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## **Response to 'Prevalence of SARS-CoV-2 antibodies in pediatric healthcare workers (pHCWs)'**

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## Letter to the Editor

**Response to ‘Prevalence of SARS-CoV-2 antibodies in pediatric healthcare workers (pHCWs)’**


Dear Editor,

We read with interest the recently published article by Morris et al., ‘Prevalence of SARS-CoV-2 antibodies in pediatric healthcare workers (pHCWs)’. The study demonstrated that pHCWs in the pediatric emergency department (ED) had a higher prevalence of anti-SARS-CoV-2-IgG than pHCWs outside the ED. It also suggests universal personal protective equipment (PPE) for pHCWs in the pediatric ED until communicable disease can be definitively ruled out (Morris et al., 2021).

While the personal travel of pHCWs was not associated with increased seropositivity in this study, any association between pHCW seropositivity and patient travel was not discussed. This is a potentially vital piece of information, considering this investigation encompassed a period early in the COVID-19 pandemic when history of patient travel was thought to be an important factor in identifying patients at risk of infection.

Understanding the effectiveness of current ED triage travel screening and provider-taken travel history to identify patients with travel-related risk for COVID-19 could inform our overall understanding of these processes in order to detect travel-related infections and interrupt transmission.

Most patients with travel-related illness present to the hospital through the ED (Burkholder et al., 2019). Consequently, ED healthcare providers are at particular risk for exposure to travel-related disease. During the Ebola epidemic in 2014, a triage travel screen was implemented in EDs across the United States at the direction of the Centers for Disease Control and Prevention (CDC) to detect persons under investigation and prevent outbreaks (Identify, Isolate, Inform, 2019; Schwedhelm et al., 2020). Since then, it has become a *de facto* screen for travel-related illness. The screen is not intended to replace a formal travel history, but instead to identify patients at risk for travel-related illness, allowing for appropriate isolation and alerting clinicians to information that may impact management.

Most ED triage travel screens ask about international travel in the 21 days prior to presentation, as part of the CDC’s ‘Identify, Isolate, Inform’ strategy for travel-related illness (CDC, 2019). However, initial studies have suggested that these screens may not adequately detect travel-related illness, and could be improved by implementing an algorithm that combines travel history, origin of travel, and symptoms to make travel alerts smarter (Greenky et al., 2020; Yaffee et al., 2019). The COVID-19 pandemic has highlighted the importance of conducting further research to identify how interventions such as improved ED triage

travel screen algorithms and PPE could better protect HCWs from communicable illness.

**Conflict of interest**

The authors declare no conflicts of interest in this study.

**Ethical approval**

There were no animal or human subjects in this study; no ethical approval was obtained or needed.

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**References**

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