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| |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | |  | | --- | | **COVID-19: What's NOW?**    Dear Rhinologists, members of the ERS.   We go through difficult times. Coronavirus is spreading rapidly throughout Europe and the world. Many of us are involved in emergency planning for our hospitals and outpatient clinics, while immediate contemporary ENT related issues are emerging.    We collected information for Rhinologist and patients and put them on the ERS website and here we are sharing the most important recommendations with you. | | | |
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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | |  | | --- | | **Information for rhinologists**- **Important recommendations**   * Avoid powered atomisation – use actuated pumps sprays or similar soaked pledgets for topical anaesthesia * Elective airway surgery patients (sinonasal, nasopharyngeal, oropharyngeal, laryngeal and tracheal) should be tested for COVID-19, where and when available, and be shown to be negative before proceeding; for acute cases specific PPE should be utilised; patients should be advised to practice hand hygiene and social distancing prior to surgery * Limit intervention in the clinic/rooms as much as possible and wear appropriate protection * Postpone any COVID-19 positive cases, anyone with recent travel history, anyone with potential symptoms of COVID-19 or anyone with COVID-19 contacts * Advice should be given to all COVID-19 negative patients undergoing elective surgery to practice social distancing and hand hygiene between the time of testing until the time of surgery   **Loss of smell** A significant part of the COVID-19 patients (20-60%) appear to have loss of smell. Loss of smell can be the presenting symptom before other symptoms like coughing/fever occur. **Patients with sudden onset loss of smell should be considered to be COVID-19 positive**. Experiences in Italy point to a favourable prognosis for the return of smell. We advise NOT to prescribe nasal or systemic corticosteroids in patients with sudden loss of smell.   **Risk for Otorhinolaryngologists** Risk to healthcare workers through transmission of COVID-19 is primarily through droplet spread. Otorhinolaryngologists are exposed to a high reservoir of viral load as we are dealing with the nose and airway.ENT may not seem to be in the frontline with COVID-19 but we do have a key role to play, and this must be planned. All the data from China, Iran, Italy suggests that ENT surgeons are an extremely high-risk group therefore we need to be vigilant to protect ourselves. There is reliable information coming from the US indicating that otolaryngology is a high-risk group from COVID-19 infection. There is anecdotal evidence that a single endoscopic sinus case in China reportedly infected 14 people who were in the operating room. There is a presumed high risk in any procedures involving the airway. We advise to postpone all non-acute surgery. Hospitals need to ensure ENT surgeons are supplied with the necessary PPE in order to avoid fatalities.     **What patients do we see at the outpatient clinic** We advise to see only patients that need non-elective care in the outpatient clinic. For patients that need to be seen in the outpatient clinic the regime for PPE would be a fluid resistant (FFP2/N95) surgical mask, single-use impermeable disposable gown, gloves and eye protection is advised. This applies to examinations including flexible and rigid nasendoscopy. Many patients can be “seen” by telephone consultation.   **Use of medication by our patients** Patients are advised to keep using their regular medication. Corona virus binds to the ACE-2 receptor (and TMPRSS2). Although there is limited data that systemic corticosteroids may be increasing ARDS in patients with SARS and MERS, there is no data indicating that the use of local corticosteroids will increase the susceptibility to corona virus. The pulmonologists also advise to continue inhaled corticosteroids. One could even argue that stopping nasal corticosteroids in patients needing them will result in more symptoms of allergic rhinitis/rhinosinusitis that may blur symptoms of COVID-19. Because it seems that patients can shed virus before they have fever, this may even increase the risk for themselves and their surroundings.   **Surgery** In response to pressures on the health system, elective surgery will be curtailed. Non-elective patients will continue to need care. We should seek the best local solutions to continue the proper management of these patients whilst protecting ourselves through proper supply of protective equipment. We understand that resources are under pressure for the response to COVID-19, however the experience in areas with many diseased highlights the necessity for PPE for ENTs.   We will be involved in airway management. We may also need to work outside of our specific areas of training and expertise, in the exceptional circumstances we may face.   *We need in particular to consider patients who are vulnerable to the consequences of catching COVID-19, including those with a tracheostomy or respiratory compromise and patients with immune suppression – such as patients with head and neck cancer – either during or soon after treatment.*   **Personal Protective Equipment (PPE) at surgery**  FFPW/FFP2 masks and full eye protection or PAPRs (Powered, Air Purifying Respirators) are recommended for COVID-19 positive patients / urgent patients that cannot be tested requiring aerosol generating procedures – this includes intubation, open suctioning, tracheostomy, high speed drilling, use of shavers and bronchoscopy. Minimal number of health care professionals should be in the OR. All should wear adequate PPE.   For more information please consult  [https://www.europeanrhinologicsociety.org/](https://europeanrhinologicsociety.us19.list-manage.com/track/click?u=1dc5f289dd8a7d5fd8c98901b&id=00a8f584f8&e=bd162dcbd8) | | |  |  |  | | --- | --- | | |  | | --- | | ***DISCLAIMER*** *The European Rhinologic Society has developed this information as guidance for its members. This is based on information available at the time of writing and the Society recognises that the situation is evolving rapidly, so recommendations may change. The guidance included in this document does not replace regular standards of care, nor do they replace the application of clinical judgement to each individual presentation, nor variations due to jurisdiction or facility type.   The European Rhinologic Society is not liable for the accuracy or completeness of the information in this document. The information in this document cannot replace professional advice.* | | | |