Reply: Correspondence—International Registry of Otolaryngologist–Head and Neck Surgeons with COVID-19

We read with interest Dr Turner's correspondence regarding our article.[1]

We completely agree with all the limitations raised, as we had already raised them in the discussion of our own investigation. What we apparently disagree on is the idea that accumulating knowledge from verified cases with contact tracing is somehow detrimental to our knowledge base and specialty. There has been increasing fear surfacing across all scientific journals that data coming out of studies that are less robust than a randomized clinical trial are dangerous to our global scientific endeavor.

As Dr Turner points out, the risk our specialty faces can be reduced with appropriate mitigation and use of personal protective equipment (PPE). Unfortunately, although access issues have abated in most developed countries, this continues to be a challenge on an international level. As we write this reply letter, 19% of all cases of coronavirus disease-2019 (COVID-19) reported in Mexico are in health-care workers, and our colleagues in otolaryngology have not been spared. The risk of death for health-care workers (HCWs) in Mexico is 4 times higher than in the United States and this is related and attributable to restricted access to PPE.[2] Sadly, some other countries are actively supressing case data and information, making the situation is even more dire—these data could not be included in our registry for fear of repercussions to the local representatives. One of the main aspirations of our registry was to help quantify situational risk and empower advocacy for proper PPE for those that do not have it—or at least to increase awareness around cases with potential risk so that whatever risk mitigation can be performed is done (ie, reverse draping the microscope during a mastoidectomy).

Dr Turner has done an excellent job of summarizing the currently established risk for HCWs. He did not include a prospective observational study from the UK looking at 9800 employees, which showed that those working on wards caring for COVID-positive patients had a higher rate than those elsewhere (21.2% vs 8.2%).[3] The numbers reported for Canada also demonstrate the pitfalls of broad surveys when studying COVID-19.[4] Although we agree that the disparate rates between HCWs and non-HCWs observed in the study by Schwartz et al are mostly due to testing, the substantially higher mortality rate in non-HCWs is attibutable to the vast majority of outbreaks occurring in long-term-care homes—80% of all Canadian deaths have been among long-term-care residents.[5] More recently, a prospective observational study of over 2 million people demonstrated, after accounting for increased testing in healthcare workers, an adjusted hazard ratio of 3.43 in the UK and 1.97 in the USA, with an even higher hazard ratio among minorities.[6]

Although we support and amplify the caution that should be used when reading these types of data, we reject the idea that simply because the media or public figures may jump to conclusions before gathering all the evidence means that all other physicians and scientists will do the same.

We have more faith in our fellow otolaryngologists' ability to take the data in the context presented and simply add it to the growing knowledge base we are accumulating about this disease process and how best to continue safely practicing and operating within a pandemic.

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