


REVIEW

Coronavirus disease (COVID-19) and neonate: What neonatologist need to know

Qi Lu MD, PhD  | Yuan Shi MD, PhD

Department of Neonatology, Key Laboratory of Pediatrics in Chongqing, Ministry of Education Key Laboratory of Child Development and Disorders, Children's Hospital, Chongqing Medical University, Chongqing, China

Correspondence

Qi Lu, MD, PhD and Yuan Shi MD, PhD, Department of Neonatology, Key Laboratory of Pediatrics in Chongqing, Ministry of Education Key Laboratory of Child Development and Disorders, Children's Hospital, Chongqing Medical University, Chongqing 400014, China.
Email: qilu_qi@hotmail.com (Q. L.) and shiyuan@hospital.cqum.edu.cn (Y. S.)

Abstract

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) cause china epidemics with high morbidity and mortality, the infection has been transmitted to other countries. About three neonates and more than 230 children cases are reported. The disease condition of the main children was mild. There is currently no evidence that SARS-CoV-2 can be transmitted transplacentally from mother to the newborn. The treatment strategy for children with Coronavirus disease (COVID-19) is based on adult experience. Thus far, no deaths have been reported in the pediatric age group. This review describes the current understanding of COVID-19 infection in newborns and children.

1 | INTRODUCTION

Since December 2019, patients with fever, dry cough, normal, or decreased white blood cell counts who were initially diagnosed as "Fever of Unknown Origin with pneumonia" have been continuously increasing in Wuhan.¹ The causative agent of this unexplained infected pneumonia was identified as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) which not only has a strong human-to-human transmission but also causes severe pneumonia to death.² SARS-CoV-2 is so aggressive that the infection has been transmitted to other countries and is seriously imperiling human life. World Health Organization has declared this disease to constitute a Public Health Emergency of International Concern on 30 January 2020.³ A total of 26 359 suspected cases and 31 225 confirmed cases with 639 deaths linked to this pathogen on 7 February 2020.⁴ Different age group are generally susceptible to SARS-CoV-2. At present, neonates have been diagnosed with Coronavirus disease (COVID-19). Neonatologists should be vigilant assessing newborn babies delivered by infected mother or brought up by infected housemaid and improve the knowledge of prevention and treatment of COVID-19.

2 | ETIOLOGY OF COVID-19

SARS-CoV-2 is single-stranded RNA viruses, belongs to subgenus Sarbecovirus of the genus Betacoronavirus.⁵ SARS-CoV-2 particles contain

spike and envelope, virions are spherical, oval, or pleomorphic with diameters of approximately 60 to 140 nm. Culture times were 4 days on human airway epithelial cell lines and 6 days on Vero E6/Huh-7 cell lines. The single-stranded RNA was 29 903 bp in length. The organization of the SARS-CoV-2 genome is 5'-leader-UTR-replicase-S (Spike)-E (Envelope)-M (Membrane)-N (Nucleocapsid)-3'-UTR-poly (A) tail with unknown open reading frames.⁶ Its reference sequence (NC_045512.2) is with an 80.26% sequence identity (and query coverage above 98%) to the human SARS-coronavirus genome (NC_004718.3),⁷ however, the Middle East respiratory syndrome (MER) coronavirus is lower related to SARS-CoV-2 which is a group 2c β -coronavirus. SARS-CoV-2 exhibits very high sequence similarity to the Guangdong pangolin coronaviruses in the receptor-binding domain which indicates pangolins may be an intermediate host of the virus before dissemination to humans.⁸ SARS-CoV-2 has weak resistance, 56°C for 30 minutes, 75% ethanol, chlorine-containing disinfectant, and peracetic acid can inactivate SARS-CoV-2.⁹ SARS-CoV-2 uses the SARS-coronavirus receptor, angiotensin-converting enzyme 2 (ACE-2) for entry host cells. ACE-2 is a surface molecule highly expressed in AT2 cells of lung, along with esophageal upper epithelial cells and absorptive enterocytes from ileum and colon which indicated digestive system along with respiratory systems is a potential route for SARS-CoV-2.^{10,11} The expression level of ACE-2 in Asian populations is significantly higher than that in European and American populations, and ACE-2 on male cells are higher than on female cells, which can partially explain the incidence rate of novel coronavirus pneumonia are higher in male and Asia.^{12,13}

3 | TRANSMISSION

The symptomatic patients with Coronavirus disease are the main disseminators, but the asymptomatic patients should not be underestimated. The current data show major transmission routes are droplets transmission, contact transmission, and aerosol transmission. fecal-oral transmission cannot be ignored, because the nuclear acid of the SARS-CoV-2 is detected in the fecal samples of patients in the United States and China.¹⁴ Maternal-infant vertical transmission is doubtful—there have been no documented neonates of intrauterine vertical transmission occurring with SARS and MERS.^{15,16} According to existing complete data, amniotic fluid, cord blood, neonatal throat swab, and breastmilk samples from six newborn babies delivered by infected mothers were tested for SARS-CoV-2, and all samples tested negative for the virus.¹⁷

4 | CLINICAL PRESENTATION OF COVID-19

The incubation periods of COVID-19 were 1 to 14 days, and the mean has been estimated to be 5.2 days (95% confidence interval [CI]: 4.4-6.0) and 97.5% of those who develop symptoms will do so within 10.5 days (95% CI: 7.3-15.3) of infection.¹⁸ From the first confirmed child case who was reported in Shenzhen on 20th January 2020 to 6 February 2020, at least 230 COVID-19 cases in children (≤ 18 years) have been reported in China. The SARS-CoV-2 rapid spread in children suggests that it has a strong transmission capacity in the special population (neonate, children). SARS-CoV-2 infection can range from asymptomatic infection to severe respiratory distress in neonates and children. However, Respiratory distress occurs in children with underlying conditions. One patient had severe malnutrition and survived surgery for congenital heart disease, the other had bilateral hydronephrosis and left-kidney calculi. The clinical course of COVID-19 was generally milder in children than adults. The most common clinical symptoms of COVID-19 included fever, fatigue, and dry cough. A few patients showed upper respiratory symptoms such as nasal obstruction, nasal discharge, and sore throat. Gastrointestinal symptoms such as abdominal discomfort, vomiting, abdominal pain, and diarrhea may also occur. C-reactive protein was normal or temporary upregulation, ALT levels and myocardial enzyme were not obviously abnormal changes. Chest imaging normalities were present in asymptomatic infected patients. SARS-CoV-2 can be mixed to different pathogen including mycoplasma pneumonia, influenza A, influenza B, RSV, and EB virus. The clearance time of SARS-CoV-2 nucleic acid from nasopharyngeal swab was recorded in three children, 9 days in two patients, 12 days in one patient.¹⁹ Thus far, no deaths have been reported in the children which are similar to SARS.^{19,20} Three newborns have been diagnosed up to date who mainly belonged to family cluster cases. One 17 days old neonate diagnosed as COVID-19 infection had a fever, cough, and vomiting

milk. In his family, the housemaid was the earliest case, subsequently, the mother was infected.²¹ The second newborn appeared fever on 5 days after birth whose mother also confirmed infected. The third one who was born by the infected mother was silent and diagnosed on 30 hours after birth by the viral nucleic acid test. Short breath, vomiting milk, cough, and fever were present in neonates. The vital signs of those neonates were stable, there is no severe emergency case until now.^{19,21-23}

5 | DIAGNOSIS

The diagnosis of COVID-19 is based on comprehensive contact and travel history and precise laboratory tests. Current diagnostic tools were the nucleic acid or virus gene tests. Samples included nasopharyngeal swab, sputum, secretion of the lower respiratory tract, blood, and feces. The nasopharyngeal swab is the most common specimens, however, its detection positive rate is less than 50%. Repeated detection is necessary for improving the positive rate. The positive rate of bronchoalveolar lavage fluid was high, but it is not suitable for most of the patients due to increased risk of cross-infection.^{24,25}

6 | INFECTION CONTROL AND TREATMENT

Neonatologist must wear protective equipment (including hats, goggles, protective suits, gloves, N95 masks, etc) to resuscitate neonates delivered by confirmed and/or suspected COVID-19 puerperant. If the puerperant is positive for SARS-CoV-2, the neonate must be isolated, then detected SARS-CoV-2.²⁶

Early identification and early isolation are imperative for COVID-19 control. COVID-19 neonates should be placed in negative pressure rooms or in rooms in which room exhaust is filtered through high-efficiency particulate air filters with reference to MERS management.¹⁶ No visiting is allowed for neonates of COVID-19. Treatment mainly depends on adult patients' clinical experience due to few cases in children. There is no specific drug treatment for SARS-CoV-2 being similar to MERS-CoV and SARS-CoV.^{19,26} Symptomatic and supportive treatment is the mainstay of therapy for patients of SARS-CoV-2 infection including the supply of oxygen, the maintenance of water-electrolyte, and acid-base balance. The supplement of water and electrolyte should be appropriate, so as to avoid aggravating the pulmonary edema and reduced oxygenation.²⁷ For newborns with severe acute respiratory distress syndrome, high-dose pulmonary surfactant, inhaled nitric oxide, high-frequency oscillatory ventilation, and extracorporeal membrane lung may be useful. In the United States, patients' conditions were improved apparently after the treatment with nucleoside analog-remdesivir, but there was just one case, the efficacy needs further verification.²⁸ Interferon- $\alpha 2b$ nebulization

were be applied in MERS-CoV and SARS-CoV, so it could be considered to use in SARS-CoV-2 infection.^{29,30} In addition, three potential drug combinations (sirolimus plus dactinomycin, mercaptopurine plus melatonin, and toremifene plus emodin) are candidate repurposable drugs.³¹ Moreover, convalescent sera from SARS-CoV-2-recovered patients may be useful for SARS-CoV-2 infection, because of a significant reduction in the mortality following convalescent sera from SARS-recovered patients treatment.³²

7 | CONCLUSIONS

COVID-19 can result in asymptomatic to severe illness, fortunately, children without underlying diseases appeared to have mild disease. The disease condition of the neonates was also minor. Though this new virus comes out without specific antiviral drugs treatment, neonatologist needs to more virological, epidemiological, and clinical data to treat and manage COVID-19.

CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

AUTHOR CONTRIBUTIONS

Qi Lu and Yuan Shi conceived this review, Qi Lu wrote the manuscript, Yuan Shi revised the manuscript.

ORCID

Qi Lu  <http://orcid.org/0000-0002-5428-4032>

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