Pan Arab Rhinology Society
PARS Reader's Digest

Reader Digest

Digested by Dr. Tarek Kandil, MD. Consultant, students Hospital, Cairo University

Introduction

This newsletter is intended to provide information that is useful to the student and specialist in the field of rhinology and allergic disorders.

The selected recent material represents important fundamental knowledge, current trends or recent developments in this field.

We hope that this newsletter will help the reader have a greater understanding of rhinology and allergic disorders

1. COVID-19 and the Otolaryngologist - Preliminary Evidence-Based Review

Neelaysh Vukkadala 1, Z Jason Qian 1, F Christopher Holsinger 1, Zara M Patel 1, Eben Rosenthal 1

Abstract

The SARS-CoV-2 virus which causes coronavirus disease 2019 (COVID-19) has rapidly swept across the world since its identification in December 2019. Otolaryngologists are at unique risk due to the close contact with mucus membranes of the upper respiratory tract and have been among the most affected healthcare workers in Wuhan, China. We present information on COVID-19 management relevant to otolaryngologists on the frontlines of this pandemic and provide preliminary guidance based on practices implemented in China and other countries and practical strategies deployed at Stanford University.

Laryngoscope 2020 Mar 26

2. Which Sampling Method for the Upper Respiratory Tract Specimen Should Be Taken to Diagnose Patient With COVID-19?

B Ye 1, C Fan 1, Y Pan 1, R Ding 1, H X Hu 1, M L Xiang 1

Abstract

Coronavirus disease 2019 (COVID-19) is raging in China, especially in Hubei Province, which has resulted great dangers in people's life and national economy. According to the guidelines drafted by China's Center for Disease prevention and Control (CDC), the positive nucleic acid test is need to the diagnosis of patient with COVID-19. Upper respiratory tract specimens are the main sources for nucleic acid detection. However, based on international guidelines of COVID-19 , no recommended level of upper respiratory tract sampling method is proposed. Therefore, which kind of sampling methods should be chosen to help the COVID-19 diagnosis and which way is the most secure for doctors and nurses is our concern. In this review, we analyzed a total of 10 literatures on the sampling methods of upper respiratory tract related to infectious diseases such as severe acute respiratory syndrome coronavirus (SARS), middle east respiratory syndrome coronavirus (MERS), and influenza A (H1N1), which were spread worldwide in past years. Literatures were collected from the three dimensions of sampling method, sampling time, and sampling safety. It was found that among all the upper respiratory sampling methods, nasopharyngeal aspirate (NPA) had a higher positive rate within 2 weeks of symptom onset, while combined nasal and oropharyngeal swabs (NS + OPS) was the least harmful to medical staff during sampling. We wish this review is helpful for the prevention of COVID-19.

Zhonghua Er Bi Yan Hou Tou Jing Wai Ke Za Zhi , 55 (0), E003 2020 Mar 13

3. The Covid-19 Pandemic and Otolaryngology: What It Comes Down To?

Jan-Christoffer Lüers 1, Jens Peter Klußmann 1, Orlando Guntinas-Lichius 2

Abstract

Here, we review the most recent findings on the effects COVID-19 pandemic for the work of otolaryngologists. The role of anosmia and hyposmia as a potential COVID-19 related symptom is presented. We discuss the clinical management of all ENT patients, but especially of COVID-19 patients from the ENT perspective. The impact of the infection on the ENT examination and ENT surgery is summarized.

Laryngorhinootologie 2020 Mar 26

4. COVID-19: Protecting Our ENT Workforce

James R Tysome 1, Mahmood F Bhutta 2

Abstract

As we write at the end of March 2020, the coronavirus disease 19 (COVID-19) pandemic is posing an urgent and significant threat to global health. It has become clear that the healthcare worker army that forms the front line are also at increased risk of exposure to the SARS-CoV-2 virus that causes this disease. In China 3.8% of all cases of COVID-19 were in healthcare workers, but 14.8% of those had severe or critical disease.

Clin Otolaryngol 2020 Apr 4

5. Role and Management of a Head and Neck Department During the COVID-19 Outbreak in Lombardy

Alberto Maria Saibene 1, Fabiana Allevi 2, Federico Biglioli 2 3, Giovanni Felisati 1 3

Abstract

The recent Italian outbreak of coronavirus disease 2019 led to an unprecedented burden on our health care system. Despite head and neck-otolaryngology not being a front-line specialty in dealing with this disease, our department had to face several specific issues. Despite a massive reallocation of resources in the hospital, we managed to keep the service active, improving safety measures for our personnel, specifically during common otolaryngologic maneuvers known to produce aerosols. Furthermore, we strived to maintain our teaching role, giving residents an inclusive role in managing the response to the emergency state, and we progressively integrated our inactive specialists into other service rotations to relieve front-line colleagues' burden. Specific issues and management decisions are discussed in detail in the article

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6. Clinical Practice Guideline: Nosebleed (Epistaxis)

David E Tunkel 1, Samantha Anne 2, Spencer C Payne 3, Stacey L Ishman 4, Richard M Rosenfeld 5, Peter J Abramson 6, Jacqueline D Alikhaani 7, Margo McKenna Benoit 8, Rachel S Bercovitz 9, Michael D Brown 10, Boris Chernobilsky 11, David A Feldstein 12, Jesse M Hackell 13, Eric H Holbrook 14, Sarah M Holdsworth 15, Kenneth W Lin 16, Meredith Merz Lind 17, David M Poetker 18, Charles A Riley 19, John S Schneider 20, Michael D

Seidman 21 22 23, Venu Vadlamudi 24, Tulio A Valdez 25, Lorraine C Nnacheta 26, Taskin M Monjur 26

Abstract

Objective: Nosebleed, also known as epistaxis, is a common problem that occurs at some point in at least 60% of people in the United States. While the majority of nosebleeds are limited in severity and duration, about 6% of people who experience nosebleeds will seek medical attention. For the purposes of this guideline, we define the target patient with a nosebleed as a patient with bleeding from the nostril, nasal cavity, or nasopharynx that is sufficient to warrant medical advice or care. This includes bleeding that is severe, persistent, and/or recurrent, as well as bleeding that impacts a patient's quality of life. Interventions for nosebleeds range from self-treatment and home remedies to more intensive procedural interventions in medical offices, emergency departments, hospitals, and operating rooms. Epistaxis has been estimated to account for 0.5% of all emergency department visits and up to one-third of all otolaryngology-related emergency department encounters. Inpatient hospitalization for aggressive treatment of severe nosebleeds has been reported in 0.2% of patients with nosebleeds.

Purpose: The primary purpose of this multidisciplinary guideline is to identify quality improvement opportunities in the management of nosebleeds and to create clear and actionable recommendations to implement these opportunities in clinical practice. Specific goals of this guideline are to promote best practices, reduce unjustified variations in care of patients with nosebleeds, improve health outcomes, and minimize the potential harms of nosebleeds or interventions to treat nosebleeds. The target patient for the guideline is any individual aged ≥3 years with a nosebleed or history of nosebleed who needs medical treatment or seeks medical advice. The target audience of this guideline is clinicians who evaluate and treat patients with nosebleed. This includes primary care providers such as family medicine physicians, internists, pediatricians, physician assistants, and nurse practitioners. It also includes specialists such as emergency medicine providers, otolaryngologists, interventional radiologists/neuroradiologists and neurointerventionalists, hematologists, and cardiologists. The setting for this guideline includes any site of evaluation and treatment for a patient with nosebleed, including ambulatory medical sites, the emergency department, the inpatient hospital, and even remote outpatient encounters with phone calls and telemedicine. Outcomes to be considered for patients with nosebleed include control of acute bleeding, prevention of recurrent episodes of nasal bleeding, complications of treatment modalities, and accuracy of diagnostic measures. This guideline addresses the diagnosis, treatment, and prevention of nosebleed. It focuses on nosebleeds that commonly present to clinicians via phone calls, office visits, and emergency room encounters. This guideline discusses first-line treatments such as nasal compression, application of vasoconstrictors, nasal packing, and nasal cautery. It also addresses more complex epistaxis management, which includes the use of endoscopic arterial ligation and interventional radiology procedures. Management options for 2 special groups of patients-patients with hereditary

hemorrhagic telangiectasia syndrome and patients taking medications that inhibit coagulation and/or platelet function-are included in this guideline. This guideline is intended to focus on evidence-based quality improvement opportunities judged most important by the guideline development group. It is not intended to be a comprehensive, general guide for managing patients with nosebleed. In this context, the purpose is to define useful actions for clinicians, generalists, and specialists from a variety of disciplines to improve quality of care. Conversely, the statements in this guideline are not intended to limit or restrict care provided by clinicians based on their experience and assessment of individual patients.

Action statements: The guideline development group made recommendations for the following key action statements: (1) At the time of initial contact, the clinician should distinguish the nosebleed patient who requires prompt management from the patient who does not. (2) The clinician should treat active bleeding for patients in need of prompt management with firm sustained compression to the lower third of the nose, with or without the assistance of the patient or caregiver, for 5 minutes or longer. (3a) For patients in whom bleeding precludes identification of a bleeding site despite nasal compression, the clinician should treat ongoing active bleeding with nasal packing. (3b) The clinician should use resorbable packing for patients with a suspected bleeding disorder or for patients who are using anticoagulation or antiplatelet medications. (4) The clinician should educate the patient who undergoes nasal packing about the type of packing placed, timing of and plan for removal of packing (if not resorbable), postprocedure care, and any signs or symptoms that would warrant prompt reassessment. (5) The clinician should document factors that increase the frequency or severity of bleeding for any patient with a nosebleed, including personal or family history of bleeding disorders, use of anticoagulant or antiplatelet medications, or intranasal drug use. (6) The clinician should perform anterior rhinoscopy to identify a source of bleeding after removal of any blood clot (if present) for patients with nosebleeds. (7a) The clinician should perform, or should refer to a clinician who can perform, nasal endoscopy to identify the site of bleeding and guide further management in patients with recurrent nasal bleeding, despite prior treatment with packing or cautery, or with recurrent unilateral nasal bleeding. (8) The clinician should treat patients with an identified site of bleeding with an appropriate intervention, which may include one or more of the following: topical vasoconstrictors, nasal cautery, and moisturizing or lubricating agents. (9) When nasal cautery is chosen for treatment, the clinician should anesthetize the bleeding site and restrict application of cautery only to the active or suspected site(s) of bleeding. (10) The clinician should evaluate, or refer to a clinician who can evaluate, candidacy for surgical arterial ligation or endovascular embolization for patients with persistent or recurrent bleeding not controlled by packing or nasal cauterization. (11) In the absence of life-threatening bleeding, the clinician should initiate first-line treatments prior to transfusion, reversal of anticoagulation, or withdrawal of anticoagulation/antiplatelet medications for patients using these medications. (12) The clinician should assess, or refer to a specialist who can assess, the presence of nasal telangiectasias and/or oral mucosal telangiectasias in patients who have a history of recurrent bilateral nosebleeds or a family history of recurrent nosebleeds to diagnose hereditary

hemorrhagic telangiectasia syndrome. (13) The clinician should educate patients with nosebleeds and their caregivers about preventive measures for nosebleeds, home treatment for nosebleeds, and indications to seek additional medical care. (14) The clinician or designee should document the outcome of intervention within 30 days or document transition of care in patients who had a nosebleed treated with nonresorbable packing, surgery, or arterial ligation/embolization. The policy level for the following recommendation, about examination of the nasal cavity and nasopharynx using nasal endoscopy, was an option: (7b) The clinician may perform, or may refer to a clinician who can perform, nasal endoscopy to examine the nasal cavity and nasopharynx in patients with epistaxis that is difficult to control or when there is concern for unrecognized pathology contributing to epistaxis

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7. Lost Sense of Smell May Be Peculiar Clue to Coronavirus Infection

Roni Caryn Rabin

Doctor groups are recommending testing and isolation for people who lose their ability to smell and taste, even if they have no other symptoms.

https://www.nytimes.com/2020/03/22/health/coronavirus-symptoms-smell-taste.html

8. Presentation of New Onset Anosmia During the COVID-19 Pandemic

C Hopkins 1 2, P Surda 1, N Kumar 3

Abstract

Introduction: Anosmia has not been formally recognised as a symptom of COVID-19 infection. Growing anecdotal evidence suggests increasing incidence of cases of anosmia during the current pandemic, suggesting that COVID-19 may cause olfactory dysfunction. The objective was to characterise patients reporting new onset anosmia during the COVID-19 pandemic METHODOLOGY: Design: Survey of 2428 patients reporting new onset anosmia during the COVID-19 pandemic.

Setting: Volunteer sample of patients seeking medical advice of recent onset self-diagnosed loss of sense of smell RESULTS: 2428 surveys were completed within 7 days; 64% respondents were under 40. The majority of respondents reported onset of their anosmia in the last week. Of the cohort, 17% did not report any other symptom thought to be associated with COVID-19. In

patients who reported other symptoms, 51% reported either cough or fever and therefore met current guidelines for self-isolation.

Conclusions: Anosmia is reported in conjunction with well-reported symptoms of coronas virus, but 1 in 6 patients with recent onset anosmia report this as an isolated symptom. This might help identify otherwise asymptomatic carriers of disease and trigger targeted testing. Further study with COVID-19 testing is required to identify the proportion of patients in whom new onset anosmia can be attributed to COVID-19

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9. COVID-19: Emerging Protective Measures

V Balachandar 1, I Mahalaxmi, J Kaavya, G Vivekanandhan, S Ajithkumar, N Arul, G Singaravelu, N Senthil Kumar, S Mohana Dev

Abstract

The COVID-19 (Coronavirus disease 2019) spreads primarily through droplets of saliva or discharge from the nose. COVID-19 is predominantly considered as an unavoidable pandemic, and scientists are very curious about how to provide the best protection to the public before a vaccine can be made available. There is an urge to manufacture a greater number of masks to prevent any aerosol with microbes. Hence, we aim to develop an efficient viral inactivation system by exploiting active compounds from naturally occurring medicinal plants and infusing them into nanofiber-based respiratory masks. Our strategy is to develop fibrous filtration with three-layered masks using the compounds from medicinal plants for viral deactivation. These masks will be beneficial not just to healthcare workers but common citizens as well. In the absence of vaccination, productive masks can be worn to prevent transmission of airborne pathogenic aerosols and control diseases

ur Rev Med Pharmacol Sci . 2020 Mar;24(6):3422-3425.

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10. COVID-19 - What Should Anaethesiologists and Intensivists Know About It?

Magdalena Wujtewicz 1, Anna Dylczyk-Sommer 1, Aleksander Aszkiełowicz 1, Szymon Zdanowski 2, Sebastian Piwowarczyk 2, Radoslaw Owczuk 1

Abstract

Over the past three months, the world has faced an unprecedented health hazard. The World Health Organization has announced a pandemic infection with an unknown species of coronavirus called SARS-CoV-2. Spreading mainly through the droplet route, the virus causes mild symptoms in the majority of cases, the most common being: fever (80%), dry cough (56%), fatigue (22%) and muscle pain (7%); less common symptoms include a sore throat, a runny nose, diarrhea, hemoptysis and chills. A life-threatening complication of SARS-CoV-2 infection is an acute respiratory distress syndrome (ARDS), which occurs more often in older adults, those with immune disorders and co-morbidities. Severe forms of the infection, being an indication for treatment in the intensive care unit, comprise acute lung inflammation, ARDS, sepsis and septic shock. The article presents basic information about etiology, pathogenesis and diagnostics (with particular emphasis on the importance of tomocomputer imaging), clinical picture, treatment and prevention of the infection. It goes on to emphasize the specific risks of providing anesthesiology and intensive care services. Due to the fact that effective causal treatment is not yet available and the number of infections and deaths increases day by day, infection prevention and strict adherence to recommendations of infection control organizations remain the basis for fighting the virus.

Anaesthesiol Intensive Ther . 2020;52(1):34-41.