INTRODUCTION

Coronavirus belongs to the family Coronaviridae, order Nidovirales. It is the type of RNA virus. The viruses range from 60 nm to 140 nm in diameter. It has spurred on the surface which looks like a crown in an electron microscope. That's why named as coronavirus. Before COVID-19 pandemic, there were 6 coronaviruses which caused the infection to humans: 229E, OC43, NL63, HKU1, SARS-CoV, and MERS-CoV. Coronaviruses cause diseases in their host species; the one who is infecting humans through interspecies transmission has become a threat to worldwide health. Severe coronavirus pandemics have occurred previously: severe acute respiratory syndrome (SARS) in 2003 and the Middle East respiratory syndrome (MERS) in 2012. Both these viruses have also believed to be originated from bats.

Epidemiology

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has caused several cases of severe pneumonia worldwide. It originated in Wuhan in Hubei province, China. SARS-CoV-2 causes infection by ACE receptors, similar to SARS. It causes potential damage to vital organs, mainly the lungs. COVID-19 mainly affects respiratory tract with symptoms ranging from upper respiratory tract infection like symptoms to full-blown ARDS. Although the pediatric age group is shown to be less susceptible to severe infection, they can very well act as an intermediate in the transmitter of the virus. Treatment is symptomatic for mild diseases, but severe disease and ARDS require ICU management and specific treatment.

Clinical manifestations

Children are mostly asymptomatic. Some may have symptoms of a common cold like fever, dry cough, with runny nose. Very few patients have gastrointestinal tract symptoms, diarrhoea being most common of them. Most children are mildly infected, and the prognosis is rather good. Adult studies have concluded that severe cases present with breathing problem 6 days after initial symptoms. These cases can land up in ARDS, septic shock and coagulopathy. Even myo-

ABSTRACT

Since December 2019, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has caused a series of Cases of severe pneumonia worldwide. It originated in Wuhan in Hubei province, China. SARS-CoV-2 causes infection by ACE receptors, similar to SARS. It causes potential damage to vital organs, mainly the lungs. COVID-19 mainly affects respiratory tract with symptoms ranging from upper respiratory tract infection like symptoms to full-blown ARDS. Although the pediatric age group is shown to be less susceptible to severe infection, they can very well act as an intermediate in the transmitter of the virus. Treatment is symptomatic for mild diseases, but severe disease and ARDS require ICU management and specific treatment.

Key Words: COVID 19, Neonate, Pediatrics, Suspetible, Treatment

Coronavirus Disease (COVID) 2019 in Children – a Short Review

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carditis has been reported. In a retrospective study by Dong et al. about the severity of COVID-19 in children (n = 2143), it is been reported that infants were high risk for becoming severely ill among pediatric age group .10.6% of all infant cases were categorized as severe. Severely ill were having pneumonia as a most common manifestation (8.7% of infant cases). Critically ill children were defined as ARDS requiring mechanical ventilation, which was 1.8% of infant cases. The median age of children was 7 years (interquartile range: 2-13), and male sex was the majority, 1213 cases (56.6%). Over 90% of all patients were not severely ill. Between 1 to 5 years of age 7.3% became severely ill and 4.2% for those aged 6 to 15 years. Age group considered for data was below 18 years old (7)

COVID-19 rarely presents in infants and newborns. In a study, 9 infants labelled as COVID-19 positive are reported (11). This is retrospective data. All cases were suspected of epidemiological exposure. Only four infants had a fever out of 9. Two babies had upper respiratory tract symptoms. For 2 babies they didn’t get information on symptoms. None of the infants became severely ill. This is contradicting to results by Dong et al. as mentioned above. Because infants younger than 1 year cannot wear masks, their caretakers have to take special precautions. Caretakers should wear masks, wash hands before close contact with infants, and sterilize the infants’ toys and tableware regularly. Cases of neonatal infection with SARS-CoV-2 have been reported in China. But none of them acquired the infection through vertical transmission (11). Newborns may acquire an infection while nursing from infected mothers.

The diagnosis of COVID-19 in the neonate should be suspected if: (a) symptoms like hypothermia or fever, decreased activity, poor feeding, or tachypnea or distress, (b) chest radiographs abnormalities which may include unilateral or bilateral ground-glass opacities, (c) history of exposure to a patient of COVID. All possible cases should be admitted to NICU. There is no recommendation of antiviral drugs for COVID-19 in the neonate. Antibiotics are only applicable if bacterial co-infection is suspected or proven. If newborns present with respiratory distress, it should be managed as other respiratory illnesses are being managed in NICU. Ventilation and nitric oxide inhalation should be considered. The surfactant may be required. In severely ill newborns, parenteral steroids or IVIG may be considered, though efficacy is questionable. Renal replacement therapy and ECMO may also be required. (12)

**Bigger concern – If children can act as effective transmitters of the virus**

In China, the reproductive number for COVID-19 estimated is 2(11). Data from China has concluded that kids of school-going age (<10 years) measures for 1% cases of SARS-CoV-2 (14). They are significantly not getting affected. This is in contrast to other viral infections as young children is considered as a risk group for severe illness after getting infected with viruses such as RSV and flu virus. Developing an immune system is thought to be responsible for increased severity of illness by viruses in this age group(15). Therefore, the absence of pediatric patients in the current pandemic has baffled clinician. Are we missing them?

In a report of 36 pediatric patients having COVID-19 infection, CT chest was done for all children. Ten (28%) patients were asymptomatic. None of them had severe disease. The most common clinical features were pneumonia symptoms in 53% case. Next common symptoms were fever and dry cough. Treatment for them consisted of aerosolised interferon alfa (100%), lopinavir-ritonavir syrup two times a day for 14 days in fourteen (39%). Oxygen was required by only 17% of cases. They were sent home after two negative SARS-CoV-2 PCR reports.

However, it is not clear which children should receive antiviral or immunomodulatory treatment, because of the high number of asymptomatic infected contacts. This study might suggest that children for some reasons have milder disease. There is a tissue called inducible bronchus-associated lymphoid tissue (BALT). Possibly, lung infiltrates in pediatric SARS-CoV-2 infection act as inducible bronchus-associated lymphoid tissue (BALT) structure development after respiratory insult. Bienenstock originally described BALT as a novel mucosal lymphoid tissue underlying a dome epithelium along the large airways (17). Other proposed theory is higher angiotensin-converting enzyme (ACE) activity. In children of 4 to 13 years of age, serum ACE progressively increases. After 13, serum ACE level gradually falls. High-ACE activity is also documented in newborns. It may be because of the fast development of lung capillaries after parturition and capillary endothelial cells are principal sources of circulating ACE (18). It can be postulated that the effect of COVID-19 on ACE2 may be protective in children.

Kids frequently do not have a serious disease, making them undiagnosed and potential virus transmitter.

**Definitions of the severity of COVID-19 in pediatric patients**

1. Asymptomatic infection: COVID-19 PCR test is positive, but the patient is completely asymptomatic with normal chest X-ray.
2. Mild: symptoms like fever, tiredness, body ache, cough, throat pain, sneezing. On examination, there may be congestion of pharyngeal wall and no findings on auscultation of the chest. Some can present with only gastrointestinal tract symptoms like diarrhea and abdominal pain.
3. Moderate: presents with pneumonia. High-grade fever and cough, which is more than that in the mild category. Some may have wheezing, tachypnea and on...
auscultation may have crept which are bilateral. Some cases can be asymptomatic, but their CT thorax shows lung infiltrates.

4. Severe: Early respiratory symptoms such as fever and cough. Gastrointestinal symptoms such as diarrhoea may be associated. After 1 week, respiratory distress starts, with hypoxemia. Requires ICU admission.

5. Critical: ARDS with other organ dysfunction like renal failure, myocarditis, coagulopathy. These patients will require ventilation and may require renal replacement therapy and other supportive care.

**Investigations**

Diagnosis is done by PCR on upper respiratory tract samples (throat swab/ nasopharyngeal swab) or lower respiratory tract samples (sputum/ endotracheal aspirates and bronchoalveolar lavage).

Send CBC, CRP, RFT, LFT, ECG in patients with severe infection. The total leukocyte count is normal or low with lymphopenia; a lymphocyte count of less than 1000 has been associated with severe illness. CRP and ESR are generally elevated. Cardiac enzymes may be checked if myocardial involvement suspected or shock present. Ferritin and LDH may be checked in severe cases at high risk of developing cytokine storm.

**Treatment**

Treatment is mostly supportive. The first step is to isolate the patient to prevent transmission to other patients and healthcare workers. Antibiotics and antivirals such as oseltamivir are of no use and should be deferred in confirmed cases.

**Treatment for children with severe acute respiratory infection in COVID-19 patients.**

1. Start supplemental oxygen if SpO2 < 94% (target SpO2 94 -98%) in children with respiratory distress or shock. Otherwise target SpO2 > 90%.
2. Nasal prongs or cannula are preferred in children as it may be better tolerated 19.
3. HFNC may be used preferably over NIV( non-invasive ventilation). It should be used only in patients with hypoxemic respiratory failure in negative pressure room 19.
4. MDI( metered-dose inhaler) with face mask preferred over nebulisation as the risk of aerosol generation higher with nebulisation.
5. NIV may be used only in selected patients with hypoxemic respiratory failure. Use of conventional ventilator for NIV with non vented oro-nasal masks is preferable over dedicated NIV and use of vented masks. Monitor closely for deterioration and intubate if the patient deteriorates or there is no improvement in 1 hour.
6. In patients with hemodynamic instability, multiorgan failure or altered sensorium invasive ventilation is preferred.
7. In situations where invasive ventilation is not available due to resource limitation bubble, CPAP may be offered for newborn and children with severe hypoxemia.
8. prone ventilation has shown to be beneficial.
9. Use N95 mask with complete PPE including long-sleeved gown, goggles or face shield, gloves) for all aerosol-generating procedures.

**Aerosol generating procedures**

- Intubation
- Manual bagging before intubation
- CPR
- Nebulisation
- Non-invasive positive pressure ventilation
- Open suction
- Disconnection from ventilation Tracheostomy

**Ventilation**

- Use low Tidal volume ventilation, 3 – 6ml/kg predicted body weight (PBW) for poor compliance and 5 - 8ml/kg PBW with better preserved compliance and maintain target plateau pressure less than 28.
- Titrate peep for persistent hypoxia. Max PEEP 15 cm of H2O for children (WHO recommendations)
- Offer prone position for 12 – 16 hrs for patients with moderate to severe ARDS
- Opt for restrictive fluid than liberal fluid therapy.
- Do not use steroids for the patient with pneumonia with no ARDS.
- In patients with severe ARDS low dose methyl pernisolone1- 2mg/kg/day for 5-7 days

**Chemotherapeutics**

Empiric antibiotic therapy should be offered to patients with severe suspected COVID pneumonia and sepsis within 1 hour of admission and appropriate de-escalation and modification may be done depending on culture reports and clinical judgement 20.

**Hydroxy chloroquine**

Two studies are showing promising results of hydroxychloroquine/chloroquine in COVID-19. Gao et al. have shown that chloroquine worked better as compared to control treatment concerning decreased pneumonia occurrence, better chest imaging findings, early clearance of virus and most importantly decrease in course of disease duration. Data is from over 100 patients 31. Gautret et al. treated 20 patients with hydroxychloroquine and compared the results with 16 controls in France. They measured the viral load on day 3, 4, 5 and 6 of treatment. All categories of patients were taken including asymptomatic. Hydroxychloroquine showed promising results in decreasing viral load. The results on day 3 indicated that 50% of the hydroxychloroquine-treated
patients had a viral load reduction with a \( p=0.005 \); on day 4, it showed a 60% reduction with a \( p=0.04 \); on day 5, a 65% reduction with a \( p=0.006 \); and on day 6, 70% of the patients showed viral load reduction with a \( p=0.001 \). They have further described the synergistic effect of azithromycin when used along with hydroxychloroquine in decreasing the viral load. The combination treatment showed a 100% decrease in the viral load with a \( p<0.001 \) by day 6, while hydroxychloroquine alone showed a 70% decrease\(^25\).

**Adult Dose:** 400mg PO BD day 1 followed by 200mg PO BD for 4 days

**Pediatric dose (<18 years):** 6.5mg /kg /dose (Max 400mg) PO BD day 1 followed by 3.5mg per kg PO BD (max 200mg/dose) for 4 days.

**Treatment duration:** 5 days. In select patients with extended ventilation or profound immunosuppression, duration may be extended.

**Adverse events:** Retinopathy, rash, nausea, glucose fluctuations, and diarrhoea. GI symptoms can be mitigated by taking hydroxychloroquine with food.

**Contraindications:** QT prolongation > 500msec, porphyria, myasthenia gravis, retinal pathology, epilepsy. If baseline QT prolongation is present take frequent ECG. Avoid taking hydroxychloroquine with antacids. Separate administration by at least 4 hours.

**Chloroquine Sulphate** (hydroxyl chloroquine (HCQ) is preferred over chloroquine)

**Pediatric dose:** 10mg /kg chloroquine sulphate base stat followed by 5mg per kg 12 hours later and then 5 mg/kg/ dose BD for 4 more days.

**Adult Dose:** Chloroquine sulphate base 600mg (10mg/kg) stat followed by 300 mg 12 hours later and then 300mg BD for 5 days.

**Azithromycin**

It is to be given along with HCQ or chloroquine sulphate\(^22,24\).

**10mg /kg day 1 (max 500mg)** 5mg/kg days 2-5 (max.250mg)

**Zinc** inhibits coronavirus RNA polymerase activity and blocks replication of the virus in cell cultures. Zinc 2mg per kg per day may be given\(^23\).

**Lopinavir/ ritonavir** may be considered in a case to case basis after written consent and medical board concurrence.

**Pediatric Dose Lopinavir /ritonavir**

14 days to 6 months : 16mg/kg/dose ( based on lopinavir component) PO BID

\(< 15kg : 12 mg/kg/dose PO ( based on lopinavir component)\)

\(15-25 kg : 200 mg-50 mg PO BID\)

\(26-35 kg : 300 mg-75 mg PO BID\)

\(>35 kg : 400 mg-100 mg PO BID\)

**Adult dose**

400/100 PO BID

**Duration of treatment :** 14 days or 7 days after becoming asymptomatic

**Adverse events:** Hepatotoxicity, pancreatitis, diabetes, QT prolongation, lipid elevations.

- Hydroxychloroquine and lopinavir should not be combined because of a drug interaction.
- Oseltamivir 3mg/kg BID may be given to all children with influenza-like illness till PCR report is available.

**Tocilizumab:**

Consider adding to antiviral therapy for patients with rapidly worsening respiratory gas exchange, radiographic infiltrates by imaging (chest x-ray, CT scan, etc.) AND SpO2 ≤93% on room air or greater than 6 L/min O2.

It may be offered to patients at high risk for cytokine storm. Criteria for patients at high-risk for developing cytokine storm. Ferritin >300 ug/L with doubling within 24 hours, Ferritin >600 ug/L at presentation and LDH >250 and Elevated D-dimer (>1 mg/L)

**Pediatric Dosing (<18yrs):**

\(< 30kg – 12mg/kg IV over 60 minutes;\)

\(> 30kg - 8mg/kg IV over 60minutes ( max. 800mg per infusion).\)

Consider giving an additional 2 dose 8-12 hours later if continued clinical decompensation

**Contraindications:** Avoid in pregnancy and newborns. Mothers should stop breastfeeding if receiving tocilizumab Monitor liver enzymes in patients receiving tocilizumab.

Serious adverse events: Gastrointestinal perforation, Anemia, Hepatitis, Infusion reaction.

**Treatment in concise**

| **ISOLATION** | **for every case** |
|--------------|-------------------|
| Oxygen       | If SpO2< 94%      | By nasal prongs or non-rebreathing mask |
| Ventilation  | If distress persists or patient deteriorates on Oxygen. | With non vented mask and preferably in negative pressure room |
| NIV          |Preferred over NIV.| 0.5-2 lit/kg/min. |
| HFNC         |                   |                      |
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ISOLATION for every case

Invasive ventilation
Preferable over NIV, as aerosol generation risk is not there.
Low tidal volume strategy.
Adequate PEEP.
Prone ventilation.

Hydroxychloroquine (HCQ)
Given In moderate, severe and critical COVID-19
6.5mg /kg /dose (Max 400mg) PO BD day 1 followed by 3.5mg per kg PO BD (max 200mg/dose) for 4 days.

Chloroquine Sulphate ( HCQ is preferred over chloroquine)
same as HCQ
10 mg /kg chloroquine sulphate base stat followed by 5mg per kg 12 hours later and then 5 mg/kg/ dose BD for 4 more days.

Azithromycin
Along with HCQ or chloroquine
10mg /kg day 1 (max 500mg) 5mg/kg days 2-5 (max.250mg)

Zinc
Can be given in all cases
2mg per kg per day.

Tocilizumab
Patient requiring NIV or invasive ventilation
< 30kg – 12mg/kg IV over 60 minutes;
> 30kg - 8mg/kg IV over 60minutes (max. 800mg per infusion).
additional 2 dose 8-12 hours apart if continued clinical decompen-sation

Discharge
If patient better, afebrile for 48 hours and off oxygen with 2 negative samples 24 hours apart.

CONCLUSION

The SARS-CoV-2, an RNA virus can cause COVID-19. It is extremely infectious; the whole population is susceptible. Respiratory droplets and contact are the main routes of transmission. All age group are susceptible including neonates and infants. Though pediatric age group has been showing the milder degree of disease mostly, they can have severe disease with ARDS which will require PICU care.

Abbreviations
ACE- Angiotensin-converting enzyme.
ARDS- Acute respiratory distress syndrome.
COVID-19- Coronavirus disease 2019
SARS-CoV- severe acute respiratory syndrome- coronavirus
MERS- middle east respiratory syndrome.
CT- Computed tomography.
CBC- Complete blood count
CRP- C reactive protein.
ESR- Erythrocyte sedimentation rate.
LFT- liver function test
KFT- kidney function test.
SpO2- oxygen saturation.
HFNC- high flow nasal cannula
NIV- non-invasive ventilation.
MDI- metered-dose inhaler.

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