



COVID-19: Interim FAQs for the interpretation and subsequent action related to repeat testing

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Evidence base

These FAQs are based on the evidence reviews by HIQA which informed the COVID-19 Expert Advisory group (EAG) decisions.

<https://www.hiqa.ie/hiqa-news-updates/hiqa-publishes-four-evidence-summaries-support-national-response-covid-19>

Note: this guidance is interim and will be updated as the situation changes and new evidence emerges. It is also important that risk assessments and clinical judgement are employed.

General information

What is the difference between a pre-symptomatic case of COVID 19, a truly asymptomatic case of COVID-19 and someone presenting with atypical symptoms?

A pre-symptomatic case of COVID-19 is when a person has had no evidence of symptoms at the time of testing but subsequently develops symptoms consistent with COVID-19. A truly asymptomatic case is a person who tests positive for COVID-19 and never develops symptoms of COVID-19.

At times, people are classified as asymptomatic or pre-symptomatic when they may in fact have had mild or atypical symptoms such as loss of appetite or loss of smell (anosmia), which have not been identified on consultation.

From what date are truly asymptomatic cases classified as cases and when does contact tracing begin?

Asymptomatic cases are defined as cases from the date when the test was taken. Contact tracing of asymptomatic cases commences from 24 hours before the date of test.

What is the advice for follow-up in relation to a truly asymptomatic person who tests positive for COVID-19?

When a truly asymptomatic resident tests positive for COVID-19 the same care protocols apply as with symptomatic COVID cases, the date of onset being the date the test was taken. Contact tracing commences 24 hours prior to the test being taken.

What restrictions apply if the asymptomatic person tests positive and then develops symptoms within the next 14 days?

This person is now considered to be someone who was pre-symptomatic at the time of testing rather than truly asymptomatic so restrictions are to remain in place for 14 days (last 5 days being fever free) from the date of symptom onset rather than the date when the test was taken.

Regarding someone who is a confirmed case of COVID 19, but has subsequently recovered, and who is later identified as a contact of a case after their recovery, could this person be considered immune and therefore not at risk from reinfection?

Acknowledging uncertainty and limited data in this area as this is a new virus, you may consider the person to be immune for 12 weeks from start of symptoms. However, given the uncertainty around the development of protective immunity, they should monitor for symptoms, self-isolate if they become unwell and be tested for COVID-19 and other respiratory viruses.

What is the advice regarding IPC precautions, confirmatory testing and discharge plans for a hospitalised patient who has recovered from COVID-19?

For those individuals with COVID-19 who have made a complete clinical recovery from their illness, are at least 14 days from symptom onset, and who have had no fever for 5 days, the requirement for repeat testing, to demonstrate that RNA is not detected, has been removed.*

- This is in light of current evidence suggesting that viable virus (as against viral RNA) has not been retrieved from respiratory samples in individuals after day 9 of illness
- This measure should facilitate the efficient transfer and discharge of patients as appropriate to their clinical management

When can immunocompromised individuals with COVID-19 be moved out of isolation?

Immunocompromised individuals with COVID-19 can be moved out of isolation 14 days from onset of symptoms, provided they have made a complete clinical recovery, and have had no fever for 5 days*

**There are certain situations where testing to ensure viral clearance after 14 days may be useful and clinical discretion may be used to determine when a "SARS CoV 2 RNA Not Detected" result for a particular patient may be helpful. For example, in patients with subtle or atypical symptoms (in particular older patients), those who might not mount a fever (immunocompromised patients), or those who might not be able to communicate effectively (patients with dementia), repeat testing may be of use. If repeat testing is performed at this time as a secondary consideration, and a general*

principle, high or increasing Ct¹ values in the absence of clinical symptoms, are unlikely to indicate infectiousness.

What is the advice for when someone who had a previous infection with COVID-19, fully recovers (14 days restrictions, last 5 days fever free) who subsequently develops symptoms consistent with COVID-19 and re-tests positive for COVID-19?

EAG advises to manage this as a contagious viral infection with appropriate IPC precautions. It is important to:

- establish the diagnosis by doing an extensive viral infection screen (a respiratory virus panel)
- seek virology/microbiology input on the interpretation of all results, including SARS-CoV-2 Ct values, to determine if this is a new infection or detection of a small amount of persistent, non-viable virus material.

Note: Tests have limitations and need to be considered in the context of the clinical picture.

If an alternative diagnosis does not explain the clinical presentation, suspected cases of re-infection should be reported to public health.

If re-infection cannot be excluded, then it cannot be assumed that the case is not infectious. Current contact tracing guidelines will apply.

What is the advice for someone with a history of COVID-19 infection who has recovered completely and remains well but is tested again e.g. during a mass testing process, and has a positive COVID-19 test result?

If this person received a positive test for COVID-19 within 12 weeks of the start of their symptoms of COVID-19, but are currently clinically well, this can be considered persistent detection of non-viable virus material rather than re-infection and are treated the same as well people.

However, if they develop symptoms, this should trigger further review including testing for other respiratory viruses and interpretation of the Ct values of the PCR test for COVID-19 in conjunction with a microbiologist or virologist, as re-infection cannot be ruled out.

Advice for Healthcare Workers (HCW)

Note: there is no requirement for pre-employment testing of well healthcare workers for COVID-19.

¹ Lower cycle threshold (ct) values indicate higher viral loads

What is the advice for HCWs, with a history of COVID-19 infection who has finished 14 days of self-isolation prior to the commencement of staff screening in residential care facilities?

If these HCWs received a positive PCR result for COVID-19 as part of the screening, but are clinically well, these staff can continue to work. The PCR test most likely detected non-viable virus material, rather than evidence of ongoing active infection.

What restrictions apply if an asymptomatic or pre-symptomatic healthcare worker tests positive for COVID-19 for the first time?

The truly asymptomatic HCW must remain off work for 14 days from the date of the test and contact tracing commences from 24 hours prior to the date of the test.

If a HCW is asymptomatic and tests positive but subsequently gives a history of previous symptoms consistent with COVID, EAG advises the following:

1. If they report symptoms consistent with COVID -19 **within 14 days** prior to the test - they must remain off work from the date symptoms commenced.
2. If they report symptoms consistent with COVID-19 **greater than 14 days** prior to the test –they must remain off work for 14 days from the date of the test.

Regarding a HCW who is a confirmed case of COVID 19, but has subsequently recovered, and who is later identified as a contact of a case after their recovery, could this person be considered immune and therefore allowed to continue working despite their new exposure?

Acknowledging uncertainty and limited data in this area as this is a new virus, you may consider the person to be immune for 12 weeks from start of symptoms. This contact can work as long as they are asymptomatic, but should self-monitor and self-isolate if they become unwell, given the uncertainty around the development of protective immunity after infection. If they develop symptoms consistent with COVID-19, they should be excluded from work immediately and tested for COVID-19 and other respiratory viruses.