AAP Chapter 3 COVID-19 Question & Answer Management Guidance

QUESTION	ANSWER
1. If a child has tested PCR positive for COVID-19, under what parameters can a WCC be considered?	Assuming that the child is asymptomatic for ≥72 hours, we suggest waiting 14 days from the onset of symptoms and repeating the PCR test. • If the test is negative, the patient may be scheduled for their WCC. • If the test is positive, we suggest weekly repeating of the PCR until it is negative before scheduling the next WCC. Note: If you are following a child with symptoms consistent with COVID-19 (but not test confirmed), it is reasonable to follow CDC clinical symptom guidelines. https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html
2. If a child has not been tested and is asymptomatic, but has had close exposure with a family member or other member who is COVID-19 PCR positive, under what parameters can a WCC be considered?	Assuming that the child cannot be separated from the symptomatic family member and that the COVID-19 family member will be symptomatic for up to 10 or more days, we would suggest using an additional 14 days from the last symptoms present in the family member, for monitoring for symptoms before considering a WCC (total of 24 days or greater).
3. In the case of a shared custody arrangement, what direction can we give if one parent tests COVID-19 PCR positive?	• The child(ren) should stay with the uninfected parent until the infected parent's PCP has cleared them to return to public. • If the child(ren) had close contact within 48 hours of the positive parent becoming symptomatic, they should be isolated with the uninfected parent for 14 days or until the infected parent is cleared by their PCP. • If the child(ren) become symptomatic following exposure to a COVID positive parent, testing should be strongly considered. Public Health should be consulted to determine where the child(ren) should stay presuming a positive test for the child(ren).
4. What guidance can you give us regarding whether a FMLA form can be completed for a parent wishing to remain at home with a child who has intermittent asthma, but is asymptomatic?	Paid family leave is available if a family member is unable to work because they are caring for an ill or quarantined family member with COVID-19 (certified by a medical professional). Unfortunately, this does not cover parents wishing to remain home with their children who they are worried about getting sick.
5. What would you consider to be "significant" risk with regards to considering testing?	Significant risk in terms of a pediatric patient would include underlying conditions that in particular are not well controlled: chronic lung disease or moderate to severe asthma, cystic fibrosis, smoking, vaping, serious heart conditions (similar to those that qualify for palivizumab/Synagis linked to poor pulmonary compliance), severe obesity, diabetes, liver disease, immunocompromised, chronic kidney disease w/ dialysis.

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6. Does mother to baby transmission of COVID-19 occur during pregnancy?	It is felt that transmission of the SARS-CoV-2 virus during pregnancy is unlikely, but that after birth, a newborn is susceptible to person-to-person spread.
7. Is it safe for COVID-19 positive mothers to breastfeed their babies?	Studies to date have not found the SARS-CoV-2 case in breast milk. Expressed breast milk obtained via a dedicated breast pump may be fed to infants by uninfected caregivers. Bearing in mind that there are differing opinions from the Academy of Breastfeeding Medicine, AAP, CDC and WHO policy makers with regards to separating mothers and babies, mothers should decide whether the choice of breastfeeding outweighs the risk of spreading COVID-19 to their newborn. Mothers who decide to breast feed should wear a facemask and wash their hands thoroughly before each feeding. https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/breastfeeding-guidance-post-hospital-discharge/
8. What is the preferred method of collecting a sample for COVID-19 PCR testing?	While acknowledging that the CDC has offered acceptable alternatives of oropharyngeal, mid-turbinate and anterior nasal swab collections, they also note that the nasopharyngeal (NP) specimen is the preferred choice. We feel that the farther back you go into the nose, the more likely are you are to have a 'sensitive' test to pick up virus. While a true NP swab causes great discomfort, during this time of the COVID-19 pandemic, sensitivity is more highly valued than comfort.
9. What PPE should I be wearing when collecting a COVID-19 PCR swab?	We recommend that the specimen collector wear a gown, gloves, N95 mask and face shield for NP specimen collections.
10. When performing a nebulizer treatment, what protection should I wear and how long do I need to close down the exam room for at our clinic (non-negative pressure room)?	For aerosol generating procedures such as nebulized treatments and deep suctioning, it is prudent to apply a similar time period used for pathogens spread by an airborne route (e.g. measles). Healthcare providers should not enter a room during a procedure or to clean it without an N95 mask, gown, gloves and eye covering until at least 1 hour has passed after completion of the procedure (depending in part, on the room air exchanges /hour). After such time, a regular mask can be substituted for an N95 mask during cleaning. Before new clinical patients can be seen in that room and (in reviewing CDC data), it is suggested to close down a room for a minimum period of 1 hour after use, assuming at least 6 air exchanges per hour. https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

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11. How long does an examination room need to remain vacant after being occupied by a patient with confirmed or suspected COVID-19 (presuming that no aerosol generating procedure was performed)?	If the patient and caregiver(s) have been masked for source control and all high touch surfaces have been thoroughly cleaned and disinfected, the examination room can be made available without further wait. If a patient (who might be actively coughing or sneezing) and/or caregiver(s) could not be masked during the entire visit, consider following guidance from Question #10 re aerosol generating procedures. Please note that in most cases, even without mask precautions, the risk of transmission to the next family and staff entering the room (having standard ventilation) should be minimal providing that high touch surfaces have been cleaned and disinfected.
12. What can you tell me about the sensitivity and specificity of COVID-19 PCR testing?	Sensitivity of PCR testing may depend upon the specimen collection technique, the site of specimen collection, the time since the onset of symptoms, and immune compromising conditions. For all of the FDA EUA approved PCR tests, the sensitivity is excellent early in the disease. Sensitivity begins to drop approximately 7 days into illness. Specificity is felt to be close to 100%.
13. What can you tell me about the sensitivity and specificity of COVID-19 serology (IgG) testing?	Sensitivity of the test also depends on the time since the onset of symptoms, with most tests only detecting about half of infected adults (measuring specific IgG/IgM antibody) by one week from the onset of symptoms. Sensitivity is much higher by 2-3 weeks from onset of illness. While specificity is quite high, positive IgG results may be due to a past or present infection with non-SARS-CoV-2 coronavirus strains, such as coronavirus HKU1, NL63, OC43, or 229E. As of May 14th, FDA EUA serology testing is only available through hospital and reference laboratories in most cases. Public health has strongly encouraged that antibody tests used have an FDA EUA and there are currently no waived (in-office) tests available with this designation.
14. What can you tell me about the sensitivity and specificity of COVID-19 antigen testing?	Antigen testing has become available with a FDA EUA and has the potential advantage of being performed as a rapid, point of care (in-office) test. Sensitivity of the test is felt to be as low as 80%. Negative results do not rule out an active COVID-19 infection and should be confirmed with PCR testing. Specificity is felt to be close to 100%, but cannot distinguish between a SARS-CoV-2 and a SARS-CoV infection. A positive result may be helpful with clinical decision making.
15. What guidance do you have regarding whom to focus our WCC efforts on?	The AAP has updated their guidance with a recommendation that all well-child care should occur in person whenever possible. Pediatricians should contact families whose children have missed well-child visits and/or recommended vaccines to schedule in person appointments. Well visits for children may be initiated through telehealth, recognizing that some elements of the well exam must be completed in-person and that payers may not be reimbursing for well-child telehealth visits.