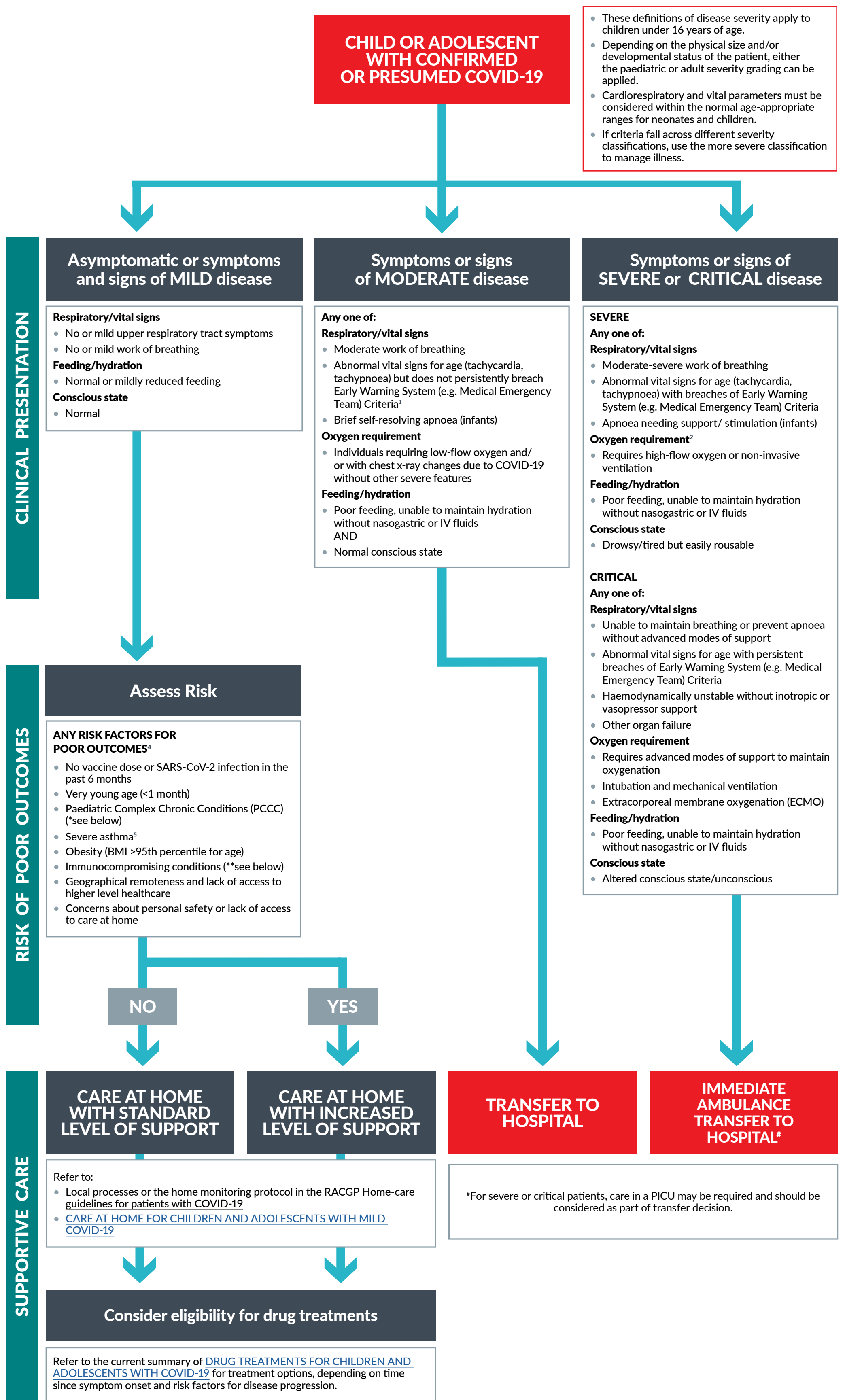


PATHWAYS TO CARE FOR CHILDREN AND ADOLESCENTS WITH COVID-19



Local adaptation may be necessary as assessment of overall risk and appropriate models of care may vary across jurisdictions



***PAEDIATRIC COMPLEX CHRONIC CONDITIONS (PCCC):**

- congenital and genetic
- cardiovascular
- gastrointestinal
- malignancies
- metabolic conditions
- neuromuscular conditions
- renal conditions
- respiratory conditions

****IMMUNOCOMPROMISING CONDITIONS:**

- Primary or acquired immunodeficiency
 - Haematologic neoplasms: leukaemias, lymphomas, myelodysplastic syndromes
 - Post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months)
 - Immunocompromised due to primary or acquired (AIDS) immunodeficiency
 - Other significantly immunocompromising conditions
- Immunosuppressive therapy (current or recent)
 - Chemotherapy, whole body radiotherapy or total lymphoid irradiation
 - High-dose corticosteroids: 0.5 mg/kg of prednisone per day (or equivalent) for ≥14 days
 - Selected other potent immunosuppressive therapies (refer to ATAGI advice)

[1] Temperature instability should be considered an abnormal vital sign in infants. Fever is common in children and does not contribute to determination of illness severity in isolation.

[2] Oxygen saturation target should be modified for children and adolescents with pre-existing illness, such as cyanotic heart disease.

[3] Infants and neonates <4 kg may be managed on high-flow nasal cannula oxygen at 2-8L/min irrespective of weight.

[4] Until further evidence emerges, modified adult risk factors have been applied. Evidence of paediatric specific risk factors is under surveillance.

[5] For example, in the past 12 months either ≥1 exacerbation requiring ICU admission or IV treatment OR ≥2 hospital admissions for asthma; children requiring biologic therapy for symptoms.