



FIGURE 1. Flowchart representing our algorithm supporting decision making on the patients' disposition. The identification of a "suspect patients" depends on WHO-updated definitions or on the presence of fever alone as CoVID-19 in children can occur with very mild symptoms. A suspect case has to be put in isolation room and 2 respiratory samples have to be collected for laboratory testing. If the first sample is positive, then the patients have to be kept isolated. If the first sample is negative and patients' flow is under control, isolation has to be kept until a second sample excludes the infection. Otherwise isolation priority can be defined according to the matrix, giving higher priority to number 1, lowest priority to number 8. The same matrix can be used to deisolate "low-risk patients" in case of need of isolation for higher-risk patients.

occur in febrile children even without signs of respiratory failure. By merging WHO/ECDC and Chinese epidemiology, we have developed an algorithm as decision-making matrix to decide on the patients' disposition (Fig. 1).¹⁻⁴

In conclusion, the pediatric emergency is more logistic than clinical. So, we urge you to plan local advice and follow your institutional and national guidelines.

Giovanna Chidini, MD

Department of Anesthesia and Intensive Care
Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico
Pediatric Intensive Care Unit
Milan, Italy

Cristina Villa, MD Eduardo Calderini, MD

Department of Anesthesia and Intensive Care
Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico

Paola Marchisio, MD

Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico
Milan, Italy

Daniele De Luca, MD, PhD

Pédiatrie et Réanimation Néonatale – Pédiatries and Neonatal Critical Care, Hôpital Antoine Béclère - "A. Béclère" Medical center - GHU Paris Saclay, APHP

REFERENCES

1. World Health Organization. Coronavirus disease 2019 (COVID-19) situation report; data as reported by national authorities by 10AM CET. 03 March 2020.
2. Wei M, Yuan J, Liu Y, Fu T, Yu X, Zhang ZJ. Novel coronavirus infection in hospitalized infants under 1 year of age in China. *JAMA*. 2020.
3. Wu Z, McGoogan JM. Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China: summary of a report of 72 314 cases from the Chinese Center for Disease Control and Prevention. *JAMA*. 2020.
4. Sun K, Chen J, Viboud C. Early epidemiological analysis of the coronavirus disease 2019 outbreak based on crowdsourced data: a population-level observational study. *Lancet*. 2020.

Use of Handheld Transceiver for Hospital Healthcare Workers-Caregiver Communication During the Coronavirus disease 2019 (COVID-19) Outbreak in Pediatric Emergency Department

To the Editors:

In December 2019 novel Coronavirus Infection (2019-nCoV) spread in China and subsequently all around the World,

The authors have no funding or conflicts of interest to disclose.

Address for correspondence: Antonietta Curatola, MD; E-mail: c.anto91@libero.it.

Copyright © 2020 Wolters Kluwer Health, Inc. All rights reserved.

ISSN: 0891-3668/20/3906-0e80

DOI: 10.1097/INF.0000000000002689

becoming a public health emergency. In Italy, first cases are reported from February 2020 and since then the virus has spread quickly in all regions. On 11th March, World Health Organization has declared Coronavirus disease 2019 (COVID-19) outbreak. Coronavirus belongs to the *Coronaviridae* family, *Nidovirales* order, and the 2019-nCoV belongs to the β -coronavirus genus.¹ Nowadays the elderly and those with underlying chronic diseases are more likely to become severe cases. Thus far, all pediatric cases in China with laboratory-confirmed 2019-nCoV infection were mild cases, and no deaths had been reported.²

The transmission of the 2019-nCoV infection happened through the respiratory droplets by infected patients, but coronavirus can also be transmitted by contact with contaminated objects, such as phones, toys and doorknobs³; however, also asymptomatic cases play a critical role in the transmission process.

Children are considered suspected if they presented fever, cough, breathing difficulties, gastrointestinal symptoms or are related with a cluster outbreak or close contact with 2019-nCoV infected/suspected cases.

All pediatric suspected cases are isolated with only one parent in special single rooms set up for sanitary emergency. It is increasingly necessary to clean and disinfect the articles used by little patients and their caregivers.²

Besides various types of personal protective equipment (PPE) are recommended and used by hospital healthcare workers (HCWs) to protect from infection, including high-filtration medical masks such as FFP2 or FFP3, gloves, gowns, goggles and face shield. The protective equipment is disposable, and for each patient, it is necessary to don and doff them about 5–6 times a day. The estimated average donning time according to the correct procedures is 3–4 minutes, while the doffing time is about 1–2 minutes; however, the doffing phase is the most dangerous because of the risk of contamination. It has been reported that about 15% of all HCWs become infected by COVID-19 after 10 days of work in emergency department (ED), due to the contact with the patients.

In this period, there is enormous demands for PPE, especially medical masks, used not only by HCWs but also by all community. Therefore, on one side it is important to reduce any unnecessary potential exposure to infection, but on the other we must keep in mind the importance of communication with patients and their caregivers, especially in a pediatric setting.

It is interesting to take inspiration from telemedicine, which uses a lot of audio-video technologies to improve patient health by facilitating interactions between patients and clinicians or between 2 or more clinicians.⁴ Our hospital tried to adapt to COVID-19 health emergency in a short time. So, some dedicated rooms to lockdown infected children, without an interphone or telemetry system, were set up, cameras were positioned inside, and handheld transceivers (HTs) were given to the parents for communication with the HCWs. HTs let these interactions be synchronous, wherein parties engage in real-time, 2-way communication, without any delay of time.

In this way, we significantly reduced the number of clinical evaluations carried out on the patient and therefore the use of PPE, reducing exposure to potential infectious sources. We believe that HT can be a useful tool both to save PPE and also to protect HCWs during COVID-19 outbreak.

Antonietta Curatola, MD
Serena Ferretti, MD

Department of Woman and Child Health
and Public Health
Università Cattolica del Sacro Cuore
Rome, Italy

Antonio Gatto, MD

Department of Woman and Child Health
and Public Health
Fondazione Policlinico
Fondazione Policlinico Universitario A.
Gemelli IRCCS, Roma-
Universitario A. Gemelli IRCCS
Rome, Italy

Antonio Chiaretti, MD

Department of Woman and Child Health
and Public Health
Università Cattolica del Sacro Cuore
Rome, Italy
Fondazione Policlinico
Universitario A. Gemelli IRCCS
Rome, Italy

REFERENCES

- Zhu N, Zhang D, Wang W, et al: China Novel Coronavirus Investigating and Research Team. A novel coronavirus from patients with pneumonia in China, 2019. *N Engl J Med.* 2020;382:727–733.
- Shen K, Yang Y, Wang T et al. Diagnosis, treatment, and prevention of 2019 novel coronavirus infection in children: experts' consensus statement. *World J Pediatr.* 2020; doi: 10.1007/s12519-020-00343-7
- Cao Q, Chen YC, Chen CL, et al. SARS-CoV-2 infection in children: transmission dynamics and clinical characteristics. *J Formos Med Assoc.* 2020;119:670–673.
- Coomes CE, Gregory ME. The current and future use of telemedicine in infectious diseases practice. *Curr Infect Dis Rep.* 2019;21:41.

Febrile Infant: COVID-19 in Addition to the Usual Suspects

To the Editors:

SARS-CoV-2, the RNA coronavirus etiologic agent of pneumonias that appeared in December 2019 was sequenced and confirmed in January 2020 by the Chinese Center for Disease Control and Prevention.¹ The World Health Organization on March 11 officially designated COVID-19 a pandemic as it spread rapidly to 196 countries with over 54,000 confirmed cases in the United States alone.²

While reports about the virus have focused on the adult population, the largest study on children to date has been reported from China by Dong et al. Their clinical severity analysis, which included both COVID-19-positive patients and those with a high index of suspicion, revealed that severe (ie, respiratory distress) and critical (ie, ARDS or shock) occurred in 5.9% of children compared with 18.5% in adults, with infants below age one comprising the highest proportion.³

We report a previously healthy, fully vaccinated, late preterm, 58-day-old male who presented with fever. On the day of admission, he was sleeping longer than normal, had watery eye discharge with periorbital erythema and a rectal temperature of 101.2F. Stools were softer and greener for the past 2 days. There was no respiratory distress, cough, decreased intake, decreased frequency of wet diapers, sick contacts, or travel.

Physical examination revealed T 100.8F (rectal), HR 176 beats per minute, slight fussiness, glassy eyes with mild surrounding erythema, soft anterior fontanelle, normal tympanic membranes bilaterally, and mild nasal congestion. The rest of his examination was normal. Laboratory assessment showed complete blood count: white blood cells (WBC) 5.44 k/ μ L (normal: 4.0–19.5 k/ μ L) with 43% neutrophils (ANC 2497/ μ L; normal: 1000–12,500/ μ L), 34% lymphocytes (ALC 1.86 k/ μ L, normal: 4.0–13.5), 10% monocytes, 10% eosinophils, 2.5% reactive lymphocytes. Platelets 278 K/ μ L (normal: 150–350 K/ μ L) and a mildly anemic hemoglobin at 9.2 g/dL (normal: 9.4–11.2 g/dL). Comprehensive metabolic panel was normal except for a mildly elevated alkaline

The authors have no funding or conflicts of interest to disclose.

Copyright © 2020 Wolters Kluwer Health, Inc. All rights reserved.
ISSN: 0891-3668/20/3906-0e81
DOI: 10.1097/INF.0000000000002693