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CORRESPONDENCE

Testing of caregivers—a response

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To the Editor:

We thank Drs. Nagesh and Murthy for their thought-provoking letter. Regarding the cost-benefit analysis of allowing Kangaroo Care in the era of the COVID-19 pandemic, we are decidedly in favor of continuing to offer this experience. The data supporting Kangaroo Care are overwhelmingly positive, with impacts lasting far beyond the neonate's admission to the neonatal intensive care unit (NICU) [1, 2]. As real as the benefits of Kangaroo Care are, so too are the risks of COVID-19. How coronavirus impacts the premature neonate and how contagious coronavirus is to infants both bear consideration.

The impact of COVID-19 on infants and children appears to be mild, except for reported multisystem inflammatory syndrome cases [3, 4]. Whether premature neonates could develop a severe illness with the SARS-CoV-2 virus certainly seems plausible given viral pathologies such as influenza and enterovirus carry a high mortality. Limitations of visitors with signs of infection should be commonplace in all NICUs, and it was likely so before the pandemic and will be after it succumbs to modern medicine.

Screening questions should remain in place and, provided parents are honest, should help to decrease the risk of transmission to the neonate, at least to a level where the benefits of Kangaroo Care supersede any risks. Additionally, while the chances of transmission to a neonate may be low, the risk of transmission to other caregivers and healthcare workers is a different concern [5]. In this instance, then, consideration of the running average of cases over a 7 day period is warranted. For example, 1–9 cases per 100,000 people represent community spread. Therefore the risk of transmission is present, especially if a parent satisfies screening questions. The current case/100,000 data for many locations are well above the community spread criteria, yet visitation to the NICU remains possible. Presumably, this means epidemiologists and policymakers believe the parents' presence at the bedside outweighs the virus's risks.

Regarding the testing of infant caregivers periodically, a robust testing algorithm, along with a support structure, would have to be in place. Questions that would warrant answers before the operationalization of such a paradigm include; at what interval would caregivers be tested, would caregivers present to the NICU for testing if their care provider suggested they receive testing, would the hospital bear the costs of testing, and what support mechanisms would the hospital need for caregivers who test positive. The logistics and record keeping of such an endeavor would be daunting but not impossible. Limited testing capacity is more likely to be a problem than record keeping. Provided a healthcare system has the capacity to test every caregiver on a periodic basis, the negatives would be limited to the process of procuring the sample itself.

In summary, we urge NICU leaders to work with local epidemiology and medical center leadership to develop a consistent, equitable and just process to allow caregivers access to their newborns during this pandemic.

Compliance with ethical standards

Conflict of interest The authors declare no conflicts of interest.

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