

## Editorial

# Asymptomatic COVID-19 patients: a threat to an active otolaryngologist

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**Received:** 18 June 2020

**Accepted:** 01 August 2020

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A new virus was reported for causing a spurt of pneumonia cases in Wuhan, Hubei 56 province in China in December 2019. This coronavirus, was initially named as the 2019- novel coronavirus (2019-nCoV) on 12 January 2020 by World Health Organization (WHO). WHO officially named the disease as coronavirus disease 2019 (COVID- 19) and coronavirus study group (CSG) of the International Committee proposed to name the new Coronavirus as SARS-CoV-2, both issued on 11 February 2020.<sup>1</sup>

Ever since the outbreak of coronavirus disease 2019 (COVID-19) the healthcare systems of the World have been overwhelmed by this pandemic. The recent statistics show that there are now over 5.7 million people infected and nearly 0.4 million deaths in 210 countries. Nations have implemented harsh disease control measures, including travel restrictions, expanded triage and quarantine and screening measures like temperature checkpoints.<sup>2</sup> A huge number of healthcare workers (HCWs) have also taken a hit during the pandemic with many countries reporting high mortality amongst HCWs.<sup>3-5</sup>

India is the second most populous country in the world with a population of more than 1.33 billion next only to China.<sup>6</sup> There is a huge gap between public spending on healthcare in India and developed countries with India spending 1.6% of its gross domestic product (GDP) viz-a-viz US 8.2% and China 3.2% spending of GDP on health.<sup>7</sup> The doctor patient ratio in India is skewed at best 1:1456 against the WHO recommendation of 1:1000.<sup>8,9</sup> This is putting a lot of pressure on the healthcare system in India.

### *Transmission risk and patient's screening*

The transmission of SARS-Cov 2 occurs by aerosols and the viable virus has been recovered from aerosols for up to 3 hours, porous surfaces (cardboard) for up to 24 hours, and non-porous surfaces (stainless steel, plastic) for up to 72 hours.<sup>10</sup> This environmental stability increases the risk of nosocomial transmission and “super spreader” events.<sup>11,12</sup>

A large percentage of COVID-19 positive patients can be asymptomatic.<sup>13,14</sup> Also patients with mild symptoms mostly present with cough, fever, fatigue, breathing difficulty, myalgias, sore throat and chills but some recent reports also indicate that hyposmia or anosmia and dysgeusia can be under recognized symptoms.<sup>15-17</sup>

Large proportion of asymptomatic patients and common ENT complaints in mild cases pose a real threat to a practicing otolaryngologist compounded by the fact that nose, nasopharynx and throat carry high viral load and thus huge infective potential.<sup>18,19</sup> Crowded out-patient departments coupled with shortage of personnel protective equipment (PPE), high viral load in respiratory tract and highly contagious disease, place an active otolaryngologist at great risk. It is also to be expected that instrumentation in or through those areas during out-patient procedures will entail a higher risk of transmission.<sup>10</sup> It is pertinent to mention here that the first fatality of a physician documented globally was that of an otolaryngology physician in Wuhan on January 25, 2020 and more than 3000 health care workers including otolaryngologists have been infected in China and above 2500 in Italy.<sup>3,20</sup>

### Way forward in otolaryngology practice

Given this greater risk, various Otolaryngology societies across the globe have recommended all otolaryngologic procedures, particularly those involving the upper airway, be deferred unless deemed medically necessary or until preoperative COVID-19 testing can be reliably performed.<sup>21</sup>

Elderly age and presence of co-morbidities are associated with poor outcome thereby posing risk for senior otolaryngologists.<sup>22</sup> Otolaryngologists should maintain high clinical suspicion for patients with mild and asymptomatic COVID-19. Routine appointments should be eliminated or delayed and telemedicine options utilized when possible. Only emergency cases should proceed in areas with high COVID-19 prevalence. Before appointment the patient screening should be implemented, including measuring temperature, acquiring epidemiologic history, and triaging according to clinical symptoms. Suspected cases should be isolated and reported immediately.<sup>23</sup> Crowding in out-patient areas needs to be avoided at all costs. Judicious use of PPE while handling the patients.<sup>23,24</sup>

When examinations or procedures must be performed, it is of utmost importance that otolaryngologist and any other healthcare workers in the chamber practice effective use of personal protective equipment (PPE). Meticulous cleaning of facilities and equipment should be maintained.<sup>25</sup>

### CONCLUSION

Otolaryngologists play a crucial role not only in the treatment of COVID-19 patients but also are care providers to non-COVID patients. Due to the inherent nature of their work, they are at a significant risk of exposure whether working in outpatient clinics, the emergency room, or inpatient wards. There is need to preserve this scarce workforce by judicious use of PPE titrated to the level of exposure. PPE should also be used even in the absence of suspicion for COVID-19 by history alone given that patients may be asymptomatic carriers or may be contagious prior to the development of symptoms.

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**Cite this article as:** Nagi RS, Singh SP, Duggal P. Asymptomatic COVID-19 patients: a threat to an active otolaryngologist. *Int J Otorhinolaryngol Head Neck Surg* 2020;6:1762-4.