CDC/IDSA COVID-19 Clinician Call

January 9, 2021

Welcome & Introductions

Dana Wollins, DrPH, MGC
Vice President, Clinical Affairs & Guidelines
IDSA

- 49th in a series of weekly calls, initiated by CDC as a forum for information sharing among frontline clinicians caring for patients with COVID-19
- The views and opinions expressed here are those of the presenters and do not necessarily reflect the official policy or position of the CDC or IDSA. Involvement of CDC and IDSA should not be viewed as endorsement of any entity or individual involved.
- This webinar is being recorded and can be found online at www.idsociety.org/cliniciancalls.

Now Available: COVID-19 Vaccine FAQs

Go to www.COVID19LearningNetwork.org and click on “Vaccines FAQ”

Updating CDC Guidance: Can We Extend the Re-test/Quarantine Period from 90 Days to 180 Days?

- Current CDC guidance recommends against retesting or quarantine of persons with prior laboratory-confirmed SARS-CoV-2 infection who are re-exposed within **90 days** post-infection
- Does evidence support extending period from **90 days** to **180 days**?
  - Little evidence for SARS-CoV-2 reinfections within first 6 months of initial infection
  - The humoral and cellular immune responses to SARS-CoV-2 (including neutralizing activity) remain present for at least 6 months
  - Seropositivity against SARS-CoV-2 appears associated with reduced risk of new SARS-CoV-2 infection (although precise correlates of immune protection remain unknown)
  - Among other coronaviruses, immunity appears largely durable and reinfections appear rare in the 6 months following initial infection

Updating CDC Guidance: Can We Extend the Re-test/Quarantine Period from 90 Days to 180 Days?

- Proposed updates to guidance:
  - Persons do not need to be assessed for potential reinfection if within **180 days** after date of most recent COVID-19 diagnosis
  - Persons do not need to quarantine if exposed to person with COVID-19 if within **180 days** after date of most recent COVID-19 diagnosis
  - May consider testing under certain circumstances (e.g., congregate settings) if within **90 days** after date of most recent COVID-19 diagnosis
- Need to balance risk for missing reinfection in persons vs. harm in unnecessarily retesting/quarantining persons
- Note that these recommendations are not meant to suggest that persons previously infected with SARS-CoV-2 are immune to further infection, nor should they be used to inform changes in SARS-CoV-2 vaccine guidance at this time

Your Feedback is Appreciated

Amish Talwar

atalwar@cdc.gov

Ask the Experts: Q&A with IDSA's COVID-19 Testing Guidelines Panel

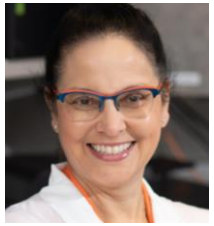
Cesar A. Arias, MD, MSc, PhD, FIDSA
Professor of Medicine, Microbiology and Molecular Genetics
Herbert L. and Margaret W. DuPont Chair in Infectious Diseases
University of Texas Health Science Center at Houston

Angela M. Caliendo, MD, PhD, FIDSA
Professor and Executive Vice Chair, Department of Medicine
Alpert Medical School, Brown University

Kimberly E. Hanson, MD, MHS
Section Chief, Clinical Microbiology and Medical Director, Mycology
Head, Immunocompromised Host Infectious Diseases Services,
University Hospital and Huntsman Cancer Center
Professor, Internal Medicine and Adjunct Professor, Pathology
University of Utah School of Medicine

Mary K. Hayden, MD, FIDSA, FSHEA
Professor of Internal Medicine and Pathology
Chief, Division of Infectious Diseases
Director, Division of Clinical Microbiology
Rush University Medical Center

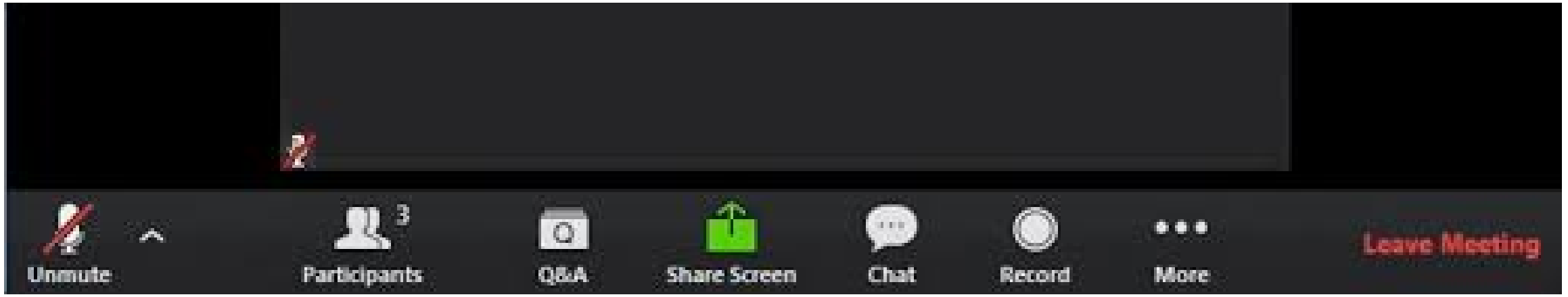
Mark Loeb, FRCPC, MD, MSc
Professor, Pathology and Molecular Medicine
Clinical Epidemiology and Biostatistics
McMaster University



Robin Patel, MD(CM), D(ABMM), FIDSA, FACP, F(AAM)
Elizabeth P. and Robert E. Allen Professor of Individualized Medicine, Mayo Clinic
Past President, American Society for Microbiology

Question?
Use the “Q&A” Button

Comment?
Use the “Chat” Button



IDSA COVID-19 Molecular Diagnostic Testing Guideline Updates

The panel focused on three main issues:

- The performance of different specimen types for the detection of SARS-CoV-2 RNA
- The accuracy of rapid versus standard laboratory-based nucleic acid amplification tests
- Molecular diagnostic testing before immunosuppressive therapy in selected groups of patients

This resulted in revisions to three recommendations (#2, #7 and #12) and the development of two new recommendations (#13 and #14).

Swab collection types for RNA testing in symptomatic individuals

Prior Recommendation	New (Revised) Recommendation
nasopharyngeal, or mid-turbinate or nasal swabs rather than oropharyngeal swabs or saliva alone	nasopharyngeal, mid-turbinate, anterior nasal swab, saliva or a combined anterior nasal/oropharyngeal swab rather than an oropharyngeal swab alone

Recommendation 2: The IDSA panel suggests collecting a nasopharyngeal swab, mid-turbinate swab, anterior nasal swab, saliva or a combined anterior nasal/oropharyngeal swab rather than an oropharyngeal swab alone for SARS-CoV-2 RNA testing in symptomatic individuals suspected of having COVID-19 *(conditional recommendation, very low certainty of evidence)*

Molecular diagnostic test performance characteristics of different specimen types compared to nasopharyngeal swab results as the reference standard

Specimen Type	Sensitivity (95% CI)	Specificity (95% CI)
Saliva with coughing	0.99 (0.94-1.00)	0.96 (0.83-0.99)
Midturbinate swab	0.95 (0.83-0.99)	1.00 (0.89-1.00)
Combined anterior nasal and oropharyngeal swab	0.95 (0.69 to 0.99)	0.99 (90.92 to 1.00)
Saliva without coughing	0.90 (0.85-0.93)	0.98 (0.93-1.00)
Anterior nasal swab	0.89 (0.83-0.94)	1.00 (0.99-1.00
Oropharyngeal swab	0.76 (0.58 – 0.88)	0.98 (0.96 to 0.99)

Rapid vs. standard NAAT in symptomatic individuals

Prior Recommendation	New (Revised) Recommendation
No recommendation for or against rapid versus standard RNA testing	Suggests rapid RT-PCR or standard laboratory-based NAAT over rapid isothermal NAAT

Recommendation 7: The IDSA panel suggests using either rapid RT-PCR or standard laboratory-based NAATs over rapid isothermal NAAT in symptomatic individuals suspected of having COVID-19 *(conditional recommendation, low certainty of evidence).*

Test performance characteristics of molecular diagnostics compared to a composite reference standard*

Test Method	Sensitivity (95% CI)	Specificity (95% CI)
Rapid isothermal NAAT	0.81 (0.75 to 0.86)	0.99 (0.96 to 1.00)
Rapid RT-PCR	0.98 (0.95 to 1.00)	0.97 (0.89 to 0.99)
Standard NAAT^	0.98 – 0.99 (NA)	0.97 (NA)

RNA testing in asymptomatic individuals before immunosuppressive procedures

Revised:

Recommendation 12: The IDSA panel recommends SARS-CoV-2 RNA testing (*versus* no testing) in asymptomatic individuals before hematopoietic stem cell (HSCT) or solid organ transplantation (SOT) regardless of a known exposure to COVID-19 *(strong recommendation, very low certainty of evidence)*.

> ***Remark:*** *Testing should ideally be performed as close to the planned treatment/procedure as possible (e.g., within 48-72 hours).*

New:

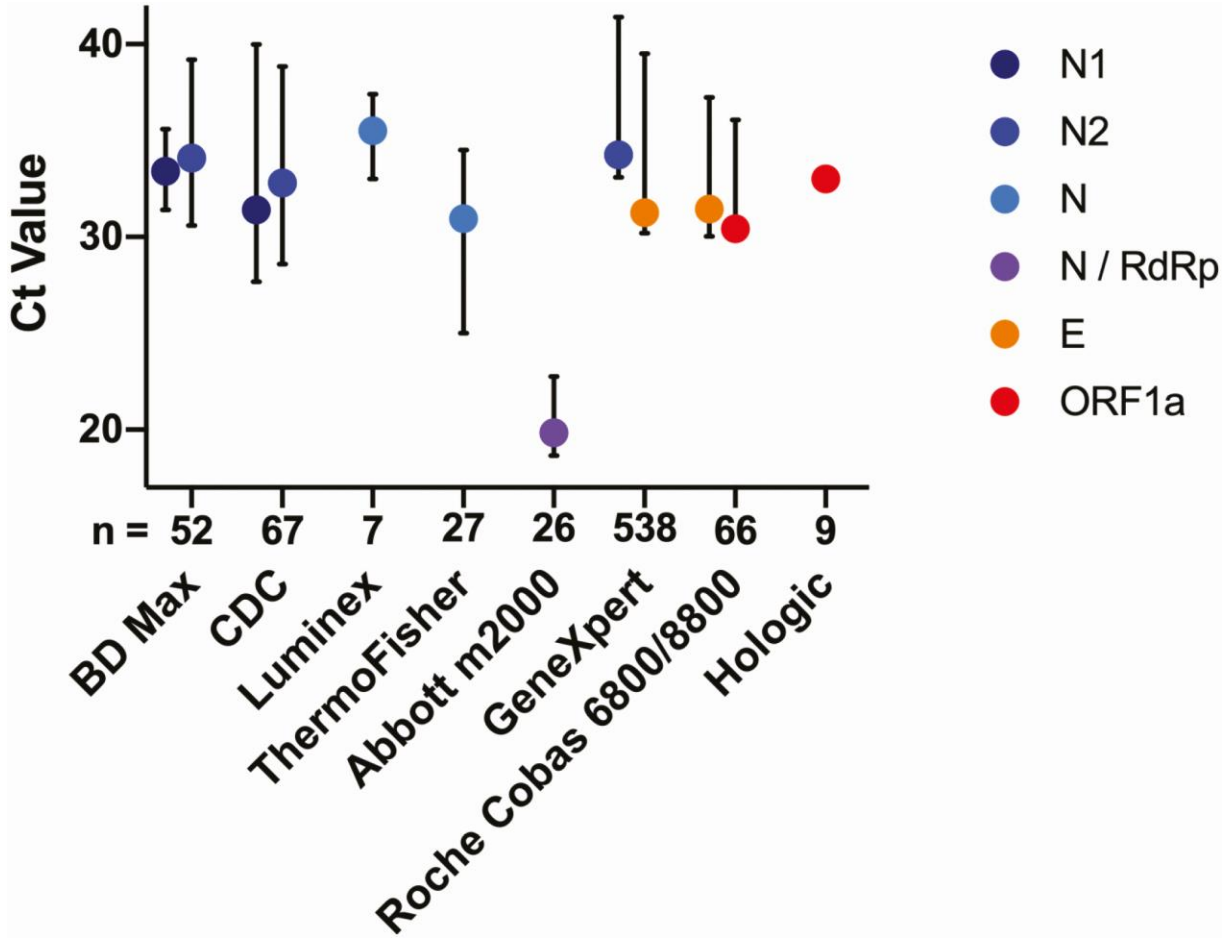
Recommendation 13: The IDSA panel makes no recommendations for or against SARS-CoV-2 RNA testing before initiating immunosuppressive therapy in asymptomatic individuals with cancer *(evidence gap)*.

> ***Remarks****: The decision to pursue testing should be individualized. Factors to consider include the type of cancer, the need for induction versus maintenance immunosuppressive therapy, the type of immunosuppressive therapy, patient comorbidities and the availability of testing. This recommendation does not apply to hematopoietic stem cell transplant candidates or recipients.*

Recommendation 14: The IDSA panel makes no recommendations for or against SARS-CoV-2 RNA testing before the initiation of immunosuppressive therapy in asymptomatic individuals with autoimmune disease *(evidence gap)*.

> ***Remark****: The decision to pursue testing should be individualized. Factors that may affect the decision to test include the type and severity of autoimmune disease, the type of immunosuppressive therapy, the need for induction versus maintenance immunosuppressive therapy, patient comorbidities and the feasibility of testing.*

Ct values for gene targets and manufacturers for the same batch of testing material.



Clin Infect Dis, ciaa1199, https://doi.org/10.1093/cid/ciaa1199

Q&A and Discussion

Continue the conversation on Twitter

@RealTimeCOVID19
#RealTimeCOVID19

We want to hear from you! Please complete the post-call survey.

Next Call: **Saturday, January 16th**

A recording of this call will be posted at **www.idsociety.org/cliniciancalls**

-- library of all past calls now available --

Contact Us:

Dana Wollins (dwollins@idsociety.org)
Deirdre Lewis (dlewis@idsociety.org)