

Response to letter in response to 'saliva is inferior to nose and throat swabs for SARS-CoV-2 detection in children'

We thank Chu and Hale for their important comments on the findings of our study investigating the use of saliva for detecting the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in children.¹ Our study followed 20 children and found that in week one and two after diagnosis SARS-CoV-2 was detected in 29% and 11% of saliva samples, 86% and 50% of nasal swabs and 58% and 40% of throat swabs respectively.² Chu and Hale got the impression that all saliva samples were taken by a parent, except for the first sample. This was not the case. Saliva samples, nose and throat swabs were collected once a week by a trained project nurse. In between those visits, parents collected saliva samples at home so that we could monitor the shedding of the virus more closely. We apologise if this was not clear.

As Chu and Hale correctly point out, the saliva samples were not added to a viral transport media and arrived at the laboratory a few days after testing. As we state in the limitations, this may have degraded the viral nucleic acid and explained the small number of positive saliva samples. This finding indicates that this kind of saliva collection method, which is easy to perform and could have been useful for mass-testing in settings such as day care centres, is not recommended.


Chu and Hale suggest that the results should have been broken down by age, but this is difficult in studies with small sample sizes. However, we did look at this and found no correlation, which is also mentioned in our paper. The age range of the children in our study was seven weeks to 16 years and the four children with a SARS-CoV-2 positive saliva sample in the first week were aged seven weeks, 19 months, six years and 13 years.

Chu and Hale find it hasty to state that saliva was inferior to nose and throat swabs without further investigations. We agree that the title may have seemed too definitive for a study with such a small sample size.

We find it important to publish all results during the pandemic, as we all need to gain knowledge on the best sampling methods for detecting SARS-CoV-2 in children.

CONFLICT OF INTEREST

The authors have no conflicts of interest.

Marie-Louise von Linstow¹ 
Alexandra Kruse²

Nikolai Kirkby³
Lillian Marie Søres⁴
Ulrikka Nygaard¹
Anja Poulsen¹

¹Department of Paediatrics and Adolescent Medicine, The Juliane Marie Centre, Copenhagen University Hospital Rigshospitalet, Copenhagen, Denmark

²Department of Paediatrics and Adolescent Medicine, Copenhagen University Hospital Hvidovre, Hvidovre, Denmark

³Department of Clinical Microbiology, Copenhagen University Hospital Rigshospitalet, Copenhagen, Denmark

⁴Department of Clinical Microbiology, Copenhagen University Hospital Hvidovre, Hvidovre, Denmark

Correspondence

Marie-Louise von Linstow, Department of Paediatrics and Adolescent Medicine, The Juliane Marie Centre, Copenhagen University Hospital Rigshospitalet, Blegdamsvej 9, 2100 Copenhagen, Denmark.
Email: marie-louise.von.linstow.01@regionh.dk

ORCID

Marie-Louise von Linstow  <https://orcid.org/0000-0002-9956-7941>

REFERENCES

1. Chu S, Hale S. Letter in response to 'saliva is inferior to nose and throat swabs for SARS-CoV-2 detection in children'. *Acta Paediatr.* 2021.
2. von Linstow ML, Kruse A, Kirkby N, et al. Saliva is inferior to nose and throat swabs for SARS-CoV-2 detection in children. *Acta Paediatr.* 2021;10.1111/apa.16049

How to cite this article: von Linstow M-L, Kruse A, Kirkby N, Søres LM, Nygaard U, Poulsen A. Response to letter in response to 'saliva is inferior to nose and throat swabs for SARS-CoV-2 detection in children'. *Acta Paediatr.* 2021;110:3388–3388. doi:[10.1111/apa.16112](https://doi.org/10.1111/apa.16112)