Return to Exercise After COVID

FAQs for Healthcare Providers

What current criteria should be met for children and adolescents to return to play?

The revised AAP Guidance published 1/27/2022, outlines the <u>following criteria be met</u> before considering any return to play and <u>a less restrictive pacing for return to play is recommended</u>:

1) Completed isolation and minimum amount of symptom free time has passed
2) Can perform all activities of daily living
3) No concerning signs/symptoms
4) Physician clearance has been given, if indicated

At what pace should children and adolescents return to play?

5) <12yo: progress according to own tolerance
6) 12+: gradual return to physical activity
    - Asymptomatic / Mild symptoms: Minimum 1 day symptom free (excluding loss of taste / smell), 2 days of increase in physical activity (i.e. one light practice, one normal practice), no games before day 3. *A mask is required for ALL physical activity, including games or scrimmages, until 10 full days from+ test or symptom onset have passed.*
    - Moderate symptoms: Minimum 1 day symptom free (excluding loss of taste / smell), and a minimum of 4 days of gradual increase in physical activity (one light cardio workout on own, two light practices, one full practice), no games before day 5. *A mask is required for ALL physical activity, including games or scrimmages, until 10 full days from + test or symptom onset have passed.*

Do pre-existing cardiac conditions, absent other risk factors or concerning symptoms, warrant EKG or referral?

This stipulation has been removed from the AAP guidelines. “Minor” cardiac conditions that should not raise alarm for an automatic referral to cardiology are small atrial or ventricular septal defects (ASD, VSD) or patent ductus arteriosus (PDA), repaired ASDs, VSD, PDAs or other lesions without significant residual lesions, mitral valve prolapse, vasovagal syncope, and many arrhythmias. These patients are typically seen infrequently (> 1 year between cardiology visits), are on no cardiac medications, and have no activity restrictions in place from their cardiologist. However, even these patients may require referral if there are concerning cardiac symptoms. For questions about whether a cardiac condition qualifies for automatic referral, please contact pediatric cardiology.

If I order an EKG, what findings require referral to cardiology?

Unless otherwise indicated in the official reading, minor EKG findings such as sinus arrhythmia (a normal finding), left or right axis deviation, incomplete right bundle branch block, and possible left ventricular hypertrophy do not need referral for exercise clearance following a COVID infection, but primary care providers can call or refer to cardiology if they have questions about EKG findings in general.

What if a child has persistent loss of taste or smell, or prolonged nasal congestion or cough? Do these symptoms raise concern for further cardiac evaluation?
No. High risk systemic symptoms include fever >100.4, myalgia, chills, or profound lethargy. Prolonged loss of taste or smell, or respiratory symptoms are often still present after release from isolation, do not constitute increased risk for myocarditis, and do not require further evaluation or referral to cardiology.

Does this apply to college-age students? Who will see our older patients – 18 years and older?
Yes, patients who are 18 years and older who qualify as higher risk by severity of COVID symptoms or current cardiac symptoms/risk should have further evaluation as per the algorithm. Pediatric cardiology will see patients through age 17 years; those 18 years and older should be referred to adult cardiology.

Do you expect revisions of this algorithm in the future?
Yes. The AAP guidance is informed by expert opinion. We continue to work with specialists in pediatric cardiology from centers around the country as more children are seen with COVID-19 to determine what revisions can be made to both age limits and screening criteria, and we will update our community accordingly.