COVID-19 Town Hall for Primary Care Providers
Thursday, January 6, 2022
Q & A Fact Sheet
Revised January 11, 2022

The following are questions submitted by primary care providers who attended a recent town hall event on COVID-19.

Please note: The CDC released new guidance shortly after the conclusion of this Town Hall in reference to isolation and quarantine recommendations and schools. Answers affected by this new information have been updated accordingly.

Q: How many deaths has Children's National experienced from COVID-19?
A: One

Q: Can you comment on how many post vaccine myocarditis admissions you have had?
A: There have been 16 possible post-vaccine myocarditis admissions to date, all of which are reported to VAERS for final adjudication. It is important to note that the background rate of myocarditis in the general population is 10/100,000. The rate of mRNA vaccine-associated myocarditis is 9/100,000 which is LESS than this background rate. The rate of COVID-19 disease-associated myocarditis is 150/100,000 which is 16 times HIGHER than the background rate.

Q: I've seen many mentions of increased testing accuracy when swabbing throats and noses. Could someone give us a sense of whether we should be swabbing more than one site, or different sites of each child? Also, can you provide information for people who are doing home tests - should they swab more than just the nose?
A: Mid- turbinate and anterior nares swabs are both utilized for testing using home tests. Each test has been validated by a specific method which is included in the test directions for that kit. The majority of people who are highly infectious with very high viral loads will be picked up by either method. CDC has guidelines for both methods, which can be found on their web site here: https://www.cdc.gov/coronavirus/2019-ncov/testing/self-testing.html. All tests have the same rate of false negativity regardless of the location used for swab, depending on the viral load present at the time of testing.

Q: What are the underlying conditions that you are seeing most frequently?
A: For primary COVID-19 hospitalization the most frequent underlying condition is obesity. Others overrepresented include neurologic/neurodevelopmental disorders, hematologic disorders (such as sickle cell disease), oncologic disorders, endocrine disorders (diabetes), cardiac disorders and respiratory disorders. Please note that in distinction to primary COVID-19 disease, for MIS-C hospitalization >80% of children have NO underlying condition.

For more detail on underlying disorders see #2 of our referenced publications below (one publication from our first wave of children (alpha) at Children's National, one from the CDC collaboration we just published with five other centers that looked at Delta wave specifically.

- DeBiasi RL, Song X, Delaney M, Bell M, Smith K, Pershad J, Ansusinha E, Hahn A, Hamdy R, Harik N, Hanisch B, Jantausch B, Koay A, Steinhorn R, Newman K, Wessel D. Severe Coronavirus Disease-2019 in Children and Young Adults in the Washington, DC, Metropolitan Region. J Pediatr. 2020 Aug;223:199-203.e1. doi: 10.1016/j.jpeds.2020.05.007. Epub 2020 May 13. PMID: 32405091; PMCID: PMC7217783.

- Wanga V, Gerdes ME, Shi DS, Choudhary R, Dulski TM, Hsu S, Idubor OI, Webber BJ, Wendel AM, Agathis NT, Anderson K, Boyles T, Chiu SK, Click ES, Da Silva J, Dupont H, Evans M, Gold JAW, Haston J, Logan P, Maloney SA, Martinez M, Natarajan P; BMBS1, Spicer KB, Swancutt M, Stevens VA, Brown J, Chandra G, Light M, Barr FE, Snowden J, Kociolek LK, McHugh M, Wessel D, Simpson JN, Gorman KC, Breslin KA, DeBiasi RL, Thompson A, Kline MW, Bloom JA, Singh IR, Dowlin M, Wietecha M, Schweitzer B, Morris SB, Koumans EH, Ko JY, Kimball AA, Siegel DA. Characteristics and Clinical Outcomes of Children and Adolescents Aged <18 Years Hospitalized with COVID-19 - Six Hospitals, United States, July-August 2021. MMWR Morb Mortal Wkly Rep. 2021 Dec 31;70(5152):1766-1772. doi: 10.15585/mmwr.mm705152a3. PMID: 34968374.

Q: How long can you expect the rapid antigen test to be positive?
A: Most people will remain positive by either PCR or antigen testing for 5-8 days, but this can be shorter or longer (up to 6 weeks or more) depending on many factors including: initial viral load at time of infection, vaccination status, underlying immune function of the host, age, variant of virus and other clinical factors. In general, a PCR test is more sensitive than antigen testing and therefore, may remain positive for longer periods of time, detecting very small amounts/fragments of virus that may not represent active virus after a period of time. Therefore, antigen testing relatively decreased sensitivity (but still very sensitive) compared to PCR is an advantage on a population level, in which the priority is identifying individuals with high viral loads of active virus that can be transmitted to others.

Q: I have had several patients continue to test positive even after 10 days of isolation/quarantine and they are no longer symptomatic.
A: Yes, that is not uncommon; it is also true that completely asymptomatic individuals can be infected, test positive after exposure and transmit virus, despite having no symptoms. See above – the CDC does not recommend testing to determine when to discontinue isolation after a diagnosis of COVID-19; it is time and symptom-based recommendation.

Q: What are recommendations for a child who tests rapid antigen negative after 10 days of isolation/quarantine after a COVID-19 positive (either rapid antigen or PCR) AND is completely asymptomatic? Is it okay to return to school?
A: See above. Different schools, districts and jurisdictions have different rules for returning to school which must be adhered to depending on where you live and attend school.

Q: On average, how many weeks will the PCR stay positive?
A: See above

Q: We need guidance about return to school/quarantine if COVID-19 positive or exposed and the effect of vaccination on those recommendations.
A: The CDC released new guidance on Jan 6th in reference to isolation and quarantine recommendations and schools. These recommendations follow the same recommendations on isolation for the general population with the caveat that students should be distanced from others during periods they are unable to mask (such as meals) through day 10. The quarantine recommendations are for those who are unvaccinated and have known close contact. Exposed individuals should quarantine for 5 days and are recommended to have testing at Day 5, if asymptomatic. Individuals should continue to mask in public through day 10 of quarantine. There is variability on where school districts are on implementing these new guidelines.

Many local school districts have contemplated implementing a test-to-stay program that would allow those in close contact to be tested at least twice a week and remain in school. However, with Omicron at the current community rates and other priorities in tracking positives, it is uncertain how quickly schools will be able to stand this up and whether the data from previous waves will hold true.

Q: Families are anxious about the situation with schools - either closing for in-person learning or about the safety of sending kids to schools. What is your guidance to school systems and families on how to navigate this with the omicron surge? (Montgomery County Public Schools have chosen a 5% cutoff to shut down schools and Prince Georges County has a system wide two-week pause). I was curious as to thoughts on school closures during omicron surge. The criteria MCPS is using does not seem to make much sense.

A: All the school districts in the area have made different determinations on how to manage the current recommendations. MCPS set a threshold of 5% of students and staff as being a threshold that puts schools in red. The initial 11 schools in the red zone have moved to virtual. An additional 89 schools are now in the red zone but as of Jan 6th remain in-person. DC Public Schools have been reporting data on their test to return (all students and staff needed a negative test to return to school). Only one DCPS school is currently virtual (11% of staff at that school were positive). Currently Virginia schools have not closed due to COVID-19 but have remained closed so far this week due to snow and weather. Prince Georges County declared it would be virtual for the first several weeks of January.

The American Academy of Pediatrics (AAP) currently is in the process of updating the school guidance but has been consistent in encouraging school districts to look at individual school level data to make determinations about keeping students in-person. The data is clear that many students suffer in virtual instruction from an academic and health perspective. We are fortunate that many schools in our area continue to require masks and have other mitigation measures in place. Currently a key variable in determining whether students can remain in-person is whether there is adequate staffing to provide instruction and supervision.

Q: I was hoping that you could address the differences between the CDC and local department of health isolation recommendations. CDC has shortened to 5 days but local department of health's (DC and MD) still recommend 10 days.

A: The New CDC Recommendations for Isolation and Quarantine [cdc.gov] do not apply to children in childcare and school settings for quarantine (which are considered "special populations"). The AAP has asked the CDC for clarification on these new standards as it pertains to schools and safety of children in being able to eat as well as mask appropriately. The DC Department of Health and Office of the State Superintendent of Education (OSSE) have confirmed that families should continue to follow current published school guidance for DC students including a 10-day isolation period with a positive COVID-19 test. Nationally, many school districts have implemented the new recommendations so we can expect local variation as well.

As it currently stands, students who are fully vaccinated and are exposed should not need to quarantine when in close contact with a COVID-19 case. CDC counts this as two doses for those under 18 years old. Close contact continues to be defined as less than six feet for greater than 15 minutes in a day without good masking. Many local school districts have contemplated implementing a test-to-stay program that would allow those in close contact to be tested at least twice a week and remain in school. However, with the Omicron variant at the current community rates and other priorities in tracking positives, it is uncertain how quickly schools will be able to stand this up and whether the data from previous waves will hold true.

Q: How soon after COVID-19 infection can a patient get a booster?

A: As soon as the patient is out of isolation and symptoms have improved, they can receive a COVID-19 vaccine if they are due (see booster eligibility). If they were treated with monoclonal antibodies or developed MIS-C, the recommend waiting period is 90 days from treatment/diagnosis so that the body can build the strongest immune system possible.

Q: Would you clarify why we need to use the COVID-19 waiver again for 16–17-year-olds?
A: The Pfizer Adult-Tris (gray cap) formulation (the "new" vaccine for 12yo+) is under Emergency Use Authorization (EUA) and, therefore, requires the Pfizer consent. The Pfizer Comirnaty (purple cap) formulation (the current vaccine for 12yo+) is fully FDA approved for only dose 1 and dose 2 (not dose 3 or boosters) in patients 16 and older. When the transition takes place, all Pfizer products available to patients of every age/dose will be under EUA.

Q: Could you share the data behind approving the Pfizer vaccine booster for 12–15-year-olds?
A: This information can be found on the CDC's website as follows:

- Booster time frame 5 months and 5-11year old 3rd dose announcement
    - https://www.cdc.gov/media/releases/2022/s0104-Pfizer-Booster.html
- Boosters for 12-15 year old announcement
    - https://www.cdc.gov/media/releases/2022/s0105-Booster-Shot.html