



**HAL**  
open science

## **No SARS-CoV-2 reinfection among staff health-care workers: Prospective hospital-wide screening during the first and second waves in Paris**

Maxime Wack, H el ene P er e, Nathalie Demory-Guinet, Najiby Kassis-Chikhani, Laurence Janot, Benoit Vedio, Laure Izquierdo, Laurent B elec, David Veyer

### ► **To cite this version:**

Maxime Wack, H el ene P er e, Nathalie Demory-Guinet, Najiby Kassis-Chikhani, Laurence Janot, et al.. No SARS-CoV-2 reinfection among staff health-care workers: Prospective hospital-wide screening during the first and second waves in Paris. *Journal of Clinical Virology*, 2021, 145, pp.104999. 10.1016/j.jcv.2021.104999 . hal-03405624

**HAL Id: hal-03405624**

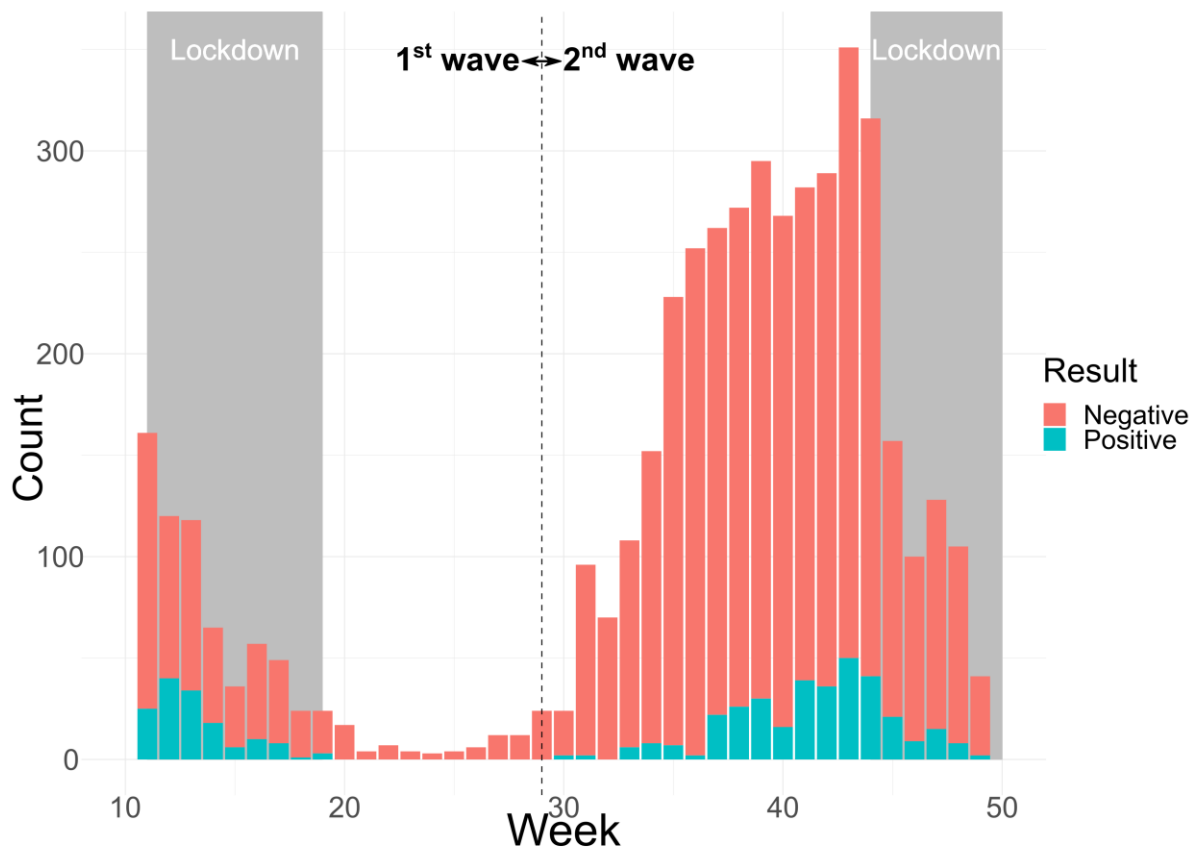
**<https://hal.sorbonne-universite.fr/hal-03405624>**

Submitted on 27 Oct 2021

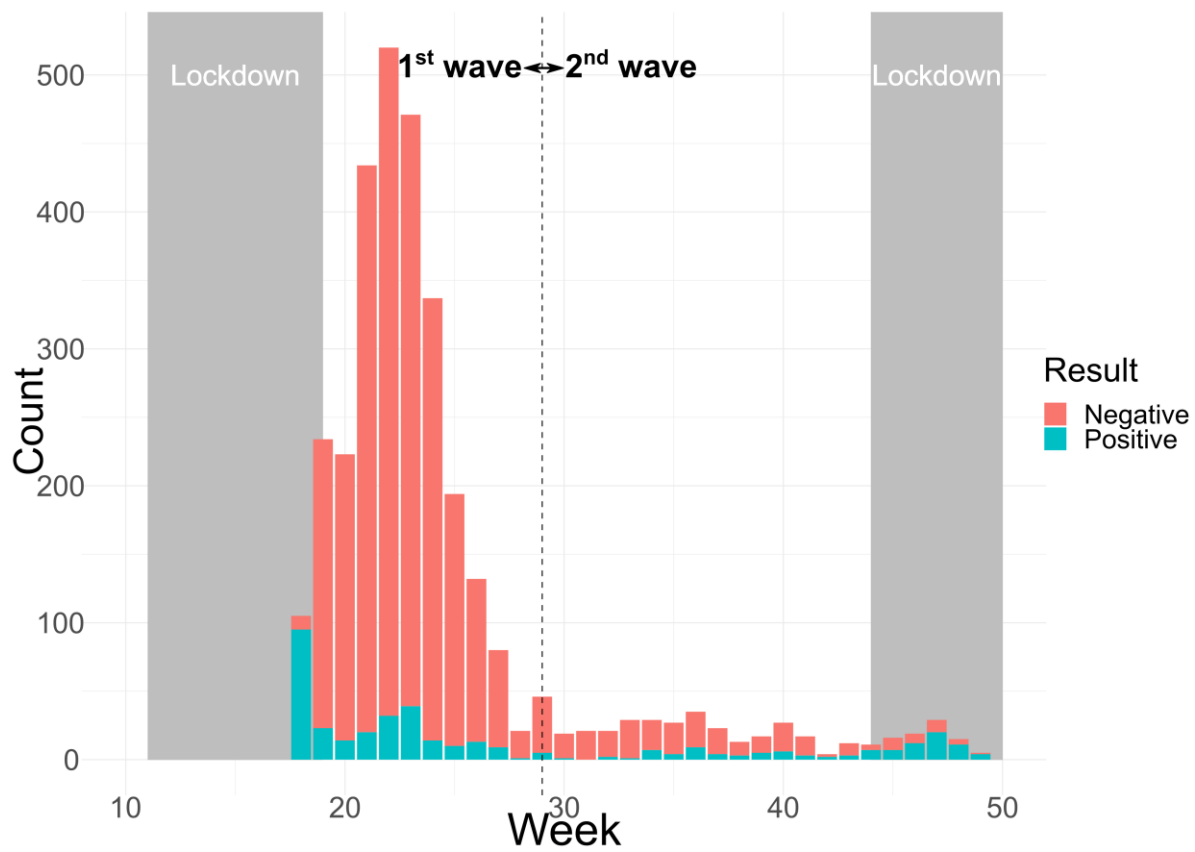
**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destin ee au d ep ot et  a la diffusion de documents scientifiques de niveau recherche, publi es ou non,  emanant des  tablissements d'enseignement et de recherche fran ais ou  trangers, des laboratoires publics ou priv es.

## A. Weekly PCR results for health-care workers



## B. Weekly serology results for health-care workers



2                   **SARS-CoV-2 reinfection among staff health-care workers:**

3                           **Prospective hospital-wide screening**

4                           **during the first and second waves in Paris**

5  
6                   **Running title:** No SARS-CoV-2 reinfection among HCWs

7  
8   **Maxime Wack<sup>1,2,\*</sup>, H  l  ne P  r  <sup>3,4,\*</sup>, Nathalie Demory Guinet<sup>5</sup>, Kassis Chikhani Najibi<sup>6</sup>, Laurence**  
9                           **Janot<sup>5</sup>, Benoit Vedio<sup>7</sup>, Laure Izquierdo<sup>3</sup>,**  
10                           **Laurent B  lec<sup>2,3,8</sup>, David Veyer<sup>3,4</sup>**

11                   <sup>1</sup>*D  partement d'Informatique M  dicale, Biostatistiques et Sant   Publique,*  
12   *h  pital europ  en Georges Pompidou, Assistance Publique-H  pitaux de Paris, Paris, 75015, France;*

13                   <sup>2</sup>*Facult   de M  decine, Universit   de Paris, Paris, 75005, France ;*

14                   <sup>3</sup>*Laboratoire de Virologie, Service de Microbiologie, h  pital europ  en Georges Pompidou,*  
15                   *Assistance Publique-H  pitaux de Paris, Paris, 75015, France ;*

16                   <sup>4</sup>*Unit   de G  nomique Fonctionnelle des Tumeurs Solides,*  
17                   *Centre de Recherche des Cordeliers, INSERM, Universit   Paris, Paris, 75005, France.*

18                   <sup>5</sup>*Service de M  decine du Travail, h  pital europ  en Georges Pompidou,*  
19                   *Assistance Publique-H  pitaux de Paris, Paris, 75015, France ;*

20                   <sup>6</sup>*Unit   d'Hygi  ne Hospitali  re, Service de Microbiologie, h  pital europ  en Georges Pompidou,*  
21                   *Assistance Publique-H  pitaux de Paris, Paris, 75015, France ;*

22                   <sup>7</sup>*Laboratoire de Biochimie, H  pital Europ  en Georges Pompidou, Assistance Publique-H  pitaux de*  
23                   *Paris, Paris, 75015, France*

24                   <sup>8</sup>*INSERM U970, PARCC, h  pital europ  en Georges Pompidou, Facult   de M  decine,*  
25                   *Universit   de Paris, Paris, 75015, France ;*

26  
27  
28  
29   **Submitted as Full Length Article. Manuscript word count: 2492; Abstract word count: 200.**

30  
31  
32  
33  
34   **Corresponding author:** David Veyer, Pharm D, PhD, Laboratoire de virologie, h  pital europ  en Georges  
35   Pompidou, 20 rue Leblanc, 75015 Paris, France. Tel: (33)1 56 09 39 58; fax: (33)1 56 09 24 47; electronic  
36   address: [david.veyer@aphp.fr](mailto:david.veyer@aphp.fr)

38 **Summary**

39 **Objectives.** Risk of reinfection with SARS-CoV-2 among health-care workers (HCWs) is unknown.

40 We assessed the incidence rate of SARS-CoV-2 reinfection in the real-life setting of a longitudinal  
41 observational cohort of HCWs from the *Hôpital Européen Georges Pompidou, Assistance*  
42 *Publique-Hôpitaux de Paris*, France, during the first and second waves of COVID-19 epidemic.

43 **Methods.** From March to December 2020, HCWs were subjected to molecular and serology testing  
44 of SARS-CoV-2. Reinfection was defined as a positive test result during the first wave, either by  
45 serology or PCR, followed by a positive PCR during the second wave. Evolution of COVID-19  
46 status of HWCs was assessed by a Sankey diagram.

47 **Results.** A total of 7765 tests (4579 PCR and 3186 serology) were carried out and 4168 HCWs had  
48 at least one test result during the follow-up period with a positivity rate of 15.9%. No case of  
49 reinfection during the second wave could be observed among 102 positive HCWs of the first wave,  
50 nor among 175 HCWs found positive by PCR during the second wave who were negative during  
51 the first wave.

52 **Conclusions.** SARS-CoV-2 reinfection was not observed among HCWs, suggesting a protective  
53 immunity against reinfection that lasts at least 8 months post infection.

54

55 **Keywords:** SARS-CoV-2; reinfection; health-care workers; vaccination; epidemiology

56

57

58

## 59 **Introduction**

60

61 Health-care workers (HCWs) constitute a vulnerable population at high risk of SARS-CoV-  
62 2 infection (1–3). During the first wave of COVID-19 epidemic in France, as of May 13, 2020,  
63 more than 4,500 professionals were infected and 4 dead from COVID-19 in the *Assistance*  
64 *Publique-Hôpitaux de Paris* (AP-HP, which represents the largest group of university hospitals in  
65 Europe, accounting for about 100 000 employees).

66 SARS-CoV-2 infection elicits both humoral and cellular, mucosal and systemic specific  
67 immunity (4–6). A key question yet to be addressed is whether SARS-CoV-2 infection induces  
68 long-lasting protective or sterilizing immunity. Our understanding of the immune correlates of  
69 protection for SARS-CoV-2 infection and their durability remains limited and depends mainly on  
70 previous knowledge gained from SARS-CoV-1, the most closely related virus known to affect  
71 humans (5,7). Furthermore, a number of cases of SARS-CoV-2 reinfection in humans have now  
72 been reported a few months after initial infection (8,9), including HCWs (10), challenging the  
73 possibility of durable protective immunity. These findings may have implications for the need of  
74 continued protective measures and of further vaccination for persons previously infected with  
75 SARS-CoV-2 (9).

76 In France, the SARS-CoV-2 epidemic officially began on January 24, 2020, with the first  
77 confirmed case of COVID-19 imported from China. Early April, the number of deaths from  
78 coronavirus increased dramatically, with more than 10,000 people dying during that period of time.  
79 The first wave of the COVID-19 epidemic was contained due to the first national lockdown that  
80 extended from March 17, 2020 until May 10, 2020, the peak of the first wave being reached on the  
81 1<sup>st</sup> of April 2020. During August 2020, COVID-19 cases began to rise again. On October 28, France  
82 entered a second nationwide lockdown with progressive lifting starting from December 15. The  
83 peak of the second epidemic wave was reached on the 20<sup>th</sup> of November 2020, but the epidemic has

84 since remained at a high plateau level. The duration period between the peaks of the first and  
85 second waves was 7.8 months (234 days).

86 Our institution, the *Assistance Publique-Hôpitaux de Paris*, has largely promoted both  
87 molecular and serological testing for SARS-CoV-2 among healthcare staff, from the first wave of  
88 the COVID-19 epidemic (1). Molecular testing for SARS-CoV-2 of symptomatic hospital  
89 employees with COVID-19-related symptoms started on February 24, 2020. In addition, starting  
90 early April 2020, the *Assistance Publique-Hôpitaux de Paris* offered HCWs serological screening  
91 for SARS-CoV-2 to assess the prevalence of the infection during the first epidemic peak.

92 The intensity of COVID-19 epidemic in France in 2020 with a high risk of re-exposure to  
93 SARS-CoV-2 infection for HCWs, as well as the availability of our centralized data-capture system  
94 of all molecular and serological SARS-CoV-2 tests results, prompted us to assess the risk of SARS-  
95 CoV-2 reinfections in a real-life setting in HCWs from our institution.

96

## 97 **Materiel and method**

98

### 99 **Study design and participants recruitment.**

100 The study was designed as an observational cohort with longitudinal analysis, focused on  
101 molecular detection of SARS-CoV-2 RNA and immune response to SARSCoV-2 in volunteers  
102 HCWs from the *Hôpital Européen Georges Pompidou, Assistance Publique-Hôpitaux de Paris*,  
103 tested during the first and second epidemic waves for suspected SARS-CoV-2 infection, contact  
104 tracing and SARS-CoV-2 infection serological surveillance. Data included HCW ages, SARS-CoV-  
105 2 PCR and SARS-CoV-2 serology sampling dates and results. HCWs gender was not available. All  
106 molecular and serological results were fully pseudonymized. July 15 2020 was considered as the  
107 limit between the first and second epidemic waves.

108 During the first epidemic wave, the HCW participants were categorized into two groups  
109 according to their molecular and serological results: positive if any SARS-CoV-2 PCR test and/or  
110 serology were positive, and negative if every SARS-CoV-2 PCR test and serology were negative.  
111 During the second epidemic wave, the participants were categorized into two groups according to  
112 their molecular results, as positive if any SARS-CoV-2 PCR test was positive, and negative if every  
113 SARS-CoV-2 PCR test were negative. In addition, HCW participants included during the first wave  
114 but not tested during the second wave, and those included during the second wave but not tested  
115 during the first wave were categorized as participants with not available results (NA). Finally,  
116 reinfection was defined as a positive result during the first wave, either by serology or PCR,  
117 followed by a positive PCR during the second wave. If iterative PCR sampling occurred, reinfection  
118 was considered if a negative result was surrounded by 2 positive results. Furthermore, if 2 PCRs  
119 were positive with more than 30 days between the sample dates without any negative results in  
120 between, results were individually assessed by a virologist to decide if reinfection was confirmed or  
121 if remnant RNA from the original infection was still detected when the cycle threshold ( $C_t$ ) value of  
122 the PCR was over 33 (11). Positive serology during the first wave followed by positive PCR during  
123 the second wave was also considered a reinfection.

124 **SARS-CoV-2 testing.** Molecular detection of SARS-CoV-2 was carried out from flocced  
125 nasopharyngeal swab samples using Allplex™ 2019-nCoV Assay (Seegene, Seoul, Korea), a  
126 multiplex real-time PCR assay that detects three coronavirus target genes (E gene, RdRP gene and  
127 N gene) in a single tube, according to the manufacturer's instructions, as previously described (12).  
128 Abbott SARS-CoV-2 IgG assay detecting IgG against SARS-CoV-2 nucleoprotein was used on  
129 Architect analyzer (Abbott Architect™ i2000), according to manufacturer's instructions, as  
130 previously described (13). Index value threshold for positivity was 1.4. Qualitative results were  
131 used for analysis.

132 **Statistical analysis.** Categorical variables are presented as number (percentage and its [95%  
133 confidence interval]), and numeric variables as median or mean (SD or IQR). The number of test  
134 results was computed on a weekly basis. The evolution of the status for COVID-19 of HCWs  
135 between the two waves was assessed using a Sankey diagram, as described (14).

136 **Ethics statement.** Our observational study was carried out in accordance with the Declaration of  
137 Helsinki with no sampling addition to usual procedures. Swab and serum specimens were obtained  
138 only for standard diagnostic following medical prescriptions in the service of occupational medicine  
139 of our institution, and further eventual care. Under these conditions, the study was exempt from  
140 informed consent application, according to the French public health code (*Code de la Santé*  
141 *Publique*, article L 1121-1.1; <https://www.legifrance.gouv.fr/>). The dataset was completely  
142 anonymous and did not contain any identifiable personal health information.

143

## 144 **Results**

145

146 A total of 7765 tests, including PCR and serology, were collected from March 5, 2020 to  
147 December 4, 2020 by the occupational medicine service at the *Hôpital Européen Georges*  
148 *Pompidou*, Paris.

149 As depicted in the Figure 1, the weekly number of PCR tests evolved in accordance to the  
150 two waves of the epidemic of cases of SARS-CoV-2 infection in Paris. The number of serology  
151 tests per week evolved according to the curve resembling the first wave of the epidemic due to an  
152 institutional campaign for SARS-CoV-2 serology testing among HCWs between May and July.

153 Overall, 4579 PCR and 3186 serology tests were performed with positivity rates of 10.7%  
154 and 12.1%, respectively. A total of 4168 HCWs (median age, 34.3 years; IQR, 20.9 years) had at  
155 least one result, either PCR or serology, during the entire period with a positivity rate of 15.9%.  
156 There were 690 HCWs with at least one PCR result during the first wave *versus* 2340 during the



157 second wave with a positivity rate of 21.3% and 14.1%, respectively. Conversely, 2737 HCWs had  
158 a serology result during the first wave *versus* 417 during the second one, with a positivity rate of  
159 9.8% and 27.8%, respectively (Table 1).

160 Among the 302 positive HCWs (either by serology or PCR) during the first wave, 102 were  
161 tested by PCR at least once during the second wave (154 total PCRs), and all their PCR results were  
162 negative (Figure 2). Furthermore, among the 330 PCR-positive HCWs during the second wave, 190  
163 had a previous result from the first wave. Among those 190 that were tested in the first wave, there  
164 were 9 positive PCRs and 14 positive serology (15 total HCWs), and 170 negative serology and 45  
165 negative PCRs (175 HCWs). All those 15 positive HCWs in the first wave were only positive in  
166 serology in the second wave. Among the 2657 negative HCWs during the first wave, 175 had a  
167 positive PCR result (185 tests) and 965 (1859 tests) had a negative result during the second wave.  
168 Overall, no case of reinfection during the second wave could be observed among the HCWs  
169 population in our hospital. The observed reinfection incidence was thus 0% [95% CI: 0 - 3.55%].

170

## 171 **Discussion**

172

173 We herein assessed the incidence rate of SARS-CoV-2 reinfection in the real-life setting of a  
174 longitudinal observational cohort of HCWs from one of the major university hospitals of the  
175 *Assistance Publique-Hôpitaux de Paris*, France, during the first and second waves of COVID-19  
176 epidemic in 2020. The longitudinal prevalence rates of SARS-CoV-2 infection among HCWs,  
177 mostly symptomatic infections due to the design of the study, mimicked the curves of both waves of  
178 the COVID-19 epidemics in France with an overall rate of SARS-CoV-2 infection around 16%,  
179 demonstrating possible occupational risk for SARS-CoV-2 infection in HCWs despite barrier  
180 protection measures within the community and hospital settings. Among the included SARS-CoV-2  
181 infected HCWs tested for SARS-CoV-2 PCR swab and/or IgG serology in both the first and second

182 waves of the COVID-19 epidemic in Paris, no case of SARS-CoV-2 reinfection could be evidenced.  
183 Thus, the risk of SARS-CoV-2 reinfection among HCWs appears negligible, despite the high level  
184 of exposure to the virus during epidemic waves. Taken together, these observations demonstrate  
185 that HCWs are at high risk of SARS-CoV-2 infection. SARS-CoV-2 reinfection was infrequent in  
186 study HCWs, highly suggestive of a protective immunity against reinfection lasting at least 8  
187 months following the primary infection.(1–3,15)

188 More than a seventh (15.9%) of HCWs showed at least one positive biological marker for  
189 SARS-CoV-2 during the nearly 8 months of study inclusion. The risk of SARS-CoV-2 infection in  
190 included HCWs strictly followed the waves of the COVID-19 epidemic in France, during which  
191 between 3% and 7% of French people will have been infected by SARS-CoV-2 (16). Thus, our  
192 findings suggest that HCWs are likely at supplementary risk for occupational SARS-CoV-2  
193 infection, as previously reported in Paris and other settings (1–3,15).

194 The possibility of SARS-CoV-2 reinfection has raised important issues about the strength  
195 and durability of the immune response to primary infection, which are key factors in predicting the  
196 course of the pandemic (8). We herein show SARS-CoV-2 reinfection was infrequent or absent  
197 among HCWs infected during the first wave of COVID-19 epidemic, despite their community and  
198 occupational re-exposure during the second wave. Our observations are in agreement with the low  
199 risk of SARS-CoV-2 reinfection generally reported (8,17), although the rates of reinfection with  
200 SARS-CoV-2 can vary widely, depending on the criteria used, and also because it is difficult to  
201 make the diagnosis with certainty, as previously pointed (18). By including the stringent criteria of  
202 viral genomic data to distinguish reinfection from persistent viral carriage, only 16 documented  
203 individual cases of reinfection confirmed by sequencing have been reported in the literature at the  
204 end of 2020 (8,19). Recently in Qatar, the risk of SARS-CoV-2 reinfection was estimated to be as  
205 low as 1 case of reinfection per 5000 infected individuals (17). However, a 2,800 person study  
206 found no symptomatic re-infections over a ~118 days window (20), and a 1,246 person study

207 observed no symptomatic re-infections over 6 months (21). Overall, SARS-CoV-2 re-infection is  
208 considered a possible but rare event (8), in keeping with our observational study based on field  
209 results from a well-documented hospital cohort.

210 SARS-CoV-2 infection consistently elicits neutralizing antibodies targeting the spike protein  
211 (in addition to other viral antigens), as well as CD8+ and CD4+ T cell responses (4–6). However,  
212 the duration of effective immunity to SARS-CoV-2 remains unknown, and the issue of waning  
213 immunity and reversion to a SARS-CoV-2 susceptible state over months to years is raised (22). Our  
214 observations of infrequent SARS-CoV-2 reinfection in hospital setting during the first and second  
215 waves of COVID-19 epidemic in Paris are strongly suggestive of efficient and protective immunity  
216 against reinfection that lasts at least 8 months post primary infection. These observations are in  
217 keeping with measurable immune memory in the three major branches of adaptive immunity (CD4+  
218 T cell, CD8+ T cell, and humoral immunity) in ~95% of subjects 5 to 8 months post symptom  
219 onset, indicating that durable immunity against secondary COVID-19 disease is a possibility in  
220 most individuals (23). Obviously, further follow-up of SARS-CoV-2-infected HCWs over time may  
221 allow characterization of potential effects of SARS-CoV-2-specific immunity waning.

222 The need to vaccinate previously SARS-CoV-2-infected individuals remains the matter of  
223 debate (9,24). It is possible that a fraction of the SARS-CoV-2-infected population with low  
224 immune memory would become susceptible to re-infection relatively soon (23). Current  
225 recommendations for COVID-19 vaccination from the World Health Organization (25) and the  
226 Centers for Disease Control and Prevention (USA) (26) do not consider the fact of having been  
227 infected with SARS-CoV-2. The National Health Service (UK) recommends to temporarily  
228 postponing vaccination for 4 weeks after the onset of COVID symptoms (27). In France, the *Haute*  
229 *Autorité de Santé*, Saint-Denis, has recommended that there is no need to systematically vaccinate  
230 people who have already developed a symptomatic form of COVID-19 (28). Our observations of  
231 HCWs infected by SARS-CoV-2 harboring durable protection against reinfection for at least 8

232 months indicate that COVID-19 vaccination does not *a priori* constitute a priority in case a previous  
233 infection, especially if vaccine doses are limited. As vaccine candidates advance worldwide,  
234 serostatus for COVID-19 could be relevant in HCWS before vaccination. If it is determined that a  
235 single SARS-CoV-2 exposure induces long-lasting protective immunity, a positive serology test  
236 could indicate that an individual does not require vaccination or should not receive priority for  
237 vaccination (29). Finally, in case of vaccination in HCWS who have already been infected, the  
238 vaccination schedule could also possibly be simplified to a single dose.

239 Our study has some limitations. Except for HCWs that were recently exposed to positive  
240 patients or colleagues (contact tracing), only HCWs volunteering for testing were included and  
241 probably most of them had symptomatic infection. Furthermore, the possibility could be that  
242 reinfections (if they occur) would have been asymptomatic or well tolerated and that they went  
243 unnoticed without a biological diagnosis. Finally, HCWs in our institution were exposed to the  
244 SARS-CoV-2 variants circulating in France until December 2020, and our study does not evaluate  
245 the possibility of reinfection by other variants, such as the new U.K. variant of SARS-CoV-2, which  
246 various modeling exercises have estimated to be up to 70% more transmissible than the previously  
247 circulating form of the virus (30).

248 In conclusion, SARS-CoV-2 reinfection appears to be a rare phenomenon, if it exists, in  
249 HCWs despite their high level of exposure to the virus during epidemic peaks. This feature may  
250 suggest that effective immunity against SARS-CoV-2 infection develops after primary infection and  
251 lasts for at least 8 months, and that it is able to protect against reinfection. Finally, HCWs already  
252 infected with SARS-CoV-2 do not constitute a priority population for vaccination, especially as  
253 vaccine doses remain rationed.

254

255 **Acknowledgments.** The authors gratefully thank the department of clinical biochemistry, *Hôpital*  
256 *Européen Georges Pompidou*, Paris, especially the technicians from the serological platform.

257  
258 **Author's contribution.** HP, LB, DV designed the research. NDG, KCN, LJ provided clinical care  
259 and biological specimens. LB, DV, LI, BV analyzed the samples. MW, DV performed statistical  
260 analysis. HP, MW, LB, DV drafted the manuscript. All authors read and approved the final  
261 manuscript.

262

263

264

265

266 **References**

267

- 268 1. Contejean A, Leporrier J, Canoui E, Alby-Laurent F, Lafont E, Beaudeau L, et al. Comparing  
269 Dynamics and Determinants of Severe Acute Respiratory Syndrome Coronavirus 2  
270 Transmissions Among Healthcare Workers of Adult and Pediatric Settings in Central Paris.  
271 Clin Infect Dis. 2020 Jul 14;
- 272 2. Hunter E, Price DA, Murphy E, van der Loeff IS, Baker KF, Lendrem D, et al. First  
273 experience of COVID-19 screening of health-care workers in England. Vol. 395, The Lancet.  
274 Lancet Publishing Group; 2020. p. e77–8.
- 275 3. Amanat F, Stadlbauer D, Strohmeier S, Nguyen THO, Chromikova V, McMahon M, et al. A  
276 serological assay to detect SARS-CoV-2 seroconversion in humans. Nat Med. 2020 May  
277 12;26(7):1033–6.
- 278 4. Canedo-Marroquín G, Saavedra F, Andrade CA, Berrios R V., Rodríguez-Guilarte L, Opazo  
279 MC, et al. SARS-CoV-2: Immune Response Elicited by Infection and Development of  
280 Vaccines and Treatments. Vol. 11, Frontiers in Immunology. Frontiers Media S.A.; 2020.
- 281 5. Galipeau Y, Greig M, Liu G, Driedger M, Langlois MA. Humoral Responses and Serological  
282 Assays in SARS-CoV-2 Infections. Vol. 11, Frontiers in Immunology. Frontiers Media S.A.;
- 283 2020.
- 284 6. Jarjour NN, Masopust D, Jameson SC. T Cell Memory: Understanding COVID-19. Vol. 54,  
285 Immunity. Cell Press; 2021. p. 14–8.
- 286 7. Le Bert N, Tan AT, Kunasegaran K, Tham CYL, Hafezi M, Chia A, et al. SARS-CoV-2-  
287 specific T cell immunity in cases of COVID-19 and SARS, and uninfected controls. Nature.  
288 2020 Aug 20;584(7821):457–62.
- 289 8. Babiker A, Marvil C, Waggoner JJ, Collins M, Piantadosi A. The Importance and Challenges  
290 of Identifying SARS-CoV-2 Reinfections. J Clin Microbiol. 2020 Dec 23;
- 291 9. Cohen JI, Burbelo PD. Reinfection with SARS-CoV-2: Implications for Vaccines. Clin Infect

- 292 Dis. 2020 Dec 18;
- 293 10. Gupta S, Wang W, Hayek SS, Chan L, Mathews KS, Melamed ML, et al. Association  
294 Between Early Treatment With Tocilizumab and Mortality Among Critically Ill Patients  
295 With COVID-19. *JAMA Intern Med* [Internet]. 2020 Oct 20 [cited 2020 Oct 27]; Available  
296 from: <http://www.ncbi.nlm.nih.gov/pubmed/33080002>
- 297 11. Yu F, Yan L, Wang N, Yang S, Wang L, Tang Y, et al. Quantitative Detection and Viral  
298 Load Analysis of SARS-CoV-2 in Infected Patients. *Clin Infect Dis*. 2020 Mar 28;
- 299 12. Péré H, Podglajen I, Wack M, Flamarion E, Mirault T, Goudot G, et al. Nasal Swab  
300 Sampling for SARS-CoV-2: a Convenient Alternative in Times of Nasopharyngeal Swab  
301 Shortage. Vol. 58, *Journal of clinical microbiology*. NLM (Medline); 2020.
- 302 13. Péré H, Védie B, Vernet R, Demory N, Kassis N, Mirault T, et al. Unexpected diagnosis of  
303 COVID-19-associated disorders by SARS-CoV-2-specific serology. *J Clin Virol*. 2020 Nov  
304 1;132.
- 305 14. Huang CW, Lu R, Iqbal U, Lin SH, Nguyen PA, Yang HC, et al. A richly interactive  
306 exploratory data analysis and visualization tool using electronic medical records Clinical  
307 decision-making, knowledge support systems, and theory. *BMC Med Inform Decis Mak*.  
308 2015 Nov 12;15(1).
- 309 15. Péré H, Wack M, Védie B, Demory Guinet N, Kassis Chikani N, Janot L, et al. Sequential  
310 SARS-CoV-2 IgG assays as confirmatory strategy to confirm equivocal results: Hospital-  
311 wide antibody screening in 3,569 staff health care workers in Paris. *J Clin Virol* [Internet].  
312 2020 Nov 1 [cited 2020 Nov 28];132:104617. Available from:  
313 <http://www.ncbi.nlm.nih.gov/pubmed/32927358>
- 314 16. Salje H, Kiem CT, Lefrancq N, Courtejoie N, Bosetti P, Paireau J, et al. Estimating the  
315 burden of SARS-CoV-2 in France. *Science* (80- ). 2020 Jul 10;369(6500):208–11.
- 316 17. Abu-Raddad LJ, Chemaitelly H, Malek JA, Ahmed AA, Mohamoud YA, Younuskuju S, et

- 317 al. Assessment of the risk of SARS-CoV-2 reinfection in an intense re-exposure setting. *Clin*  
318 *Infect Dis.* 2020 Dec 14;
- 319 18. Tomassini S, Kotecha D, Bird PW, Folwell A, Biju S, Tang JW. Setting the criteria for  
320 SARS-CoV-2 reinfection – six possible cases. *Journal of Infection.* W.B. Saunders Ltd;  
321 2020.
- 322 19. CDC. Investigative Criteria for Suspected Cases of SARS-CoV-2 Reinfection (ICR)  
323 [Internet]. Centers for Disease Control and Prevention. 2020 [cited 2021 Jan 29]. Available  
324 from: <https://www.cdc.gov/coronavirus/2019-ncov/php/invest-criteria.html>
- 325 20. Wyllie D, Mulchandani R, Jones HE, Taylor-Phillips S, Brooks T, Charlett A, et al. SARS-  
326 CoV-2 responsive T cell numbers are associated with protection from COVID-19: A  
327 prospective cohort study in keyworkers. *medRxiv.* medRxiv; 2020. p. 2020.11.02.20222778.
- 328 21. Lumley SF, O'Donnell D, Stoesser NE, Matthews PC, Howarth A, Hatch SB, et al.  
329 Antibodies to SARS-CoV-2 are associated with protection against reinfection. *medRxiv.*  
330 medRxiv; 2020. p. 2020.11.18.20234369.
- 331 22. Overbaugh J. Understanding protection from SARS-CoV-2 by studying reinfection. *Nat*  
332 *Med.* 2020 Nov 1;26(11):1680–1.
- 333 23. Dan JM, Mateus J, Kato Y, Hastie KM, Yu ED, Faliti CE, et al. Immunological memory to  
334 SARS-CoV-2 assessed for up to 8 months after infection. *Science* (80- ). 2021 Jan  
335 6;eabf4063.
- 336 24. Chung JY, Thone MN, Kwon YJ. COVID-19 vaccines: The status and perspectives in  
337 delivery points of view. Vol. 170, *Advanced Drug Delivery Reviews.* Elsevier B.V.; 2021. p.  
338 1–25.
- 339 25. Organization WH. WHO SAGE values framework for the allocation and prioritization of  
340 COVID-19 vaccination, 14 September 2020 [Internet]. Geneva PP - Geneva: World Health  
341 Organization; Available from: <https://apps.who.int/iris/handle/10665/334299>



- 342 26. Dooling K, McClung N, Chamberland M, Marin, M, Wallace M, Bell BP, et al. The  
343 Advisory Committee on Immunization Practices' Interim Recommendation for Allocating  
344 Initial Supplies of COVID-19 Vaccine — United States, 2020. *MMWR Morb Mortal Wkly*  
345 *Rep* [Internet]. 2020 Dec 11 [cited 2021 Jan 29];69(49):1857–9. Available from:  
346 [http://www.cdc.gov/mmwr/volumes/69/wr/mm6949e1.htm?s\\_cid=mm6949e1\\_w](http://www.cdc.gov/mmwr/volumes/69/wr/mm6949e1.htm?s_cid=mm6949e1_w)
- 347 27. COVID-19: the green book, chapter 14a - GOV.UK [Internet]. [cited 2021 Jan 29]. Available  
348 from: <https://www.gov.uk/government/publications/covid-19-the-green-book-chapter-14a>
- 349 28. Haute Autorité de Santé - Stratégie de vaccination contre le Sars-Cov-2 - Recommandations  
350 préliminaires sur la stratégie de priorisation des populations à vacciner [Internet]. [cited 2021  
351 Jan 29]. Available from: [https://www.has-sante.fr/jcms/p\\_3221338/fr/strategie-de-](https://www.has-sante.fr/jcms/p_3221338/fr/strategie-de-vaccination-contre-le-sars-cov-2-recommandations-preliminaires-sur-la-strategie-de-priorisation-des-populations-a-vacciner)  
352 [vaccination-contre-le-sars-cov-2-recommandations-preliminaires-sur-la-strategie-de-](https://www.has-sante.fr/jcms/p_3221338/fr/strategie-de-vaccination-contre-le-sars-cov-2-recommandations-preliminaires-sur-la-strategie-de-priorisation-des-populations-a-vacciner)  
353 [priorisation-des-populations-a-vacciner](https://www.has-sante.fr/jcms/p_3221338/fr/strategie-de-vaccination-contre-le-sars-cov-2-recommandations-preliminaires-sur-la-strategie-de-priorisation-des-populations-a-vacciner)
- 354 29. West R, Kobokovich A, Connell N, Gronvall GK. COVID-19 Antibody Tests: A Valuable  
355 Public Health Tool with Limited Relevance to Individuals. *Trends in Microbiology*. Elsevier  
356 Ltd; 2020.
- 357 30. Kirby T. New variant of SARS-CoV-2 in UK causes surge of COVID-19. *Lancet Respir*  
358 *Med*. 2021 Jan;  
359  
360

361 **Table 1.** SARS-CoV-2 RNA PCR and SARS-CoV-2-specific IgG serology results carried out  
 362 among HCWs in *Hôpital Européen Georges Pompidou*, Paris, France, during the first and second  
 363 waves of the COVID-19 epidemic in 2020.

364

	First wave	Second wave	Total
<b>HCWs tested by PCR and/or serology [n]</b>	2902	2506	4168
<b>Age of tested HCWs [median (IQR); years]</b>	37.1 (20.6)	32.1 (19.5)	34.3 (20.9)
<b>SARS-CoV-2 PCR and serology [n]</b>	3510	4255	7765
<b>PCR [n]</b>	759	3820	4579
[percent of positive (CI)]	19.5% (16.7 – 22.5)	8.9% (8.0 – 9.8)	10.7% (9.8 – 11.6)
<b>Serology [n]</b>	2751	435	3186
[percent of positive (CI)]	9.8% (8.7 – 10.9)	26.7% (22.6 – 31.1)	12.1 % (11.0 – 13.3)
<b>HCWs tested positive by PCR and/or serology [n]</b>	302	379	666
[percent (CI)]	10.4% (9.3 – 11.6)	15.1% (13.7 – 16.6)	15.9% (14.9 – 17.1))
<b>HCWs tested by both PCR and serology [n]</b>	525	251	1565
[percent of positivity by PCR or serology (CIs)]	41.5% (37.3 – 45.9)	47% (40.7 – 53.4)	31.3% (29.0 – 33.7)
[percent of positivity by both PCR and serology (CIs)]	21.5% (18.1 – 25.3)	26.7% (21.3 – 32.6)	11.6% (10.1 – 13.3)
<b>HCWs with at least one PCR result [n]</b>	690	2340	2719
[percent of positivity (CI)]	21.3% (18.3 – 24.5)	14.1% (12.7 – 15.6)	17.5% (16.1 – 18.9)
<b>PCR per HCW [mean (SD)]</b>	1.10 (0.30)	1.63 (0.90)	1.68 (1.02)
<b>HCWs with at least one serology result [n]</b>	2737	417	3014
[percent of positivity (CI)]	9.8% (8.7 – 10.9)	27.8% (23.6 – 32.4)	12.3% (11.2 – 13.4)
<b>Serology per HCW [mean (SD)]</b>	1.01 (0.08)	1.04 (0.23)	1.06 (0.25)

365 CI: Confidence interval; IQR: Interquartile range; HCW: Health-care worker; n: number; SD: Standard deviation;

366

367

368

369 **Figures Legends**

370

371 **Figure 1.** PCR and serology results during the first and the second wave of the COVID-19

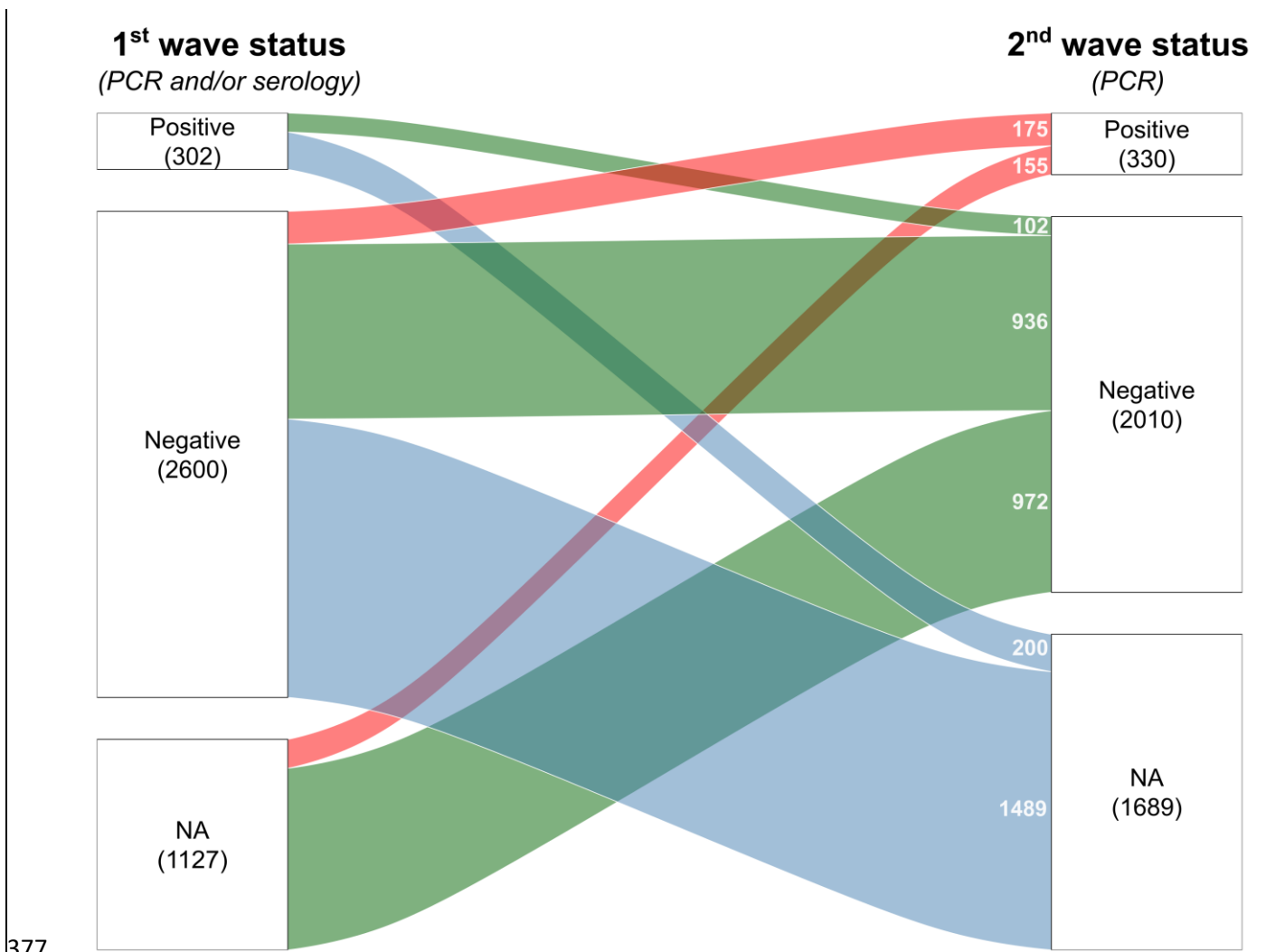
372 pandemic. Weekly SARS-CoV-2 RNA PCR results (A.) and SARS-CoV-2-specific IgG serology

373 results (B.) among staff HCWs in *Hôpital Européen Georges Pompidou*, Paris, France, during the

374 first and second waves of the COVID-19 epidemic in 2020. The dashed vertical line indicates the

375 separation between the first and second waves. The shaded areas correspond to the lockdown period

376 decided by the French government. Positive and negative results are in red and blue, respectively.



377

378 **Figure 2.** Health-care workers COVID-19 status evolution between the first and the second wave of

379 the COVID-19 pandemic. Sankey diagram showing the evolution of SARS-CoV-2 status among

380 HCWs in *Hôpital Européen Georges Pompidou*, Paris, France, between the first and the second

381 waves. Boxes on the left represent results either by PCR and/or serology during the first wave of the  
382 SARS-CoV-2 epidemic, while those on the right represent results only by PCR during the second  
383 wave. The different lanes show the status evolution with lane sizes proportional to the number of  
384 HCWs. The blue lanes are for HCWs with no result during the second wave. The green lanes are for  
385 HCWs with a negative result during the second wave. The red lanes are for HCWs with a positive  
386 result during the second wave. NA: Results not available.

387