COVID and Laryngology - Fall Voice Webinar Community Discussion
3/24/20

Link to full webinar:
https://zoom.us/rec/play/vcAqcuuu_Wo3HNOWuQSDVvMtW43pKv-s23Qar6VeyE6wUHcANQLzN-YbY-VONKIEyGohLo2JuAExg8W_

Q&A thread Summary

PPE related topics and laryngoscopy/nasopharyngoscopy

1. Dr Sulica said non COVID consults. Aren't all patients COVID pts unless they have a negative test? Are you using this airborne level PPE with all patients or just patients on the COVID pathway?
    a. we are using N95 if any aerosolized procedure. so yes. presuming all are positive.
    b. Who is still scoping patients except in an emergency? It does require N95. There is no doubt.
    c. We are treating non-tested asymptomatic patients as if positive. N95 etc for all scopes.
    d. All of our surgery patients are tested.
    e. If they test positive, then we will likely delay the surgical intervention unless it is urgent airway. Cancer can wait 2-3 weeks until the severity of their covid infection declares itself
    f. We are testing all airway patients and trachs prior to surgery
    g. ID refused us on this in asymptomatic patients. How did you argue for this? Particularly for airway stenosis patients.
    h. Lucian and Milan, I think some of the denial from our institutions in NC to be as aggressive for PPE and testing and medical lockdown is they think we have smaller cases less density and we aren't NYC. Of course our concern is we will be in same scenario if we don't do those things now. Can you give your advice/perspective in this regard?
        i. You are not alone...same boat on the other end of the state.
    i. In #otolaryngology, PPE scarcity & well founded fear/concern drive the most important decisions we'll make: just what is "urgent"? Our @UWMedicine clinic is pared down dramatically but open. Can we limit near-term risk, resource use & morbidity by acting now on certain patients?
2. What are the panelists top reasons to scope a pt in the Laryngology clinic?
    a. Airway urgency/emergency
    b. High suspicion for cancer
    c. Before this all started, I always told my residents that we should have an 80% guess on what is going just by the history and the sound of the voice without scoping.
3. Are institutions using PAPRs for aerosol generating procedures?
4. Will your institution give you n95 and ppe for all aerosolizing OR cases?

    a. Walter Reed - we have a limited number of N95s. We do have PAPRs available for cases if they are needed.
    b. Emory. Yes. But only emergent cases. Urgent is even more of an emergent case at this point
    c. yes, but using your one n95 allotment for emergent cases
5. Flexible laryngoscopy now requires full PPE and only done when absolutely necessary. Are there any recommendations for Rigid Laryngoscopy?
    a. Aerosolization can occur with coughing. So is rigid all that different?
    b. I wouldn't think rigid is that different. I am considering laryngoscopy whether flexible or rigid to be aerosolized.
    c. More risk they'll cough with rigid
    d. Majority of viral load is in nasal cavity and nasopharynx, so flexible is going through most concentrated area. Flex also needs aerosolized lido. Few of my patients cough with rigid laryngoscopy.
    e. Would we consider indirect rigid laryngoscopy different in term of precaution to nasal endoscopy?
    f. Does any one know if rigid transoral endoscopy is less likely to aerosolize than flex transnasal?
6. Have you changed the way in which you are applying local anesthesia to the upper airway? Which methods have you stopped and which are you currently using?
    a. We are not allowed to spray topical agents. We use pledget application.
    b. Use of MAD has less aerosol than the powered sprayers.
    c. I am using a 1 cc or a 3 cc syringe "squirt" without the MAD, and it works fine. Dr. VyVy Young did a study about this method being equally effective for patient satisfaction with level of comfort with procedure.
7. Are you terminal cleaning your rooms after interventional procedures or flex laryngoscopy?
8. Interesting Google Doc with policies and practices of multiple ENT departments across the country. Feel free to peruse and update your department info. https://bit.ly/33IbGy4

Laryngeal Surgery in general

1. Will your institutions test any patient undergoing high-risk surgery (jet ventilation, sinus surgery, etc) or only those with symptoms?
    a. If patient wasn't tested, do they recommend treating them as though they were covid-positive?
    b. Our institution is treating asymptomatic patients as NEGATIVE unless proven otherwise.
    c. Responses:
        i. Same at our institution and lots of push back for testing asymptomatic patient
        ii. We cannot test asymptomatic. Remember the test isn't very sensitive anyways

iii. Same for us - they will test for 2 symptoms or 1 + active duty. But they wont do rapid tests - so it takes 4-5 days
iv. lots of pushback from ICUs on testing trach consults
v. Our institution quoted us false positive rate of 25% making a negative test result useless. We are doing urgent cases using PAPRs
vi. Same for us in Houston in terms of pushback against testing before trachs/airway procedures - in my case for an ARDS patient that I really wanted pre-trach testing for. As said we're getting directed toward using PAPR as of tomorrow…
vii. Please avoid jet. We need to minimize aerosolization of secretions.
    1. Precedex and low flow o2
    2. You can over-inflate the cuff and impact it on to the supraglottis without having to fully intubate.
    3. Isn't Thrive supposed to be more likely to aerosolize
viii. The asymptomatic (+) patient is a real thing. Do not assume that they are negative. I think of them as "untested".
ix. Doing cases with rapid sequence intubation, deep extubation. No one in the room except me and anesthesiologist. When extubated, covering the patient's face with a drape (seems strange)
x. Dilation, steroid injection, and move on.
xi. Regarding airway surgery, precedex , helps with patient doing spontaneous ventilation, with o2 blow by

d. I wouldn't do papilloma just because of preparation of the patient for the procedures especially for laser office based procedures - too much risks

Tracheotomy

1. I have heard anecdotally that tracheostomy may actually not be helpful in long term ventilation COVID-19 patients (maybe due to quick decompensation?). Do any of you have any information about this, and would you advocate the use of powered air-purifying respirators (PAPR) in this population?
    a. The indications for elective trach in COVID19+ patient intubated for COVID19 related ARDS are indeed low, as they tend to declare themselves one way or the other. Additionally, viral RNA is likely infectious for up to 2 weeks, therefore, waiting to 3 weeks is probably best. If you do it, PAPR is indicated if available.
        i. I agree, but I have also read that viral shedding stops at 8 days.
    b. Tracheotomy is usually NOT an emergency procedure. It is not worth it. Should be avoided unless there is a negative test
    c. Just an FYI. The airway and swallowing committee is currently putting together tracheotomy decision-making and procedural protocols that we should be disseminating over the next few days. In general, yes, trach delayed a number of weeks in covid+ and patients should be tested preop if resources are available, trach in the ICU room, preferably with negative pressure room
    d. The Koreans have reported a high rate of patients getting trach. Wonder why so different from China?

e. PAPR are now required for all trachs and airway procedures at our center
    i. We're getting there, but only 4 in the hospital
    ii. we only have 14 in the hospital. we have requested them.
    iii. We have one in hospital, 6 coming today from autobody shop, and ordered 14 more.
f. How are you managing trach care in patients with existing trachs or stomas who are admitted for COVID or other reasons? We are considering putting HMEs and in-line suctioning to avoid aerosol generation.
g. Has anyone had an acute airway case during this time eg needing flex awake intubation or awake trach?
    i. I had an awake intubation. We did SLN blocks, viscous lidocaine, and full PPE.
    ii. As close to full PPE as you can get. PAPR ideally, but at least N95.
h. Our center will not allow anyone over 55 on the airway evaluation / trach team is that reasonable since it takes a lot of experience away?
i. Yes same preop covid testing policy at UMiami. No trachs for intubated Covid19+ patients.
j. We have decided also to not trach these patients in Westchester NY
k. The institution should be aware of the massive viral transmission that would occur from a hospitalized trach patient with COVID. Preventing that transmission is enough rationale to not perform trach unless confirmed negative.
l. How did you all decide not to trach Covid19 patients? We are having the discussion with anesthesia/interventional pulm/ACS. They are still advocating for trach within time frame of 7-14 days, possibly as a way to decompress the ICUs.
m. I don't think these patients get off the vent faster as the problem is interstitial lung disease. The thought is that they will be on the vent to just with a trach and a more open airway that could increase aerosolized viral load.

Redeployment

1. Has anyone been in dialogue requiring "redeployment" to staff an ICU, presumably in a team with critical care MDs? Any thoughts on this?
    a. Our hospital has been talking about this - I am also interested in what people think. I need to do some education to make that work
    b. Department was asked today about willingness to work supervised in ED, ICU, or floor.
    c. Our department has been asked about ED, ICU, telehealth, assist Gen Surg, Airway Team
    d. We have filled out an "inventory" of what our certifications and skills are. I get the impression there's also the possibility of being pulled for things like laceration repairs, I&D's, other minor things we could do in order to free up acute care surgery and ED for other things
    e. We just got notified 3 fac members per week are on call for ED staffing
    f. This was floated at the VA here in New Orleans. Waiting for the other shoe to drop.

    g. ICU training is here: https://sccm.org/covid19

Residents/trainees

1. Should we be allowing our residents to scope patients during this pandemic… inpatient, outpatient? And if not for how long should we restrict resident involvement?
    a. Does anyone limit the number of people in the room?
    b. Our policy is only the attending and one experienced assistant.
    c. residents being redistributed

Botox

1. Anyone still doing botox?
    a. The botox pateints are the ones that don't seem to want to reschedule
    b. agree. calling in to make sure they can get. increased stress
    c. oddly enough I am seeing the same thing
    d. same, but I'm not doing them to preserve resources. Al and Rick, are you doing them with N95 or faceshield or are you going bareback?
    e. NYC suburb - most patients are canceling - we are about 3-5 days behind Manhattan
    f. we have ZERO n95s. All scavenged for ER. I sutured a HEPA vacuum filter to my mask and pray it'll work as well. and eye protection. 95% do not cough, thankfully
    g. I am letting the patients decide if they want to take the risk to come in for Botox when I call them. RN is doing a pre-screen on the phone day of visit. Non-Botox patients can cough in our presence.
    h. I'm going to add that my chronic cough for SLN block are the same at the Botox patients- insistent on coming in
    i. for cough patients: I'm deferring.
    j. I have not been doing Botox, but another in our practice has. If I start doing it I will use full PPE. Another concern about Botox is that we put them at greater risk for aspiration temporarily. Does the put the pt at greater risk to get a COVID-19 infection?
    k. Should we be reducing cough strength in this at risk population?

Voice Therapy prior to laryngoscopy

1. As an SLP, our best practice is to send a patient to ENT prior to initiation of voice treatment or to send a patient for FEES or MBS if they have clinical signs of dysphagia. However, considering that laryngoscopy and instrumental swallow evaluations is riskier now, would you recommend initiating voice or dysphagia therapy without an instrumental examination at this point?
    a. Reasonable to do so
    b. Acute care SLP here— We have discontinued FEES at our facility as of today. The newest question that arose is what PPE are practitioners donning for deep suctioning through a trach? If a mask, which one specifically?

    c. Suctioning is high likely for aerosolization. Therefore, N95 or higher are indicated. We are not flexibly scoping any patient unless it is an emergency.
2. For the SLP's out there - many are not processing the pneumotachs for the PAS? We DEFINITELY do not use PPE during aerodynamic maneuvers in therapy assessment

Telemedicine

3. Who is doing SLP televisits?
    a. SLPs cannot bill for evaluations via telehealth in SC.. huge roadblock to establishing that therapeutic relationship with new patients referred to voice clinic in our state. We cannot initiate therapy without evaluation.
    b. Medicare is now paying in-office visits for telemedicine for this service during this time. Other insurances as well.
    c. SLPs can't bill out our institution
4. Are you seeing NEW patients on telemedicine or just RETURNS
    a. for now only established patients - will roll out news down the road - Large Private Practice - in NY / Long Island
    b. Often our patients have examinations from outside ENT that were done 2 to 3 weeks ago. These are very helpful for telemedicine visit.
    c. You can bill for a phone call visit now. It only bills about $14, but if a patient doesn't have the ability to do a teleconference type visit, phone calls are an option.

Dysphagia

5. With relation to the question of NPO / dysphagia management would insertion of a Nasogastric tube be considered an aerosol generating / risky procedure? Should NGTs be avoided?
    a. NGTube placement is an aerosol generating procedure. Use full precaution when placing.
    b. Curious about your thoughts about prophylactic placement of NGT at intubation of COVID patients to ensure nutrition/PO med access post extubation?

TEP

6. Are different centers continuing to do voice prosthesis changes?
    a. TEP changes should be considered aerosolizing, defer as able, full PPE as able

Miscellaneous

1. Number of cases doesn't mean anything without wide spread testing
2. I heard that there is a relatively high % of ENT's who were infected. Can you comment?
3. Anybody have a comment on the conflicting info from ENT exposure from China vs Korea. We have heard reports from China that ENT and Optho had a very high infection rate and then our Korean colleagues said that there has been no ENT's infected with COVID.
4. What kind of liability coverage are these hospitals providing for practices beyond the scope of your practice?
    a. We have only received a verbal from leadership that our institution has our back...not tremendously reassuring.

5. Do you foresee we will be back to normal after we acquire the virus and recover or will converted Health care providers continue to utilize maximal Hi J. Can you please place on our email list?
6. How do we change our practices after the wave passes, What will laryngology look like in 2021?