**Asymptomatically infected children – infection control implications**

Although the COVID-19 narrative has focused firmly on adults, there is increasing concern about the role played by asymptomatic children in the spread of infection.1 This is relevant to all staff involved in the care of children. A large number of paediatricians across Europe appear to have been infected with COVID-19.

ENT surgeons are extremely concerned that nose and throat examination poses significant risk for healthcare professionals.2 We are equally concerns and agree that the oropharynx of children should only be examined if absolutely essential. It currently forms part of the routine paediatric examination; we suggest that during the COVID-19 pandemic, the default is reset to examination of the throat being the exception rather than the norm. We suggest that if a diagnosis of tonsillitis is considered, the [feverpain](https://www.mdcalc.com/feverpain-score-strep-pharyngitis) scoring system is used to decide if antibiotics are indicated (validated in children 3 years and older).3 We suggest that the child is automatically given a score of 1 for purulent tonsils and a score of 1 for severely inflamed tonsils in the absence of examining the throat. However, only children with a total score or 4 or 5 should be prescribed antibiotics (we suggest children with a score of 3 or less receive safety netting advice). Although this is likely to result in a temporary increase in antibiotic prescribing in children, at this current time we feel that this is preferable to healthcare staff being unnecessary exposed to COVID-19. Antibiotics rarely confer a benefit in children under 3 years with tonsillitis and should only be prescribed in exceptional circumstances or if a diagnosis of scarlet fever is strongly considered. If the throat needs to be examined, personal protective equipment (including a surgical face mask) must be worn, irrespective of whether the child has symptoms consistent with COVID-19 or not.

In addition, we recommend that anyone conducting an aerosol generating procedure on any child (irrespective of the presence of symptoms consistent with COVID-19), including intubation by anaesthetists or operating on the oropharynx (ENT) needs to wear FFP3 masks. See current [Public Health England (PHE) guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) for information about aerosol generating procedures.

**ADDITIONAL infection control measures:**

1) Minimise footfall on G level – if not delivering direct patient care, don’t come into the hospital. Avoids risk of staff to staff transmission.

2) Meetings should be virtual where possible (concept of social distancing should apply to healthcare professionals as well as the public).

3) Speciality teams require shadow rotas to mitigate for staff absence / self-isolation

4) No food/ drinks in clinical areas

5) Assume that all children are potentially COVID positive (unless tested negative). Be obsessive with hand hygiene and assume all computer keyboards are infected.

6) Front line staff managing children should consider wearing scrubs – change on arrival and removal before leaving. Wash scrubs at home each day.

7) All staff on PICU to wear PPE including FFP3 masks. No distinction between ‘clean’ and ‘dirty’ area.

8) Masks (surgical masks and FFP3 masks) can be worn between patients, as long as they are not touched.

Our priority is to keep our colleagues safe whilst remaining pragmatic and remembering that PPE is in limited supply!

1. Kam KQ, Yung CF, Cui L et al. A Well Infant with Coronavirus Disease 2019 (COVID-19) with High Viral Load. *Clin Infect Dis* 2020.

2. Lu D, Wang H, Yu R et al. Integrated infection control strategy to minimize nosocomial infection of corona virus disease 2019 among ENT healthcare workers. *J Hosp Infect* 2020.

3. Little P, Hobbs FDR, Moore M et al. Clinical score and rapid antigen detection test to guide antibiotic use for sore throats: randomised controlled trial of PRISM (primary care streptococcal management). 2013; **347**: f5806.