

Pediatric Grand Rounds at Nicklaus Children's Hospital

COVID-19 VACCINE & TREATMENT UPDATES - DISPELLING THE MYTHS

Speakers:

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Moderator:

Dr. Rani Gereige (RG), Director, Medical Education at NCHS

The following is a chat transcript is from the Q&A portion of the live Pediatric Grand Rounds session taking place on Friday, January 29, 2021, and begins at approximately 1:01:15.

RG: There's a couple of questions in the chat about pre-medication with Tylenol related to the vaccine, or even after the vaccine for myalgias, and ***“would premedication with [Tylenol] decrease the effectiveness of the vaccine or would taking ibuprofen”***... is preferable? What's your take on that for them...for the vaccine?

CSV: To me?

RG: Um... anyone [*laughs*] I don't know, either with you or Dr. Ramos...

CSV: I think that there's some evidence in previous studies, in children, when you give vaccines that if you pre-medicated with acetaminophen they had a lower antibody response. So, in general, the recommendation is not to pre-medicate before the vaccine, but if you, um... if you do have symptoms of myalgia you can take it afterwards. There's no contraindication for it.

I will tell you that when I had mine, I had some mild – just with the second dose, or some chills, and I did not take anything because I didn't want to touch that immune response. But, uh, but you can take it afterwards, not...not preemptively.

OR: I'll tell you the advice that I gave to my son, uh, you know he called me yesterday that he got the second vaccine and had a lot of arm pain. I said move the arm, put a little bit a bit of ice on it, and forget about it. You're just developing antibodies, and that's a good thing

RG: **Good advice.**

Um, uh, let's see... There's couple of questions related to sequencing, and *“is there a way”*, uh, that people, um, *“to have people's individual COVID virus infections sequenced?”* I know Dr. Ramos had talked about the different variants and the mutations that have been happening...

OR: All right, so, the sequencing is great, and there are some virologists that believe that you should do thousands and thousands of viruses, but the only problem is it is expensive. It can only be done by the government or very special institutions. It's not something that is in any way available to us.

Uh the world health organization does a lot of that – we broke off our relationship last year, so that made a change. We have not done a lot of sequencing, now they realize how important it is, so we're going to see more of it, but it's not something that is available to us. It's something that is done by public health, or by very good up-to-date laboratories affiliated with universities.

RG: **Thank you, uh one question about, if somebody...uh...*“how to counsel patient when they are exposed at home and they have received the vaccine. Can the person come to work, and when?”*** So, an exposure after being vaccinated.

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- OR: So the problem is the data that we have for efficacy is based on very, very, few patients... uh, even though it's been given into 40 million people, the data after exposure and so forth is very limited, so there's still – at best a 5%, or maybe a 10% – chance that that person could develop mild COVID, and may be able to transmit it, so it would be the same recommendations as anybody who is exposed. I would say probably that person is not going to develop serious COVID, or even moderate – probably if they develop anything is going to be mild – but there is a chance for transmission, so it's the same as anybody who's not been vaccinated.
- RG: **Um...regarding... there was a question regarding contact tracing, “have we given up on that in the United States?”** [laughs]
- CSV: [laughs]
- OR: [laughs] uh... we did. Unfortunately we, uh, we never really started. There was a little bit done initially... We're not doing it. There are countries like, uh, South Korea and Japan that, they have done a great job... We have not, and... I think England learned their lesson, they're doing a great job now. They kind of forgot about the whole thing and left it, but now they're doing it, so... we're not there yet, unfortunately
- RG: **Uh, another question about not including patients that have been treated with plasma: “Is there a waiting period, other than the recommended 10 to 14 quarantine”, I'm assuming for 10 to 14 days, “to not be infectious prior to receiving the vaccine”... I'm assuming it is related to somebody that was exposed and...**
- CSV: Somebody that received, um, convalescent plasma? Or whether or not they should...
- RG: **...when they can be immunized...**
- CSV: I think, I'm not sure, Dr. Ramos, do you remember if there should be a delay in those?... Um because if they received antibodies, there may be some blockage of the immune response, but I'm not sure...
- OR: There are no, I don't remember that there are specific guidelines for this but there is a concern that, if you have received antibodies, that the vaccine is not going to be effective. In most cases you probably would want to wait three months, but again, I have not seen any specific guidelines. But the concerns are there, that the vaccine may not be as effective because it could be blocked by the antibodies that you got.
- CS: Similar if you got the disease... some say because people, three months after, don't develop...the majority don't develop reinfection, that you may wait up to three months, or 90 days, after infection to get the vaccine.
- RG: **How about “children older than 16 years old or adults with down syndrome or congenital disorders including autism, are they able to get the vaccine?”**
- CSV: There's no, yeah, there's no contraindications.
- OR: The only contraindications for the vaccine is people who have had allergic, severe allergic reactions, such as anaphylaxis. There is no other contraindication. Even pregnancy, you know a lot of people

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have mistaken this. Pregnancy is not a contraindication. They have actually... in the initial trials there were a lot of women that ended up getting pregnant during the trial, about, I think, 250 or so, and they're being followed very carefully. Most people don't see how a messenger RNA vaccine can affect the baby. I think it's perfectly safe.

RG: ***“Are you aware of any oral manifestations for COVID 19?”***

CSV: Loss of taste is the most common one, but also I did see some, um, evidence or reports of gingivitis and ulcers, but I don't think it's been something that it's been predominant...

RG: **One question about... *“any thoughts about the sputnik...”* the Russian vaccine, from Dr. Della Volpe.**

OR: I think that it will work. Uh, I have not seen anything that is as effective as the Pfizer or Moderna vaccines. I think it's going to work. I think different countries have different situations. For example, you know China has a very large population. They need to go ahead and – even if their vaccine is only 50% or 40% to whatever it is – they need to go out and immunize as many people as possible, because a very serious outbreak could kill millions and millions of Chinese. And then, obviously Russia also has their financial limitations, so this is the vaccine that they have, the one that they developed. It hasn't been studied as well as the ones developed here and in Europe, other European countries, but I think for them it makes sense to use it in Russia because a lack of vaccines is very, very serious.

RG: **Okay. Uh, let's see, there was a question on...um... I guess recommend...uh *“what's the earliest age for children receiving the COVID vaccine now?”***

OR: So that's going to change very quickly. Uh, Pfizer said that they had completed the 12 to 15 year-old, and they did a small amount of patients – they only did 2,000 patients – it is being submitted to the FDA. If they approve it, then we'll be able to start vaccinating people from 12 [years old and] on.

RG: **One question related to masks, *“I wanted your opinion as to whether the use of masks might have been a selective pressure to the development of more infectious strains”***

OR: I don't think so. I think viruses are going to mutate, they do whatever they want, that's why they're viruses – because they do whatever they want – and they're going to mutate whether you wear a mask or you don't wear a mask. There are pressures, there are physical pressures, there are chemical pressures that cause these mutations. They are very complex – and they will happen.

RG: **Uh one thing, maybe a word of caution, related to your opinion about the people who make the argument that *“mortality rate is so low so that there shouldn't be too much [to] worry about getting sick”*. As far as, um, there are maybe vaccine-hesitant people who might say, you know, the mortality rate is low...um...**

OR: My answer to that is, you shouldn't worry about getting sick unless you get sick, or your family members get sick – then worry about it a lot – because... Uh, you know I think I've been involved with over 100 patients that have been sick, and...you can't predict this. It's not...you could have a person who is 24 years old – an athlete – a person who runs 10 miles a day, and that person could end up having myocarditis and not be able to do that ever again. And it's happened to professional athletes.

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There are baseball players, there are basketball players, who had excellent careers that now are not as good as before because they got COVID... So stay away from it, get vaccinated

RG: **Related to, I guess, the Johnson & Johnson that's coming up, the vaccine...*"Does it create more immune response and is it only one vaccination"* you know if it's...one dose...**

OR: Yeah, I think it's a very good vaccine. Like I said, in all age groups it happened to cause about 90% immunity. In the younger age group, which was, uh, below 55, uh, 100%. These are small numbers, Johnson & Johnson is supposed to put out their Phase 3 studies next week, so we will...it'll be in The New England Journal. Anything that's going to be important that's going to come out is going to be in The New England Journal. We want to see the bigger trials because what we're looking [at is] Phase 1 and 2 studies. Phase 3 studies they haven't published yet, but I think it's coming next week.

RG: **Uh one question about... *"A person who gets the disease after the first dose of the vaccine"*, so between the first and the second dose, so, *"should they get the second dose?"***

OR: So, there are no official recommendations for that. There are no ofic- no they have not addressed that. What I have told them, and that has happened, is get the second vaccine because if you don't get it now and you wait three months, you probably need two vaccines. So it depends on whether you wanna- you wanna have one shot or two shots. I think it's better... If you started already, finish the vaccination.

CSV: What I, um, I heard some talking about that and the recommendation is to wait the 14 days that you're not contagious anymore, just because you don't want to go to a vaccine site and spread it to everybody. So just wait your quarantine, if even if that delays the vaccine for like a week... Or you know... If you're really sick, wait until you're not sick anymore and then go, you'll get your second dose.

RG: **What about *"If you have an elderly parent with comorbid conditions with allergies, but not to the vaccines, should you vaccinate?"* That was, I guess a report in Norway of frail, elderly people in nursing homes [that] died after vaccination – which probably they might have died anyway – but, um, would you recommend...**

OR: So it appears, that, what happened in Norway is they vaccinated people that were already under hospice. They were very, very, old – they were very sick. If you have an older person that is not dying by any means, that has the usual problems of hypertension, or heart disease, or whatever – but they're functioning – please get them vaccinated.

RG: **And then, uh, we'll take one, two more... Going back to what was stated about women getting pregnant, *"during the clinical trials with the vaccine, which company trialed these women? Is it Pfizer, Moderna, or both?"***

OR: I think both, but the one that I read was... and that information is available. I read with Pfizer, that there were well over – I think it was 240, or 250 women who got pregnant. They are, you know, the companies are doing an absolute great job – they're following up on these patients. Uh, we're gonna have the data. They're 100% honest, uh, so we can look at the results. But again, the people that know a lot more about virology than I do, the real virologists, are telling me that messenger RNA affecting a baby... uh, it doesn't sound like it's something real. I would be very surprised if they find any problems.

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RG: Uh and the last one, I think, uh, probably was answered before, but, um, again – just to double check – “*if we develop antibody, should we take the second dose?*” So I'm assuming the person is asking, um, with the first dose, you know, do we need to – if there is antibodies – do we get the second dose?

OR: We should because we don't know how those antibodies are going to last. We should follow [the] manufacturer's recommendation because that is how the studies have been done. Uh, we know that, probably, if you get vaccinated you're gonna be protected at least for about four months. [With] one vaccine the protection may be less than four months.

RG: Awesome, thank you so much! That was that was great, and thank you for staying. Uh, we have – almost 100 people stayed, uh, to get their questions answered...so obviously it's a very well needed topic. And thank you for making it so up to date, and answering these people's questions. I think you get all these questions all the time [*laughs*], so thank you! Thanks everyone for joining us, have a happy weekend, have a great weekend, and we'll see you next week.

CSV: Thank you!

OR: Thank you very much!

[End of Q&A]

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