Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Letter to the Editor

"COVIDphobia" influences early otolaryngology diagnoses

Dear Editor in chief,

This letter demonstrates the opinion that various misdiagnoses can happen during COVID-19 era. Many of the non-specific symptoms of COVID-19 are common in emergency ENT diseases whose delayed diagnoses proves to be fatal. Fever, fatigue and dry cough are the most common ones [1]. Dyspnoea, sore throat, rhinorrhoea, nasal congestion, throat congestion, tonsillar enlargement, enlarged cervical lymph nodes or dizziness are symptoms that an otolaryngologist might encounter while examining patients during COVID-19 pandemic, in addition to hyposmia/anosmia and taste disturbances [2].

It is known that examinations and procedures potentially exposing to projections and aerosolizations of organic material of human origin are considered to be at risk of staff contamination. Flexible Fiberoptic Laryngoscopy (FFL) is included in these examinations and authors issued recommendations [3]. After all, the level of precaution recommended for the medical personnel depends more on the type of procedure than on the patient's proved or suspected COVID-19 status [4].

Various authors underline personal protective equipment's shortages and the need for faster diagnostics. Although, physicians and otolaryngologists should be aware of COVIDphobia because it influenses daily otolaryngology practice in various cases. We present such a case of a 52-year-old male that presented to the Emergency Department of our hospital with pharyngalgia, odynophagia and fever up to 40 °C. The patient was triaged through a special COVID-19 – suspect examination booth by an internist. Clinical examination was unremarkable and chest X-ray had no findings. Lab tests revealed elevated inflammatory markers. A nasopharyngeal swab was collected for SARS-CoV-2 RNA testing and under "COVID-19-suspect" characterization he was referred for initial otolaryngology evaluation. Oral and oropharyngeal examination was insignificant. No FFL was performed, and a Computerized Tomography (CT) scan was ordered. His first swab test was negative, and was admitted to the internal medicine ward under broad-spectrum antibiotics. In order to proceed to a CT scan in the no-COVID suite, a second confirmatory nasopharyngeal test after at least 48 hours is mandatory according to hospital rules. On day-3 his symptoms had partially improved but odynophagia persisted, and the patient was still febrile. After a second swab was confirmed negative, on day-4, a CT scan was eventually performed that revealed a retropharyngeal abscess (RPA) (Fig. 1). He was immediately taken to surgery and the abscess was drained intraorally under general anesthesia. The patient improved the following days and discharged on day-15.

Early diagnosis is crucial due to RPA might affect neighboring structures causing airway obstruction, sepsis, mediastinitis, aspiration pneumonia, empyema, thrombosis of jugular vein or carotid artery erosion [5]. Odynophagia and fever are symptoms that "shouts" for face-to-face ENT consultation and FFL examination using the suitable and recommended personnel protective equipment. Such patients theoretically all considered as COVID-positive [3,4]. There should be no delay of CT scanning and FFL which are tremendous addition to the diagnostic armamentarium for disorders such as RPA. Postponement due to COVIDphobia proves to be as dangerous and life-threatening as COVID-19.

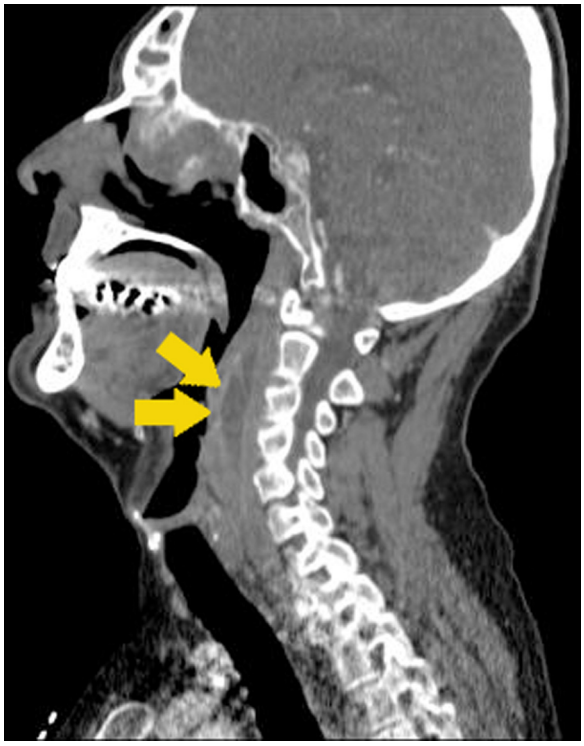

Fig. 1. Contrast enhanced Computerized Tomography Scan of the patient with existence of an abscess in the retropharyngeal space with maximum diameter of 6 cm (yellow arrows).

Disclosure of interest

The authors declare that they have no competing interest.

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