Royal College of General Practitioners

Paediatrics top tips: COVID-19 relating to children and young people

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As we go into winter as GPs we will increasingly see children who have upper respiratory tract symptoms and sore throats at a time when COVID-19 prevalence is likely to increase. It is important to recognise that the evidence suggests that children, if unwell with a temperature are more likely to have another pathology rather than COVID-19 (e.g. UTI, Parvovirus, flu, meningitis), however we must still advise these children and families of the risk of COVID-19 and need to follow the advice to isolate the whole family as per national guidance, or until a test has been performed and has been returned as negative*.

The Royal College of General Practitioners (RCGP) and the Royal College of Paediatrics and Child Health (RCPCH) produced an excellent webinar along with the Academic Health Sciences Network (AHSN) entitled "COVID-19 and children, what the busy clinician needs to know" that can be viewed here.

Top tips for children and young people:

1. **The diagnostic criteria for COVID-19 applies to children of all ages**
   If a child has a cough, temperature or loss of taste / smell then they should be considered at risk of having COVID-19. The child should not attend school and the whole family (and any support bubble) should isolate as per national guidance until a test has been performed and has been returned as negative*, or continue to complete the isolation period if they test positive letting all contacts know.

   *If there is a high clinical suspicion for a COVID-19 infection and a negative test, the accuracy of the test needs to be taken into account when decisions around isolation or return to school are considered. Detailed advice can be found on the RCGP Frequently Asked Questions (FAQ) page here.

2. **You cannot reliably differentiate between a cold, flu and COVID-19 over the telephone or by examination alone**
   Whilst there are some symptoms more common with upper respiratory tract infections and the flu, there is significant cross over with COVID 19. For this reason, any child or young person with the diagnostic criteria for COVID-19 should follow the national guidance, isolate with their family and apply for a test.

3. **The way children are assessed is based on clinical need**
   COVID-19 does not change our need to take a full history and assess children and young people. If indicated by the history, following initial remote consultation and where there is clinical need, further review and examination of the child should be

undertaken, this can be via video call or face to face based on shared decision making principles.

4. **Clinical assessment should include vital signs**
   It is still recommended to document the vital signs of children and young adults, even when consulting remotely. Consider asking if the family own their own thermometer or pulse oximeter. Describe to the parent / carer how to perform a capillary refill test and observe it being completed. You can count the respiratory rate over a video call and there are great apps such as 'R rate' that patients can download to count it themselves. Ask about signs of deterioration and always check for the risk of sepsis. If there are any concerns then a face to face appointment should be arranged.

5. **The guidance on oral examination and tonsil examination has now changed**
   The oropharynx should only be examined if deemed absolutely essential and then only after risk assessment.

   The use of the FeverPAIN score is recommended when assessing children and adults with sore throats as per NICE guidance. As part of the FeverPAIN score assessment of the pharynx is recommended. This can be approached pragmatically using photographs submitted by patients or live during a video call. In this case, only with a total FeverPAIN score (including examination) of 4 or more should antibiotics be prescribed.**

   If it is not possible to examine the child and you are happy that they are not at risk of sepsis, the Royal College of Paediatrics and Child Health does advocate a pragmatic approach to sore throats, with antibiotics offered at a FeverPAIN score of 2 in lieu of an examination if deemed clinically appropriate.

   If however it is felt essential to examine the oropharynx following a risk assessment, the Royal College of Paediatrics and Child Health and Royal College of Surgeons (based on updated evidence) now state that this examination can be completed using standard community PPE (surgical mask, gloves, eye protection and apron/gown). This is in line with Public Health England guidance and aligns with the PPE used for COVID-19 testing and ENT procedures such as nasendoscopy. They go on to state that children should not be referred to A&E simply for an examination of the oropharynx, but caution should be applied, and we therefore recommend that if you have any doubt, to call your local paediatric team and seek their advice and guidance.

**It is important to note that the FeverPAIN score is not validated in children under 3 years of age, but that in this age group antibiotics rarely of benefit and should therefore only be prescribed in exceptional circumstances or if scarlet fever is strongly considered.

6. **If a child is very unwell, they are much more likely they have another diagnosis than COVID-19**
   Evidence shows that when children and young people present, if they are very unwell, the diagnosis is much more likely to be a pathology other than COVID-19. It is essential we do not forget other causes of the sick child such as meningitis, DKA or an untreated UTI during the pandemic. Rapid appropriate assessment and onward management of these children is essential.

7. **Paediatric multisystem inflammatory syndrome (PIMS)**
   A small number of children have been identified who develop a significant systemic inflammatory response to COVID-19 (also known as PIM-TS). The Royal College of Paediatrics and Child Health states that this rare syndrome shares common features with other paediatric inflammatory conditions including Kawasaki disease, toxic shock syndrome, bacterial sepsis and macrophage activation syndrome and importantly their SARS-CoV-2 PCR test may be positive or negative. Early recognition and secondary care referral is essential and must be considered in any child presenting with a persistent fever, inflammation (neutrophilia, elevated CRP and lymphopenia) and evidence of single or multi-organ dysfunction (including shock).

   Stable children presenting with a persistent fever should be discussed as soon as possible with secondary care to determine if blood tests and paediatric review is required.

8. **Adolescents have their own specific health needs and must not be forgotten**
   Ensure that those under 18 are not disadvantaged by your practice's approach to remote consulting. This group of patients can access medical care by themselves as long as they have capacity. Be aware that there may be issues that they do not want to discuss with their parents / carers present, who may be in the background of the call, and offer for them to go to a place more secluded to continue the conversation if appropriate. Use the same principles to assess capacity as you would in a f2f consultation and document this clearly in the notes and consider structuring your consultation using the Headsss approach (Home/relationships, Education/employment, Eating, Activities,

Drugs/alcohol/tobacco, Sex and relationships, Self harm/ suicide, mental health, Safety)

9. **Safeguarding**
   Safeguarding must not be forgotten. All professionals who look after children and young people must continue to base their judgements on the best interests of that young person. Continue to be curious. Have a low threshold for a face to face consultation if there are any potential or documented safeguarding risks, and when children and young people do not attend for appointments, document this in the notes and ask yourself do you need to contact them again?