

Comment: While this study provides helpful clinical information to assist emergency physicians in identifying potential COVID-19 patients, we must understand the limitations. Most significantly, this was only a very small portion of the overall sample size of confirmed COVID-19 patients. Additionally, be cautious in directly applying these results to patients in the United States as populations may differ.

**□ DRIVE-THROUGH SCREENING CENTER FOR COVID-19: A SAFE AND EFFICIENT SCREENING SYSTEM AGAINST MASSIVE COMMUNITY OUTBREAK.**

Kwon KT, Ko JH, Shin H, et al. *J Korean Med Sci*. Published online March 16, 2020. doi: <https://doi.org/10.3346/jkms.2020.35.e123>.

The current Coronavirus Disease 2019 (COVID-19) pandemic has necessitated the testing of significant numbers of patients. Modeled after those used during a previous bioterrorism disaster and influenza pandemic, the authors present a descriptive report of their drive-through screening center and processes.

The authors recommend use of a large parking lot geographically removed from large population centers. Additionally, they recommend either a tent or temporary building to be used for work space and shelter from weather. They utilized a four-step process: Entrance → Registration → Examination → Specimen collection → Instructions → Exit. Patients do not leave their cars during this process. To minimize contact and preserve personal protective equipment (PPE), communication is performed either by mobile phone or electronic medical record whenever possible. Temperature is obtained with a contactless thermometer. If the physician strongly suspects COVID-19 during the examination step, the patient is transported to a designated hospital after specimen collection. Test specimens were collected with the car window opened the minimum amount necessary and car ventilation mode on internal circulation. Patients are provided with information about obtaining test results, home quarantine, and anticipatory guidance.

Healthcare workers (HCWs) who had direct contact with patients wore the following PPE: N95 respirator, eye shield/face shield/goggles, hooded coverall/gown, and inner and outer gloves. To decrease viral spread and minimize the possibility of specimen contamination, HCWs wore two gowns and two pairs of gloves for patients who required testing; the external gloves/gown were removed and hands disinfected after each patient contact. The authors reported that this process took approximately ten minutes per test, allowing them to screen 100 people per day with a staff of 4-8 HCWs. This is estimated to be 1/3 the amount of time that a typical screening process would take.

The authors recommended rotating staff every 1-2 hours if possible, and to ensure that no HCW wore an N95 respirator for longer than four consecutive hours. They also noted the need to be cognizant of relevant environmental issues, such as hot/cold weather, etc., and to adapt the working environment accordingly. Lastly, there must be adequate communication with the public regarding the limitations of the screening center to minimize the number of people who may attempt to use this resource inappropriately. They recommend considering a

similar process for other uses such as medication distribution or vaccine administration.

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Comment: While not a typical research manuscript we would select for Abstracts, this article describes a non-novel approach to a novel viral pandemic. The drive-through screening process has a number of advantages as outlined above, especially as centers begin seeing higher numbers of potential COVID-19 patients. It is important to consider and plan for the unintended consequences of such a program, including how HCWs will handle unexpectedly ill patients and patients arriving by alternative transportation (bike, walking, public transportation). Healthcare leaders considering a drive-through screening option should also consider the heightened emotions and fear that are present during epidemic/pandemic conditions and plan for security accordingly.

**□ EPIDEMIOLOGICAL CHARACTERISTICS OF 2143 PEDIATRIC PATIENTS WITH 2019 CORONAVIRUS DISEASE IN CHINA.**

Dong Y, Mo X, Hu Y, et al. *Pediatrics*. 2020; doi: [10.1542/peds.2020-0702](https://doi.org/10.1542/peds.2020-0702).

Novel coronavirus (SARS-CoV-2, which causes COVID-19) is a pandemic with many countries employing massive public health responses. Little is known about the severity of illness in the pediatric population. This study sought to identify demographic information and severity of disease in pediatric patients with COVID-19.

This was a retrospective study conducted on patients less than 18 years who were suspected or confirmed to have COVID-19 and were reported to the Chinese Centers for Disease Control (China CDC). Children were considered high risk and suspected if they had positive exposure to an endemic area or a confirmed case of COVID-19. High suspicion also included those with fever, respiratory symptoms, digestive symptoms, or fatigue, normal or low white blood cell count and increased C-reactive protein, or abnormal chest radiography, or those at lower risk for whom influenza or other respiratory illnesses were ruled out. Confirmed cases were defined as having a nasopharyngeal swab or blood sample positive via PCR or a genetic sampling of respiratory secretions or blood consistent with SARS-CoV-2. Once identified, patients were categorized by severity of disease using clinical features as well as laboratory and radiographic findings. Severity categories included asymptomatic (no symptoms but positive test), mild (mild respiratory symptoms and normal lung exam), moderate (pneumonia, fever, and cough but without hypoxemia or respiratory distress), severe (above symptoms as well as oxygen saturation less than 92% and respiratory distress), or critical disease (acute respiratory failure, acute respiratory distress syndrome, shock, or other life-threatening organ dysfunction).

There were 2143 patients included who were suspected (65.9%) or confirmed (34.1%) to have COVID-19. Median age was 7 years (IQR 2-13) and the majority (56.6%) were male. The median time from onset of symptoms to presentation