

## A Retrospective Cohort Analysis of Indications, Treatments, and Factors related to Otolaryngology visits for COVID-19 Patients

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### Abstract

The Coronavirus SARS-CoV-2 (COVID-19) epidemic devastated communities and healthcare systems around the globe, with over 449 million accretive verified cases worldwide and a death risk overhead of 5.9 million (1). Healthcare professionals modified routines and procedures to cover themselves, with a cross-sectional multi-institutional check of 55 otolaryngology departments across North America revealing near-universal (n = 53 of 55,96.3) cancellations of optional cases at the height of the epidemic (2). With these oscillations in cases and responses, otolaryngology attending and resides have continued to operate and take call across the country, with ineluctable exposure to cases verified or under disquisition for COVID-19 (3). Although otolaryngology symptoms of COVID-19 similar as olfactory dysfunction, sneezing, and nasal traffic have been well-characterized to date (4), there remains a deficit of literature establishing outpatient trends of otolaryngology consults since the onset of the epidemic, with the many published studies demonstrating variable changes in consult patterns. Only one case series and one small cohort study have addressed the issue of oropharyngeal bleeding taking operation by otolaryngology services (8).

**Keywords:** Otolaryngology consults; Otorhinolaryngology diseases; Covid-19; Epistaxis; Anticoagulation

### Introduction

In response to high rates of thrombotic events observed among cases with COVID-19, remedial dosing of anticoagulants was extensively espoused as standard treatment, despite the innately increased pitfalls of bleeding. As similar, the overall bleeding rate in rehabilitated COVID-19 cases is estimated at 2-5, with a proportion reckoned for by upper airway bleeding. Recent findings have questioned the mileage of remedial anticoagulation in perfecting overall survival in cases with severe cases of COVID-19, shifting the focus rather to the implicit morbidity of this practice. The observed high figures of interventions for oropharyngeal bleeding in cases with severe COVID-19 infection, in light of new data challenging the benefit of remedial anticoagulation, urged this single-institution study of inpatient otolaryngology consult rates grounded on COVID-19 status. In particular, we sought to determine whether cases with COVID-19 were more likely to bear otolaryngology discussion for bleeding than cases without COVID-19, and if they would bear a lesser frequency of interventions to control their bleeding. Consultations were divided into 12 orders. Trauma included cases estimated for facial trauma, temporal bone and laryngeal fractures, and traumatic injury to original structures (e.g. facial whifflings, parotid conduit, etc). Infections included peritonsillar abscess, cellulitis of the head- and- neck, Pott's fluffy excrescence, epiglottitis, parotitis, and sialadenitis [1-3].

Bleeding included epistaxis and oropharyngeal hemorrhage. Otolologic evaluations included otitis, mastoiditis, hair loss, vertigo, and infections of the auricle. Post-operative consultations included post-tonsillectomy hemorrhage, loosening of tackle (e.g. mandibulomaxillary obsession bias), and enterprises for surgical point infection. Rhinologic evaluations included sinusitis, cerebrospinal fluid leaks, and pituitary millions. Tracheostomy operation included consults for placement, accidental decannulation, exchanges, and bleeding from tracheostomy. Head- and- neck millions included consults to probe reservations for malice, given head- and- neck malice, and benign endocrine millions. Airway evaluation included consults that needed an assessment of the upper airway secondary to enterprises for airway concession or active stridor that weren't secondary to foreign body inhibition. The

dysphonia order included consults involving an assessment of the upper airway in cases with altered phonation. Foreign body consults involved an airway evaluation if there was debited or known foreign object causing inhibition.

### Discussion

Consults for dysphagia were accepted for cases with concern for aspiration or incapability to tolerate oral input. Bedside laryngoscopy was performed using a flexible fiberoptic laryngoscope to estimate consults including dysphonia, dysphagia, and foreign body evaluation. Dressing and quilting of contagious or post-surgical injuries was accepted using iodoform quarter or half- inch quilting strips and Keflex (Medline, Illinois, USA) reek girth rolls. Operation of bleeding in the oropharynx included saline or tranexamic acid- soaked Keflex (Medline, Illinois, USA) reek girth rolls. Nasopharyngeal bleeding operation involved the operation of gelatin absorbable Surgifoam (Ethicon, New Jersey, USA) bloodsuckers wrapped in Surgical (Ethicon, New Jersey, USA) and soaked in oxymetazoline which was placed in the nasal depressions to gain hemostasis. At our institution, facial rent check was rotated between the otolaryngology, plastic surgery, and oral and maxillofacial surgery services. Tracheostomy operation includes tracheostomy changes and relief with flexible laryngoscopy to estimate for tube/ cuff relegation, patency, or post-tracheostomy positioning [4,5].

Routine tracheostomy care was performed by respiratory

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therapists and wasn't tabulated. Gash and drainage passed most constantly for operation of peritonsillar abscesses. Drainage of other cutaneous abscesses of the head and neck as well as simple hematoma evacuation were also performed bedside. Fine needle aspiration and vivisection was accepted for millions and nodes taking pathologic opinion. Rigid nasal endoscopy included the use of a 0- degree compass for an complete nose and a 30- degree compass for apost-surgical evaluation or evaluation of cerebrospinal fluid leak. Closed reduction of facial fractures included those of the beak and nasal bones and was generally performed in the exigency department. There was no invariant protocol or instrumentation for foreign body junking in the airway. Other bedside interventions included wick placement for otitis external, lingual frenectomy, and crack vacuum placement. Procedures taking intervention in the operating room were different and included tracheostomy, direct laryngoscopy, hematoma evacuation, complex abscess gash and drainage, complex rent form, endoscopic sinus surgery, and transsphenoidal hypophysectomy among others. The standard intervention for epistaxis at our institution involves placing absorbable hemostatic quilting similar as Surgifoam and Surgical( Ethicon, New Jersey, USA) in the nasal depression, and drenching it with topical specifics similar as oxymetazoline, phenylephrine, tranexamic acid, or in refractory cases, epinephrine. The standard intervention for oropharyngeal bleeding in cases who are mechanically voiced involves placing saline wet Keflex reek girth rolls (Medline, Illinois, USA) in the oropharynx. Success is defined as observed hemostasis upon completion of the procedure. Rebreeding was exceptionally common in the positive cohort counting for reprise procedures and substantial morbidity attributed to revitalizations from blood loss.

In response, we offer the following anticipant guidance in COVID-19 positive cases given the increased threat for upper airway bleeding fresh care orders to include constantly listed nasal saline sprays, oral saline rinses, topical lubrication, and humidification. In critically ill cases with significant occurrences of bleeding taking interventions and transfusions, frequentre-evaluation of remedial anticoagulation to determine whether the threat outweighs the benefit. Of consummate significance is the ongoing forestallment of transmission by cases to providers, as otolaryngologists are particularly susceptible due to the high volume of aerosol generating procedures in the head- and- neck. Current recommendations are to use N95 mask protection when in contact with positive cases in addition to standard particular defensive outfit (PPE), especially when performing aerosol generating procedures. Nasal and oral quilting procedures beget coughing, sneezing, and sticking taking considerable mucosal exposure and suctioning [6-8].

Need for reprise interventions further expose providers to increased threat of compression, buttressing the necessity to gain definitive hemostasis and drop reprise hassles. For the five- month period of study, high- threat aerosolizing bedside procedures (laryngoscopy, tracheostomy operation, nasal endoscopy, and foreign body junking) were performed a aggregate of 385 times for a mean0.34 procedures performed per case. Of note, no otolaryngology resides at this institution contracted COVID- 19 during the time period in which this study data was collected. With an cornucopia of caution, webbing, and proper PPE, the threat of transmission can be eased. Increased reports of anxiety, torture, collapse, and overall drop in internal health were noted in health care providers during the SARS pandemics. As in our cohort, rehabilitated cases with COVID- 19 taking evaluation by otolaryngologists are frequently veritably ill, with high rates of mortality also, symptoms of torture amongst otolaryngology providers have been reported during this COVID- 19 period and are increased in

countries with lesser than,000 cases or,000 COVID- 19 affiliated deaths.

Although not totally surveyed, our frontal- line otolaryngologists reflected on the disturbing morbidity associated with repetitious nasal and oropharyngeal quilting procedures needed to control bleeding in COVID- 19 cases. In addition to mollifying patient morbidity, re-evaluating the operation of COVID- 19 cases with high threat of upper airway bleeding could appreciatively impact the internal health and heartiness of otolaryngologists. There are essential limitations within our study design that could be addressed in unborn studies. The retrospective nature is innately less important than a prospective study and is prone to misclassification bias. Correlates between COVID- 19 status and race in our cohort warrant generalizability due to the small sample size and specialty-specific nature of our study, and consequences may be better explained by further robust epidemiological examinations. In addition, institutional policy really affects the part of otolaryngologists in the care of cases [9,10].

## Conclusion

COVID- 19 studies, neither airway- nor tracheostomy- related consults composed significant proportions of our positive cohort. This difference is likely deduced from institutional consulting practices, as nearly all tracheostomies within our cohort were performed by pulmonology and cardiothoracic surgery rather than otolaryngology. For the pulmonology service, there was no reported divagation in policy regarding COVID status. Generally, at our institution, the pulmonology service performs all tracheostomies for the ferocious care units. With respect to thoracic surgery, COVID-positive cases were subjectively more likely to be appertained for percutaneous tracheostomy compared to routine open tracheostomies. Farther studies of otolaryngology discussion patterns at other tertiary care centers may reveal different demographic factors, treatment patterns and issues. Our study corroborated the association between ant coagulated COVID- 19 positive cases and bleeding. Farther studies assessing the effect of precautionary interventions and changes in operation are warranted to guide care of the COVID- 19 case in future surges. Bleeding and associated interventions comprised the predominant distinction between COVID- 19 positive and negative cases in our cohort. The threat of bleeding in COVID- 19 cases should be considered when assessing the need for remedial anticoagulation. We encourage routine use of simple and cost-effective styles to drop the threat of bleeding in COVID- 19 cases.

## Acknowledgement

None

## Conflict of Interest

None

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