



SPANISH ASSOCIATION OF PAEDIATRICS

Main changes in the “COVID-19 in paediatrics” clinical practice guideline[☆]



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Abstract We present a summary of the main modifications to the “COVID-19 in Paediatrics” clinical practice guideline made from its initial version, published in 2021, and the version published in 2022. The document was developed following the structured steps of evidence-based medicine and applying the GRADE system to synthesize the evidence, assess its quality and, when appropriate, issue graded recommendations (based on the quality of the evidence, values and preferences, the balance between benefits, risks and costs, equity and feasibility). This update also includes the modifications proposed by external reviewers.

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Signs and symptoms;
Diagnosis;
Treatment;
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Update

PALABRAS CLAVE

COVID-19;
Medicina basada en la
evidencia;
Pediatria;
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Tratamiento;
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Vacunas;
Actualización

We summarised the main modifications in the following sections: epidemiology, clinical features, diagnosis, prevention, treatment and vaccines. In relation to the body of knowledge achieved in the first year of the pandemic, the literature published in the second year contributed additional data, but without substantial modifications in many the areas. The main changes took place in the field of vaccine research. This update was completed in December 2021, coinciding with the emergence of infections by the omicron variant, so the document will need to be updated in the future.

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Principales modificaciones en la guía de práctica clínica «COVID-19 en pediatría»

Resumen Presentamos el resumen de las principales modificaciones surgidas en la guía de práctica clínica “COVID-19 en Pediatría” entre su versión inicial publicada en el año 2021 y la publicada en el año 2022. El documento se ha elaborado siguiendo los pasos estructurados de la Medicina basada en la evidencia e incorporando el sistema GRADE para realizar síntesis de la evidencia, con valoración de su calidad y, cuando se consideró apropiado, emitir recomendaciones jerarquizadas (en función de la calidad de la evidencia, los valores y preferencias, el balance entre beneficios, riesgos y costes, la equidad y la factibilidad). En esta actualización se incluyen también los cambios recomendados por los revisores externos.

Se sintetizan las principales modificaciones en los siguientes apartados: epidemiología, clínica, diagnóstico, prevención, tratamiento y vacunas. En el conjunto del conocimiento alcanzado a lo largo del primer año de pandemia, las publicaciones durante el segundo año añaden nuevos datos, sin que en muchas de las áreas se produzcan modificaciones sustanciales. Los principales cambios acaecen en el campo de investigación de las vacunas. Esta actualización finaliza en diciembre de 2021, coincidiendo con el aumento de la infección por ómicron, por lo que será necesario una futura actualización del documento.

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Introduction

“The SARS-CoV-2 pandemic has caused drastic changes in our everyday life, in addition to important health care and socioeconomic repercussions.” This was the opening of an editorial¹ published in *Evidencias en Pediatría* as an introduction to the document titled “COVID-19 en Pediatría: valoración crítica de la evidencia” (COVID-19 in paediatrics: critical assessment of the evidence”) developed as a clinical practice guideline using the GRADE methodology, of which the full version was published in *GuíaSalud* in March 2021² and in *Anales de Pediatría* in June 2021.³ The guideline was also published in the websites of the Asociación Española de Pediatría (AEP, Spanish Association of Pediatrics) and the Asociación Española de Pediatría de Atención Primaria (AEPap, Spanish Association of Primary Care Paediatrics), both societies that support the Working Group of Evidence-Based Paediatrics, whose members were in charge of its development.

Given the continuous and prolific growth of the scientific evidence on the coronavirus disease 2019 (COVID-19) pandemic, that first document already contemplated periodic updates. There is no question that ample knowledge on this disease has been acquired in record time, and therefore updating the paediatric COVID-19 guideline has required a

new and exhaustive search of the literature published after the first guideline of March 2021.

The update to the guideline was published in February 2022, approximately a year after the first version. The literature review included documents published from March to November 2021 and followed the methodology described in the original publications.^{2,3} The update also includes the modifications proposed by external reviewers of the guideline, following the recommendations of the *GuíaSalud*.

Updates on epidemiology

Cumulative incidence

Globally, the cumulative incidence of disease (COVID-19) in individuals of any age is of 3512.16 cases per 100 000 inhabitants, and the global cumulative mortality is 68.29 deaths per 100 000 inhabitants.

In Spain, the cumulative incidence of disease in individuals of any age is 12 066.93 cases per 100 000 inhabitants, and the cumulative mortality of 190.11 deaths per 100 000 inhabitants; the case fatality rate is 1.94% and the infection fatality rate is 1.1% (95% confidence interval [CI], 1.0%–1.2%).⁴

Transmission mechanisms

There seem to be virus-related factors (increased transmissibility, previous immune evasion, lower detection by diagnostic tests, pathogenicity) that may promote infection, as evinced by the different SARS-CoV2 variants that have emerged to present.⁵ This is obvious in the new omicron variant, which, due to a change in its capsule proteins, can better bind ACE2 receptors, which, in addition to other potential contributing factors, increases infectivity.^{6,7}

The incubation period may change depending on the variant: omicron is exhibiting a shorter incubation period compared to previous variants, of 3 days (interquartile range, 3–4) versus 4.3 for the delta variant and 5 for previous non-delta variants.⁸

Risk factors

There are no changes regarding the risk factors predisposing to COVID-19. The patients at highest risk continue to be the elderly, especially those in residential facilities.

As regards the factors associated with case numbers, obesity increases the probability of a positive SARS-CoV-2 test, as confirmed in a literature review with data from the 50 countries with the highest incidence of COVID-19.⁹

New studies have contributed evidence on the association between the incidence of COVID-19 and socioeconomic status: the incidence of infection was greater in families residing in areas with lower household incomes, lower rates of employment and lower rates of health insurance.¹⁰ Unexpectedly, there had been studies that found that smoking could act as a protector against COVID-19, but more recent studies suggest that this association may result from confounding factors.¹¹

Updates on clinical presentation

Signs and symptoms

The case series reviewed for the updated guideline were larger and contributed more information on patients managed at the outpatient level and the general population, with little representation of severely ill patients and a high risk of bias.

As regards the clinical manifestations, fever and respiratory symptoms continue to be most prevalent. The frequency of systemic, gastrointestinal and neurologic symptoms varies based on the care setting, while the frequency of cutaneous and mucosal symptoms decreased and cases of multisystemic inflammatory syndrome in children (MIS-C) were only reported in one series. One of the most relevant trends was the higher percentage of asymptomatic patients.^{12,13} The seroprevalence study conducted in Spain between April and June 2020 found a proportion of asymptomatic cases of 45%.¹⁴ This implies that the frequencies of all symptoms have declined.

At the individual level, the most frequent symptoms are fever and cough. Upper respiratory tract symptoms, such as sore throat/pharyngitis and rhinorrhoea, continue to be very frequent, while the frequency of dyspnoea/shortness of

breath declined considerably compared to the first edition of the guideline. Laryngitis has been described in association with SARS-CoV-2.¹⁵ There have been no changes in the gastrointestinal symptoms (vomiting, diarrhoea and abdominal pain), but they have been reported in fewer series and with lower frequencies. Systemic symptoms have also remained the same (fatigue, changes in appetite), with fatigue being the most frequent. Of all neurologic symptoms (headache, anosmia or dysgeusia), headache continues to be most prevalent. As regards cutaneous or mucosal involvement, there have been reports of urticaria and angioedema secondary to SARS-CoV-2 infection.

Forms of disease

There have been changes in reported forms of disease, such as a more frequent association of certain presentations with specific age groups: more frequent symptoms in children aged less than 5 years, and more frequent pain in adolescents. As regards the predictive value of clinical features, there is evidence of associations that, with the exception of anosmia and ageusia, are very nonspecific.¹⁶ The best combination to predict COVID-19 continues to be the one described in the first version of the guideline, consisting of headache, nausea/vomiting and anosmia/ageusia (positive likelihood ratio, 65.92; 95% CI, 49.48–91.92). As regards risk factors, age less than 6 months is associated with more severe disease (OR, 2.54; 95% CI, 1.08–5.98), as is the presence of underlying chronic disease, chiefly neurologic disorders (OR, 5.16; 95% CI, 2.30–11.60) and obesity (OR, 2.54; 95% CI, 1.08–5.98). The clinical manifestations associated with a less favourable course of disease were diarrhoea (OR, 3.97; 95% CI, 1.80–8.73), other gastrointestinal manifestations (OR, 2.93; 95% CI, 1.19–7.22) and MIS-C (OR, 2.79; 95% CI, 1.84–4.22). The presence of shortness of breath or respiratory distress was associated with a less favourable course of disease, but with a low precision (OR, 8.69 [95% CI, 1.58–47.70] vs OR, 48.29 [95% CI, 10.88–214.33]).¹⁷

COVID-19 complications: multisystemic inflammatory syndrome in children (MIS-C) and other

The COVID-19 complication that has been addressed most extensively in the literature is MIS-C. There have been no changes in the manifestations most frequently associated with this syndrome, which continue to be fever and gastrointestinal symptoms. The symptoms that are most useful to differentiate MIS-C from severe COVID-19 are the presence of cardiorespiratory or cutaneous/mucosal manifestations in MIS-C, as opposed to respiratory symptoms in isolation.¹⁸ Cardiac involvement, which is probably the greatest concern, develops in slightly more than one third of patients with MIS-C, mainly in the form of left ventricular dysfunction and coronary abnormalities, although in most cases these abnormalities resolve within a few months after discharge.

As regards other complications, there has been significant variability in the reported frequency of severe disease, defined as need of admission to the intensive care unit (ICU), ranging from 1.6% in China or Turkey to 31% in a sample of adolescents in the United States, which could be

attributed to the substantial heterogeneity of the samples. Excluding studies focused specifically on MIS-C, 11% of the total of children admitted to hospital due to COVID-19 (29 studies, 7582 patients) required admission to the ICU. Poor outcomes have been associated with different factors, with variation between studies: age other than 1–14 years (especially infants aged less than 1 month), male sex, underlying disease, MIS-C, acute respiratory distress syndrome, abdominal pain, kidney injury, elevation of C-reactive protein or D-dimer levels and low white blood cell count. Thromboembolic events occur in slightly more than 1% of hospitalised children and are generally associated with known risk factors for this complication.¹⁹ Severe neurologic complications occur in 2.5%–5% of paediatric patients admitted due to COVID-19, most frequently encephalitis, stroke and Guillain-Barré syndrome.²⁰

We ought to highlight the larger body of evidence reviewed in the current update on long-COVID symptoms that persist for months after the acute disease, although most of it is based on telephone interviews and therefore carries a high risk of bias. The most frequently described symptoms are fatigue, exercise intolerance and insomnia, and other reported symptoms include cough, headache, difficulty concentrating, other neuropsychiatric symptoms, gastrointestinal symptoms and bone and muscle pain.^{21,22}

Perinatal disease

Infants born to mothers with COVID-19 are at higher risk of admission to the ICU and increased morbidity, although there has not been an increase in neonatal mortality. There is evidence of an association between caesarean delivery and the probability of a positive test in neonates born to mothers with COVID-19, but not of an association with exclusive breastfeeding.²³ There were no new data on the clinical manifestations in newborns with a positive result for SARS-CoV-2.

Updates on diagnosis

Microbiological testing

The real-time reverse transcription polymerase chain reaction (RT-PCR) test continues to be the gold standard for diagnosis of infection by SARS-CoV-2. The preferred type of sample continues to be a sample of respiratory secretions, although saliva specimens have exhibited a similar validity, albeit somewhat inferior, to that of nasopharyngeal swab samples (sensitivity, 83.2% [95% CI, 74.7–91.4]; specificity, 99.2% [95% CI, 98.2–99.8]), leading to a weak recommendation in support of the use of saliva specimens in low-prevalence areas.^{24,25}

The use of antigen tests in asymptomatic patients has been found to offer a pooled sensitivity of 58.1% (95% CI, 40.2–74.1) and a pooled specificity of 98.9% (95% CI, 93.6–99.8). In asymptomatic individuals with no known positive contacts, the sensitivity is below 40%, based on evidence of low-to-moderate quality. The authors of the guideline concluded that serial antigen tests may be indicated in asymptomatic patients with known exposure to SARS-CoV-2, but that antigen testing is not recommended

in asymptomatic individuals with no known exposure due to the low yield of this diagnostic method.²⁶

Serologic testing

No new articles of sufficient methodological quality have been published to warrant modification of the previous guidelines. A recent study²⁷ analysed the sensitivity and specificity of oral fluid assays for IgG antibody measurement, finding a sensitivity of 80% (95% CI, 71–88) and a specificity of 99% (95% CI, 98–100). This assay could be useful to establish seroprevalence, although little is known about antibody kinetics and how they would affect measurements with this kit.

Blood tests

There has not been any relevant new evidence. Available studies are observational, with small samples and of poor methodological quality, which precludes drawing reliable conclusions on this subject.

Imaging tests

There have not been relevant additions to the evidence. A Cochrane review conducted by Islam et al.²⁸ concluded that imaging tests offer a good sensitivity: 87.9% for computed tomography, 80.6% for the plain chest radiograph and 86.4% for ultrasound; with a moderate specificity of 80%, 71.5% and 54.6%, respectively, as the imaging features are indistinguishable from those of other viral infections.

Updates on prevention

Masks

The observational studies reviewed in the previous guideline found a significant preventive effect in reducing the risk of transmission of viral infections, including SARS-CoV-2, that is more pronounced with N95 or equivalent masks. However, the reviewed randomised clinical trials (RCTs) did not evince this protective effect. The quality of the evidence, assessed with the GRADE method, was poor. There were no studies specifically focused on the paediatric population, although paediatric-age subjects were included in some community-based studies. The current update of the guidelines has included a retrospective cohort study in health care workers (N = 1440) and a large community-based cluster-randomised trial in Bangladesh (N = 342 126 adults).

The results of the retrospective cohort study (Li A et al.)²⁹ showed, consistent with previous observational studies, that the use of masks reduced the risk of infection by SARS-CoV-2, in both the case of N95 masks (OR, 0.5; 95% CI, 0.28 to 0.90) and the case of surgical masks (OR, 0.45; 95% CI, 0.29 to 0.72).

The results of the cluster-randomised trial (Abaluck J et al.)³⁰ show a protective effect of masks, and this is the only clinical trial reviewed to date that has found evidence of this effect. Different strategies were implemented in the intervention group (IG) at the village level to promote the

use of surgical and hygiene masks in public areas. Mask use increased significantly in the IG after the intervention compared to the control group (CG) (42% in IG vs 13% in CG). This increase in mask use was associated with a lower symptomatic SARS-CoV-2 seroprevalence in villages subject to the intervention compared to control villages (adjusted prevalence ratio, 0.907; 95% CI, 0.817–0.997) and the effect was greater in individuals aged more than 60 years (adjusted prevalence ratio, 0.65; 95% CI, 0.46–0.85). Since this was a community-level study, it was not possible to assess the impact of mask use at the individual level.

Breastfeeding and vertical transmission

The risk of vertical SARS-CoV-2 transmission from the infected mother is very low, and recent studies have found substantial variability in sample collection, postpartum mother-infant contact and other factors.³¹

As regards the presence of SARS-CoV-2 in breastmilk or transmission through breastfeeding, new studies have corroborated the findings of the previous literature. The authors concluded that breastfeeding is safe and highlighted the passage of maternal antibodies to the infant.^{32,33} In addition, since vaccines became available, there have been studies assessing the presence of vaccine-induced antibodies in human milk.³⁴

Schools

The first edition of the guideline considered the efficacy of closing schools to reduce the incidence and severity of the COVID-19 pandemic. The updated version has contemplated whether reopening schools and the return to in-person educational activities had a negative impact on the course of the pandemic.

Recently published studies^{35–37} have reported that reopening schools, as long as appropriate hygiene and social distancing measures were upheld, did not seem to have a deleterious impact, although most studies acknowledged that the behaviour of new variants of the virus could change this. At the same time, numerous studies highlighted the negative impact of school closures on different aspects of child and adolescent health.^{38,39} This evidence, combined with the uncertainty regarding the positive impact of school closures on incidence and mortality, made the recommendation to keep schools open prevail.

Updates on treatment

Chloroquine and hydroxychloroquine

There has not been new evidence contradicting the lack of efficacy of hydroxychloroquine and chloroquine; the partial results of trials currently underway confirm the unfavourable risk-benefit ratio.

Steroid therapy

The final results with more detailed information of 2 preliminary studies and 2 new systematic reviews have been

published since the last edition.^{40,41} There are no changes to the previous recommendations as we await data from paediatric studies.

Tocilizumab

A systematic review and meta-analysis published by the World Health Organization in July 2022⁴² assessed the efficacy of interleukin-6 antagonists (tocilizumab [TCZ] or sarilumab), concluding that TCZ achieves a minimal reduction in mortality and the risk of mechanical ventilation, although without a clear risk-benefit ratio, so that recommendations in favour or against its use in the paediatric population cannot be established at this point.

Convalescent plasma and hyperimmune immunoglobulin

New studies included in a systematic review⁴³ confirmed that there is no evidence of the efficacy of convalescent plasma or hyperimmune immunoglobulin.

Other treatments

As regards the efficacy of other treatments, the reviewed evidence continues to be indirect and of very poor quality due to methodological limitations or imprecision. Only casirivimab + imdevimab,^{44,45} molnupiravir⁴⁶ and calcifediol⁴⁷ have shown promising results. These treatments should be assessed in paediatric studies before issuing general recommendations on their use in clinical practice. Intravenous remdesivir has only proven effective in outpatients in reducing the risk of admission. The recommendations against the use of other treatments have not changed.

Management of MIS-C

When it comes to MIS-C, there is evidence of very poor quality, on account of the observational design of the studies and the inconsistent results, on the comparison of intravenous immunoglobulin alone or combined with steroid therapy, so that recommendations cannot be made in favour of one or the other approach.^{48–50} The evidence in favour of steroid therapy as monotherapy versus intravenous immunoglobulin is also of very low quality. The recommendations on this aspect have changed, as it is now advised to use intravenous immunoglobulin for management of MIS-C, monitoring treatment and resorting to rescue steroid therapy in case of clinical worsening. In a scenario in which access to immunoglobulin is limited, initial treatment with steroids as monotherapy with use of combined therapy for rescue is a possible alternative.

Updates on vaccination

The available evidence on vaccines is constantly changing, and therefore this is the area in which there has been the most changes in the updated clinical practice guideline.

Manufacturing

The current literature review excluded phase 1 and 2 trials and focused in phase 3 and 4 trials, and included additional vaccines, such as the COVID-19 Janssen© vaccine (Janssen Biologics B.V.) and Nuvaxovid© (Novavax CZ).

Efficacy and effectiveness

The most salient aspect is the publication of studies on the efficacy of RNA vaccines in children and adolescents. A multinational RCT of the Comirnaty© vaccine (Pfizer-BioNTech) has been published that included followup data through 6 months after the second dose of the vaccine and included participants aged 12 or more years.⁵¹ The trial found a vaccine efficacy against symptomatic COVID-19 of 91.1% (95% CI, 88.8–93.0). On the other hand, a phase 3 in adolescents aged 12–15 years⁵² found a vaccine efficacy of 100% (95% CI, 75.3–100) in the prevention of laboratory-confirmed symptomatic COVID-19. The results of phases 1, 2 and 3 of another RCT in children aged 5–11 years have also been published,⁵³ and the authors reported a vaccine efficacy of 90.7% (95% CI, 67.4–98.3) with no cases of severe COVID-19 or MIS-C.

A phase 2/3 RCT⁵⁴ in adolescents aged 12–17 years given 2 doses of the Spikevax© vaccine (Moderna Biotech Spain SL) 28 days apart versus placebo was published in June 2021. The trial found a vaccine efficacy of 93.3% (95% CI, 47.9–99.9) 14 days after the second dose in symptomatic cases and of 39.2% (95% CI, –24.7–69.7) in asymptomatic cases.

Another novelty is the evidence regarding vaccination of pregnant women: comparable efficacy as that observed in the general population with no evidence of adverse events in the foetus or the mother.

Immunogenicity

New evidence has been added regarding the duration of immunity, of which there was hardly any in the first edition.

Adverse events

New evidence has been added, for instance regarding arterial and venous thromboembolism and myocarditis/pericarditis.

Vaccination schedule

Updated vaccination schedules for single-manufacturer vaccine schedules and mixed vaccine schedules.

Summary of the update

In this update, there have been modifications particularly in the field of research on vaccination against SARS-CoV-2. Compared to the body of knowledge accrued in the first year of the pandemic, publications in the second year have contributed additional data that have not resulted in substantial modifications in many areas.

The update was completed in December 2021, as infection by the omicron variant was surging. This variant has brought changes as regards transmission, burden of disease, infectiousness and affected age groups. We need to continue studying and analysing publications regarding infection by SARS-CoV-2 to be ready to effectively manage potential new infections.

We recommend a full perusal of the second version of the guideline “COVID-19 en Pediatría: valoración crítica de la evidencia”, a 386-page document that contains a relevant summary of the quality of the evidence and recommendations in each of its sections (epidemiology, clinical presentation, diagnosis, treatment, prevention and vaccines).⁵⁵

Appendix 1. Members of the Working Group on Evidence-Based Paediatrics of the AEP and AEPap that contributed to this document

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