most severely ill adults.

William Raszka, MD, UVMCH & LCOM Dept. of Pediatrics: This article is a devastating article on so many fronts, primarily because I think it is actually incredibly misleading and inflammatory. I'll spend more time on this next week, but this is a very small study and they compared two children who were part of a program at MGH, which included PCR testing for COVID-19. They tried to quantitate the level of virus in the nose. They report high levels in the nose but neglect to mention their cutoff points are actually not consistent with high levels that would be infectious, as defined by researchers published in *Nature* or other scientific magazines. It's all about the single comparison, which is really unfortunate. The researchers compared the viral load they report in a small subset of their sample and children who are symptomatic in the first 2 days. The comparison group was adults who may have been symptomatic for at least 26 days. So, the groups they compared were radically different, which is inappropriate. A group of us will be writing a rebuttal to this. There are lots of other issues about them saying 20% of children were school aged. When people use PCR data to imply or infer infectivity, they're taking a giant leap, given there are a huge number of factors that go into establishing how infectious a child is.

Practice Issues: ALGORITHM: COVID-19 in Pediatric Patients: Triage, Evaluation, Testing and Return to School

William Raszka, MD, UVMCH & LCOM Dept. of Pediatrics: We listened to the advice from the community, which indicated a preference for an algorithm, so that's what we decided to do. I'm really appreciative of all the feedback from all of you. So many of you emailed really great suggestions and reviewed the protocol. We decided to break the algorithm into two separate pages. The first page has to do with what we initially called very high pretest probability, meaning that children had exposure to a patient with COVID-19 or participated in high-risk travel. We're really encouraging a COVID-19 test for those meeting criteria for high pretest probability. We try to keep the language pretty specific, however, there are some complications about a negative test with high risk exposure, which is why there are a lot of different things in there. However, we want to make sure people have a really clear algorithm for every scenario they might face. We would assume that the school nurses are probably not going to be so involved in the first page because that's all about people who've been traveling or with other high-risk exposure. Theoretically, children with high pretest probability should not be in the school environment, but we wanted to make sure you had that information as well. We wanted to get it out to you today with the evening email to make sure you could take a look at it to provide feedback and see if we've made any errors of omission by Monday.

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

Questions/Discussion

C: Melissa Kaufold, RN, UVM Health Network Home Health & Hospice; Family and Children's Program:
Subject: Staffing Remains A Top Concern As Vermont Child Care Centers Look To The Fall | Vermont Public Radio <https://www.vpr.org/post/staffing-remains-top-concern-vermont-child-care-centers-look-fall>.

Q: I have been asked by a parent to order COVID antibody testing for her children prior to them returning to school. They had febrile illnesses in early 3/2020 that may have been COVID. I want to make sure that the recommendation for VT children is to not do COVID antibody testing unless concerns about MIS-C. Is that still the current recommendation?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Yes, that has been our recommendation.

A: Breena Holmes, MD, VDH: If helpful, we have that serology workgroup recommendation on VDH website. <https://www.healthvermont.gov/sites/default/files/documents/pdf/VDH-SerologyWorkingGroup-FinalRecommendations.04.16.2020.pdf>

Q: Last week we got a PowerPoint regarding teachers and school opening. It was in the Tuesday/Thursday meetings. Does anyone know if this has been sent out to the schools or should we be sharing with schools that we are working with?

A: Breena Holmes, MD, VDH: You are welcome to share that PowerPoint with schools. They get it through school nurses and administrators but good to have shared resources. The link is in our schools/childcare section of the website.

Q: The private school in my area that was recommending shields in the classroom without masks are now on the same page as our recommendations.

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: We do not think face shields are equivalent. Good job changing that.

A: Breena Holmes, MD, VDH: <https://www.healthvermont.gov/response/coronavirus-covid-19/schools-colleges-child-care-programs>

Q: Studies indicating lower risk of spread by children were often done following closure of schools, more similar to the current situation locally. How do we project this will apply to school opening? What about cases in Israel school Georgia camp, etc.?

Q: I'm speaking to our local school staff/teachers next Thursday. I will be using some of the slide deck you provided, thanks! But, do you have talking points already somewhere for why it is safe to return, the numbers from VT (I have the info about kids transmitting etc.)? And also, anything in writing about face shields and use, i.e., when they can be used, for example in speech therapy, etc.?

A: Breena Holmes, MD, VDH: The facial shield answer is easy. There is great language in the guidance document under the facial covering section. I think the slide deck has a slide on the current VT statements (copied from AAP-VT press release) about this.

Q: What COVID-19 tests are acceptable for algorithm?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: These are not antigen tests. Please don't do an antigen test. These are PCR tests.

Q: With regards to your comment about repeating PCRs, we're getting more requests for repeating a positive, including request from contact tracing. Given high specificity and lower sensitivity (especially over time), why would we do this?

A: Monica Ogelby, Clinical Services Director, VDH: I'm not sure if it belongs in this algorithm but noting for providers that if a patient tests negative after testing positive, that does not discount the initial positive results. We're seeing a LOT of retesting because people don't believe they're positive. We do not recommend repeat testing for PCR tests. We treat a positive PCR as a positive specimen, not matter what subsequent testing results. The CDC does state that if someone has 2 negative tests at least 24 hours apart after testing positive, then they may end isolation. But this holds less and less water with time. We highly suggest people follow the time based recommendations for ending isolation.

Q: The only thing I still struggle with is kids who have several symptoms and no test, no alternative diagnosis? Or maybe I am reading it wrong. Is a cold and alternative diagnosis and is it a full 10 days? Or 24 hours no fever and symptoms improving?

A: Breena Holmes, MD, VDH: That's a hard one. Maybe we won't have the kid with the prolonged respiratory symptoms this year because of masks and hygiene and people staying home when they're sick! Yes, of course a cold is an alternate diagnosis. I just don't know how you're going to make that with the confidence without a test during the time of COVID. 24-hours no fever and I wouldn't say symptoms improving with respiratory symptoms, they have to be resolved.

A: Barbara Kennedy: The low risk column needs to connect with alternative diagnosis, for those kids that have single prolonged symptoms such, as diarrhea.

Q: So, the runny nose that has become clear, but still happens, does that qualify as "marked improvement"?

A: Breena Holmes, MD, VDH: The color of the nasal discharge does not line up perfectly with resolution. Some kids have clear and are quite ill and some kids have discolored, green and they're allergic or getting well.

Q: Sports question: should we be allowing locker room use?

A: Breena Holmes, MD, VDH: No, I would consider that a congregate setting like a gymnasium or a cafeteria. If you told me the locker room was big enough where kids could be 6 feet apart, with good ventilation and meets the HVAC requirements in our guidance, then I guess it's okay. But right now, schools are starting in step 2, which is not where the state is epidemiologically, but, that's where the schools want to start. It's very clear, no gymnasium and no cafeteria. So, that's no locker room. But in a few weeks, if the data stays good, there's going to be an expansion to step 3 which describes that you may consider using the gymnasiums and cafeteria. The language is "consider", so don't use them if you don't have to. They are very difficult settings to manage.

A: Ashley Miller SRHC: Thanks, I will clarify with schools.

Q: Is this saying that a kid who has cold symptoms but no test, has to stay home until 10 days after symptoms appeared? If that's the case, some kids are going to be home all winter, unless we really test frequently, which worries me about testing supplies running out.

A: Wendy Davis, MD, VCHIP: I think that falls into establishing the URI as the alternative diagnosis, but it's not easy.

A: Breena Holmes, MD, VDH: Yes, either establishing the alternative diagnosis or testing. The commissioner speaks to this frequently (about the test supplies). We're securing as many supplies as we can for college and school return, recognizing that we'll have to do a lot of symptomatic testing, being

very clear that the asymptomatic testing the colleges are doing is not on VT's supply. They are working with outside vendors. The school opening will lead to more testing and we've got solid supplies.

Q: Regarding face shields, I just searched the school opening document and did not see anywhere that it is ok to use them with speech therapy for the kids. Not sure if I missed it? So, I'm getting push back that they need to see the kid's mouths.

A: Breena Holmes, MD, VDH: We don't say it for the kids. We say it for the speech and language pathologists. Here's what we're saying about kids: We really don't want them in face shields but we're acknowledging that for that 40 minutes or 20 minutes in special education where a student is working with a speech and language pathologist, that if they really need to wear a face shield to get the therapy in, that's okay, but then they go right back to the cloth mask.

Re: flu clinics

C: Alex Bannach, MD, North Country Pediatrics: Our hospital is looking at organizing community-wide flu clinics in appropriately large spaces, as the patient flow in the office would not allow flu clinics due to distancing needs. Most of our community members (adults and kids) are already patients at the hospital practices and therefore admin challenges should be minimal. So, we will not be doing flu clinics in our office (we would see as many as 150-200 in a day and have 20 or more at the same time in the waiting room in the past, impossible this year).

C: Wendy Davis, MD, VCHIP: That sounds great! The CDC COCA call (were you on?) had some specific workflow diagrams.