
Letter to the Editor

In Reference to *COVID-19 and the Otolaryngologist: Preliminary Evidence-based Review*


Dear Editor:

In their commentary Drs. Baba, Takada, and Kato highlight the potential for missed diagnosis of recurrence in asymptomatic head and neck cancer (HNC) patients in whom flexible endoscopies are deferred. Our initial manuscript described delaying all non-essential (malignancy, airway risk) flexible endoscopies for a 30-day period.¹ This policy was put in place early in the pandemic when much was unknown about viral transmission and the resources needed to ensure safe procedures were in shorter supply.

Since our article was initially published in March 2020, an increase in testing capacity, environmental systems changes including high efficiency particulate air (HEPA) filtration in some clinic rooms, and a more consistent supply of personal protective equipment (PPE) have allowed us to resume endoscopies in the screening of HNC patients. In our clinics, the indications for flexible endoscopy have largely returned to those practiced before the pandemic, although most clinics require pre-visit testing, have appropriate PPE available, and allow adequate time between patients for filtration of the air. International consensus guidelines on the management of HNC in resource limited settings have also been published. These include strong agreement for the recommendation “For asymptomatic patients with previous history of head and neck cancer attending clinic for routine follow-up: do not use flexible nasoendoscopy in absence of adequate PPE.”²

The use of saliva-based diagnostics to assess for recurrence during the COVID-19 pandemic is a plausible

idea and has certain advantages as a self-administered diagnostic option. However, the value of nasal endoscopy is not limited to the diagnosis of recurrence, but rather a critical element of the exam that is used to stage the tumor, assess resectability, and determine a reconstructive plan. Resumption of nasal endoscopy is critical to management of the patient, but salivary biomarkers have the potential to become another tool in post-treatment surveillance of HNC patients. Despite recent release of the vaccine, COVID-19 will continue to be a real threat in the near term, and easier-to-use diagnostic methods will be valuable in identifying positive cases and containing spread.³

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BIBLIOGRAPHY

1. Vukkadala N, Qian ZJ, Holsinger FC, Patel ZM, Rosenthal E. COVID-19 and the otolaryngologist: preliminary evidence-based review. *Laryngoscope* 2020;130:1–7. <https://doi.org/10.1002/lary.28672>.
2. Mehanna H, Hardman JC, Shenson JA, et al. Recommendations for head and neck surgical oncology practice in a setting of acute severe resource constraint during the COVID-19 pandemic: an international consensus. *Lancet Oncol* 2020;21:e350–e359. [https://doi.org/10.1016/S1470-2045\(20\)30334-X](https://doi.org/10.1016/S1470-2045(20)30334-X).
3. Wylie AL, Fournier J, Casanovas-Massana A, et al. Saliva or nasopharyngeal swab specimens for detection of SARS-CoV-2. *N Engl J Med* 2020; 383:1283–1286. <https://doi.org/10.1056/nejmc2016359>.

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