**BEAUFORT PEDIATRICS**

**Common Sense, Children, Schools, and COVID 19**

October 26, 2020

To our parents and families:

We are now 8 months into the COVID Pandemic in Beaufort and 10 months worldwide. We continue to gain even more experience with the virus and its risks, and there is good news.

As we have been reporting and stating since June, children are not at unusual risk for illness during the COVID pandemic. In our office we have not had a single patient/child with anything more than a mild upper respiratory infections (URI) from COVID-19. No child in Beaufort has been hospitalized for a COVID related illness.

 Yes, over 8 months we had over 300 children with positive tests; but have seen no significant illness in our young patients. Tests were performed when children were exposed, usually from an adult in the family.

Children can spread the virus for brief periods (5-10 days) when they are mildly ill or rarely when asymptomatic. It is clear asymptomatic cases do not spread the virus as readily as those who are actively ill with cough, congestion, and sneezing. Like all viral illnesses, once resolved the adult or child is then immune and is no longer a vector.

As stated above the positive COVID tests we have found in children have been in contact tracing. Repeatedly, we have seen a child or parent positive for COVID (asymptomatic or mild illness) and the rest of the family, including close siblings, not become ill nor even test positive.

How can this be? Isn’t the virus highly contagious? The only logical answer is a substantial number of people (particularly healthy young people) are already resistant or immune to the virus.

Researchers are focusing on the probability that 40% to 60% of the population is resistant to COVID -19 due to T cell immunity derived from previous Corona virus colds (URIS). This makes a lot of sense, fits with our knowledge of how virus immunity works, and squares with the observation that most children are in a resistant group

As the media focuses on school starting, there will be increased reports of children “with COVID”, or “COVID Cases”. Unfortunately, there are no attempts in the media to differentiate an asymptomatic or mildly ill child testing positive in school “as a positive case” from children who are sick.

The total number of positive tests will continue to rise, but that is not bad news, as positive tests do not necessarily translate into sick patients. More asymptomatic positive cases result in more people who become immune going forward, no longer capable of spreading the disease. The end point of a Pandemic is when enough people have become immune (herd immunity or community immunity) that the virus dies down.

Whether one ‘catches” COVID from another person with the illness depends on 4 factors:

1. Distance
2. Duration of exposure
3. Viral load (how much virus a person is spreading when positive, the “inoculum”)
4. Susceptibility (health, age, genetic predisposition, by far the most important factors)

We know in viral illnesses the “viral load” or “inoculum” is highest the days just before symptoms and the first days of symptoms. In the COVID epidemic most children have some natural resistance and lower viral loads which seems to play a role in younger children not being major vectors.

In the media age, it is difficult to keep perspective and resist fear. If a child dies from or with COVID; it is headline news because it is unusual. Of the 240,000 total national death count so far from COVID, 120 have been children, almost all with pre- existing serious chronic diseases.

For perspective: It is 40 times more likely a child will be the victim of homicide or child abuse than die from COVID and 30 times more likely a child will die in a motor vehicle accident. Sadly, it is 20 times more likely a child will commit suicide this year, especially with the current social upheaval, than die from COVID.

In the last flu season 3 times more children died from the flu than have died from COVID, even with the flu vaccine available. The flu is unequivocally more dangerous to those under 40.

The worldwide data confirms our experience in the U.S.; children are at minimal risk for COVID 19.

In contrast harm has been done to children and families by attempts to control spread of the virus. Young families are put under incredible stress as parents wrestle with the impossible scenario of working full time, being physically with their children full time, and being teachers’ full time.

Kids miss out on class time, social interaction, and normal growth and development. A rise in depression, anxiety, and other psychological issues have occurred, not to mention that 7 million American children have no internet access to even attempt online learning.

(Let us pause for a moment and consider: What if children were as severely affected by this pandemic as the geriatric population? Can one imagine what a catastrophe that would have been? Thankfully, that is ***not*** the case, and, after 8 months, it is time to re-set and focus on what is best for our children).

It is not necessary *t*o close schools or keep children socially isolated. The harm done by such a course outweighs any benefit. The World has come to the same conclusion; China, Denmark, and Norway opened schools in April. Taiwan and Sweden never closed schools. Austria and Belgium reopened in May. Even hard-hit Spain opened schools May 25th. In the U.S., during the peak of the NY outbreak, day cares were kept open for the children of essential first responders. There were no reports of any issues.

Just recently (October) evidence from Spain, England and the US has been published showing the opening of schools did not cause surges in COVID infection rates, matching what we have already observed and have been reporting since June.

As schools work toward re opening it behooves us all to keep a grounded perspective and use rational and reasonable precautions as we move forward

June 29th the American Academy of Pediatrics published a statement advocating strongly that children be in the classroom come Fall with a list of best practices to maximize infection control.

May 19th the CDC published an extensive outline of recommendations for schools. It should be emphasized that the list included recommendations, not requirements, and has many qualifying statements such as “when feasible” and “when practical”.

**CDC Guidelines**: The recommendations (“when feasible, when practical”) include:

1. Wear masks for over age two. OOPS! It is a good thing this is a recommendation and not a requirement. Clearly it is not practical in younger children. Older ages may be able to use masks when in a situation ***where social distancing cannot be maintained***. Masks can be helpful in certain situations (example of riding a crowded bus), but other mitigation factors are more important than masking.
2. Desks 6 feet apart. Is that possible in most schools? The American Academy of Pediatrics says to try for at least 3 feet. Evidence suggests 3-foot spacing approaches the benefits of 6 foot spacing in asymptomatic students, particularly if other mitigating policies are followed.
3. Stay in same group and minimize changing rooms.
4. Limiting class size as possible.
5. Physical barriers (like the plexiglass shields now at checkout counters) between sinks and in bathrooms.
6. Staggered start times.
7. One-way hallways, tape on the floor to encourage distancing, and planning to avoid congestion and student “traffic jams”
8. Using outdoor space whenever possible, for academic classes, music, PE and lunch.
9. Use personal pens, pencils, tools, and supplies, avoid unnecessary sharing
10. Temperature checks every morning at arrival was recommended by the CDC; but the AAP recognizes that may not be practical and admits it is of limited value.
11. Generally avoiding large groupings such as assemblies

These CDC recommendations can be helpful if practical, but their importance pales when compared to the most basic ***common-sense*** precautions we as parents already take every school year during the cold and flu season:

**Parent and Family Guidelines:**

1. If a child has a cough, congestion, sneezing (cannot control secretions) and or fever they must stay home at least until the cause of the symptoms is documented. (allergy, illness, environmental irritant?)
2. Hand washing several times a day and whenever practical.
3. Use of hand sanitizer.
4. Teaching our children how to control secretions and practice rational and effective infection prevention to the extent that their age and maturity will allow.
5. Keep immunizations up to date, get regular checkups with your child’s doctor and obtain a flu vaccine when they are available this fall. An uncontrolled flu outbreak on top of COVID is going to be a problem.
6. If you have a child at higher risk because of a serious medical issue, discuss with your doctor the advisability of at home schooling.
7. If family members have a COVID positive test and/or COVID illness and the child is exposed (defined by the CDC as more than 15 minutes less than 6 feet apart), do not send to school, self- quarantine following your doctor’s recommendations
8. Encourage outside play, sun and fresh air. Positive Vitamin D levels, undoubtedly beneficial, is related to outside play and sun exposure.
9. Use the commonsense test, be ready to be adaptive and flexible as the circumstances warrant. For our parents that will mean a back-up plan for childcare if your child must be home from school for a week even for a minor illness. A necessary plan during any cough and cold winter season.

 COVID 19 is a dangerous disease to the elderly. As has been stated repeatedly: the elderly with preexisting medical problems (particularly hypertension, immune deficiency, heart disease, COPD, and diabetes) are at risk.

 Individual teachers must consider their risk profile. The older adults at school with preexisting serious medical conditions will be at higher risk, as they are in the community at large.

 It is important to face the COVID pandemic rationally, understanding and weighing the real risks while resisting the constant barrage of misinformation, hyperbole, and even fear mongering that typifies the time in which we live.

Each family will need to decide on attending school versus virtual learning. For most families, the benefit of attending school will outweigh the risk. Some may find it possible, or necessary, to continue at home virtual learning until the Pandemic eases further. We support our families in whichever method they choose for the education and benefit of their children.

Dr. Joseph Floyd

Beaufort Pediatrics