Government of Western Australia
Department of Health

Clinician alert #58 – all clinicians

Effective from 14 May 2021

New information

The COVID-19 CDNA National Guidelines (COVID SoNG) were updated on 11 May 2021. The following sections should be noted by all clinicians:

- The disease
- Case management
- Case definition
- Testing
- Contact management

The disease - vaccination

The SARS-CoV-2 vaccination program commenced in Australia on February 2021 using Therapeutic Goods Administration (TGA) approved Pfizer and AstraZeneca vaccines. The Australian Technical Advisory Group on Immunisation (ATAGI) has noted evidence of a rare but serious side effect involving thrombosis with thrombocytopenia following receipt of the AstraZeneca vaccine and now recommends the Pfizer vaccine for adults aged under 50 years.

Case management

Confirmed cases must isolate according to isolation and restriction guidance until they meet the appropriate release from isolation criteria, regardless of vaccination status. All newly confirmed cases should undergo whole genome sequencing.

Confirmed historical cases do not need to isolate and their contacts do not need to quarantine, unless it can be determined the case is a recent historical case that has not met release from isolation criteria.

Case definition

A **historical case** requires laboratory suggestive evidence AND either:

i. previous (prior to the past 14 days) clinical evidence OR
ii. previous (prior to the past 14 days) epidemiological evidence.

A **historical case** should not have symptoms of COVID-19 (or not have had symptoms of COVID-19 for the past 14 days).

Laboratory suggestive evidence includes:

1. Detection of SARS-CoV-2 by polymerase chain reaction (PCR) on two specimens at least 24 hours apart with results suggestive of a historical infection on both specimens AND detection of IgG or total antibody, in the absence of vaccination; OR
2. Negative SARS-CoV-2 PCR AND detection of IgG or total antibody, in the absence of vaccination; OR
3. Detection of SARS-CoV-2 by PCR with initial test results suggestive of a historical infection AND a subsequent PCR is negative, taken at least 24 hours apart.

Testing

Individuals meeting the suspect case definition should be tested for SARS-CoV-2, regardless of vaccination status.

Individuals meeting the enhanced testing criteria should be tested for SARS-CoV-2. However, if presentation for enhanced testing is within 48 hours of receiving a vaccine, in the absence of respiratory symptoms (including loss of smell), testing may not be required.

Routine testing is required for international travellers, international aircrew, COVID-19 quarantine and isolation facility workers and primary close contacts in quarantine.

Serology may be useful for diagnosis of historical COVID-19 cases, further investigation where nucleic acid testing is negative, and research purposes. However, currently no serological assays can reliably prove immunity to SARS-CoV-2 and the ability of serology to detect anti-spike antibody following vaccination for COVID-19 is unknown. The detection of anti-spike antibody cannot distinguish between natural infection and vaccination. Routine diagnostic serological testing is not recommended following COVID-19 vaccination.

Individuals must follow all relevant post-testing instructions, **regardless of vaccination status**.

Testing following a possible vaccine-related adverse event

If a **vaccine recipient** is not a suspect case and develops fever, headache, fatigue or other mild systemic symptoms within and lasting for less than 48 hours after receipt of a COVID-19 vaccine in the absence of respiratory symptoms (including loss of smell), it is more likely that they have an expected vaccine response and testing may not be required. In this situation, the local epidemiology should be considered when determining if SARS-CoV-2 testing is necessary. If symptoms persist past 48 hours post vaccination, these individuals should get tested.

Contact management

Primary close contacts must quarantine for 14 days following the last close contact with the confirmed case during their infectious period, regardless of vaccination status. Primary close contacts should be actively monitored for development of fever or COVID-19 symptoms during this period, where feasible, and should be tested if symptoms develop. Primary close contacts should also be tested on entry to and (where appropriate) exit from quarantine, even if asymptomatic.

Reporting

Clinicians are encouraged to notify PHEOC on 1300 316 555 (9328 0553 A/H) if they strongly suspect a patient has COVID-19 or if they see an unwell patient who is a close contact of a case.

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