Long COVID in Children and Adolescents

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Whilst acute COVID has not affected children as much as adults, there have certainly been direct and indirect effects on children in what the children’s commissioner called ‘a rising tide of childhood vulnerability’ (1).

The impact on mental health functioning is complex, but has increased considerably in certain areas such as eating disorders (2).

Early data suggests that CAMHS referrals dipped early on in lockdown 1, but subsequently soared in early Autumn 2020 (3).

Possibly surprisingly, a significant minority appears to have benefited from lockdown. Around 1/3 of school children report their mental health to be better during lockdown than before (4) and children suffer fewer and less intense headaches during lockdown due to the fact that they are experiencing less stress (5).

NICE (6) defined the different stages as follows:

- **Acute COVID-19**: signs and symptoms of COVID-19 for up to 4 weeks.
- **Ongoing symptomatic COVID-19**: signs and symptoms of COVID-19 from 4 to 12 weeks.
- **Post-COVID-19 syndrome**: signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis.

There is now considerable data on the existence of long Covid symptoms in adults, and emerging data in children.

Data from the UK Office for National Statistics (7) released in February showed that 13 percent of COVID-19 patients under the age of 11 and about 15 percent of those aged 12 to 16 had at least one symptom more than a month after diagnosis.

And in a preprint posted on medRxiv at the end of January (8), researchers surveying caregivers of 129 patients under the age of 18 in Rome found that more than half of the children had yet to completely recover within four months of a positive SARS-CoV-2 test, and nearly one-quarter of the children had three or more symptoms that persisted for at least that long.

Symptoms like fatigue, muscle and joint pain, headache, insomnia, respiratory problems and palpitations were particularly frequent, very similar to those described in adults.
For 35% of children, parents reported that the ongoing symptoms distress the child a little or quite a lot. One problem with this data is that it was collected without a control group.

What can we do about it?

60 Long Covid clinics have been set up around the country for adults, but none for children. However, the need to help children has been recognised.

A national taskforce specifically for children has been set up. A stepped care approach is needed given the enormous differences in severity of symptoms.

The proposal is that most children should be seen and managed in primary care by their GP, health visitor and through online information and self-support management. It is hoped that the website https://www.yourcovidrecovery.nhs.uk/ will be able to support adults as well as children.

Some children may need to be referred on to a Paediatrician who follows up medical concerns and acts as a gatekeeper to a specialist multidisciplinary assessment and treatment team, which it is hoped should be from a range of disciplines including psychology.

The question is still whether the MDT team should be a new service or part of existing services (e.g. chronic fatigue services). The question is then also immediately whether children with long Covid should be prioritised over children who have been on waiting lists for longer.

One other problem this approach highlights is the huge inequity in children’s rehabilitation services across the country.

Patient groups have been active already.

Longcovidkids.org is particularly dynamic in surveying the problem and advocating on behalf of children with long Covid.

Given the fact that many symptoms are ‘vague’ and not necessarily associated with pathology, there is a danger that symptoms will not be taken seriously and in some cases written off as ‘psychological’. This potentially leads to psychologists being drawn into discussions around whether symptoms are physical or ‘all in the mind’, similar to the discussions around chronic fatigue.

Psychologists would do well to avoid this discussion and focus instead on what they do best: engagement of children and families, listening, managing physical symptoms which cannot be treated medically as well as reduce barriers to recovery: fear avoidance, anxiety, low mood, social and systemic issues.

But, with dwindling numbers of COVID infections, nobody yet knows how many children will ultimately require specialist help.

So far, services have not reported huge numbers. Let’s hope it stays that way.
References

1) Children’s Commissioner (2020). Childhood in the time of COVID.


