Athough I have reviewed important aspects of COVID-19 in the pediatric and adolescent age groups in two previous editorials,1,2 new information is published daily. There is more clinical information that has been reported regarding a pediatric immune multisystem syndrome that resembles Kawasaki disease or toxic shock syndrome, which the Centers for Disease Control and Prevention has called multisystem inflammatory syndrome in children (MIS-C).3-8,10 Children have presented with persistent fever and a variety of clinical manifestations, which may involve multiple organ systems and elevated proinflammatory markers. MIS-C may present weeks after a mild or even clinically asymptomatic infection.9,10 Second, a variety of cutaneous manifestations have been reported, most commonly in adults but also in pediatric patients.11-14 A registry has been set up by the American Academy of Dermatology for clinicians to report these skin findings.9 Third, there is also a report of the clinical manifestations and outcomes of a convenience sample of patients admitted to pediatric intensive care units (PICU) in the United States and Canada.15 There were 48 patients admitted to the PICU, with a median age of 13 years13 with COVID-19 diagnosis confirmed with nasal swab polymerase chain reaction. A total of 40 (85%) had preexisting underlying medical conditions including medical complexity, immune suppression/malignancy, and obesity.13 This group of patients presented with respiratory symptoms most frequently, and 39 required respiratory support above their baseline and 21 were managed noninvasively.13 Targeted antiviral therapies were used in 28 (61%) of patients. Two patients died, both of whom had preexisting medical comorbidities and developed multisystem organ failure.15 At the time of this editorial, 15 children (31%) were still hospitalized including 5 of whom were still critically ill.15 Fourth, an article by Wu et al.16 summarizes the characteristics of 74 pediatric patients with COVID-19, which included (1) abnormalities in leukocyte count in 23 (31%) patients, (2) abnormal lymphocyte count in 10 (13.5%) patients, (3) co-infection with common respiratory pathogens in 19 patients (51%), and (4) prolonged fecal shedding in 10 patients (13.5%). Fifth, what about COVID-19 and postinfection immunity? The limited available data on antibody responses to COVID-19 and one small animal study, “suggest that recovery from COVID-19 might confer immunity against reinfection, at least temporarily.”17

What is clear is that the clinical spectrum of COVID-19 continues to evolve, and investigators continue to update the literature as quickly as possible. This information will help clinicians provide optimal care for our pediatric patients.

REFERENCES


