# UEP Position Statement relating to Phoniatric and Laryngological services during the COVID-19 pandemic.

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**Ahmed Geneid[a], Tadeus Nawka[b], Antonio Schindler[c], Haldun Oguz[d], Viktor Chrobok[e], Orietta Calcinoni[f], Antoinette am Zehnhoff-Dinnesen[g], Mohamed Farahat[h], Tamer Abou-Elsaad[i], Mieke Moerman[j], Eugenia Chavez[k], Jonathan Fishman[l], Reinaldo Yazaki[m], Barbara Arnold[n], Miroslav Tedla[o], Simone Graf[p], Christina Pflug[q], Teemu Kinnari[a], John Rubin[r]**

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[a] Department of Otorhinolaryngology and Phoniatrics-Head and Neck Surgery, University of Helsinki and Helsinki University Hospital, Helsinki, Finland

[b] Charite Hospital, Berlin, Germany

[c] Department of Biomedical and Clinical Sciences L. Sacco, University of Milan, Milan, Italy

[d] Haldun Oguz, Private Practice, Ankara, Turkey

[e] Department of Otorhinolaryngology and Head and Neck Surgery, University Hospital Hradec Kralove, Charles University, Faculty of Medicine in Hradec Kralove, Hradec Kralove, Czech Republic

[f] Voice and Music Professionals' Care Team, Milan, Italy

[g] Clinic of Phoniatrics and Pedaudiology, University Hospital Muenster, Germany

[h] Research Chair of Voice, Swallowing, and Communication Disorders, Department of Otolaryngology, Head and Neck Surgery, King Saud University, Riyadh, Saudi Arabia

[i] Phoniatric Unit, ORL Department, Faculty of Medicine, Mansoura University, Mansoura, Egypt

[j] Private practice, St.-Martens-Latem, Belgium

[k] Centro de Foniatria y Audiologia, Mexico City, Mexico

[l] The Royal National ENT Hospital, University College London Hospitals NHS Trust, London, UK.

[m] Osvaldo Cruz German Hospital, Artistic Voice Institute, São Paulo, Brazil

[n] Private practice, Munich, Germany

[o] Department of Otorhinolaryngology, Head and Neck Surgery, University Hospital and Comenius University Bratislava, Slovakia

[p] Otorhinolaryngology / Phoniatrics, Klinikum rechts der Isar, Technical University Munich, Munich, Germany

[q] Department of Voice, Speech and Hearing Disorders, Center for Clinical Neurosciences, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

[r] University College London Hospital NHS Trust, London, United Kingdom

**The following position statement from the Union of the European Phoniatricians (UEP) contains a series of recommendations to Phoniatricians and ENTs who provide and/or run Voice, Swallowing, Speech and language or pediatric audiology services.**

The opinions and recommendations below are the collective recommendation of UEP presented through the authors in their personal capacities. They are not necessarily the same in each of the authors' hospital/clinic neither do they necessarily represent the opinion of the authors' hospital/practice.

**Introduction**

The COVID-19 pandemic is ongoing and its preliminary manifestations will continue for some months. Subsequently, there is the possibility of resurgence or recrudescence of the virus at some time towards the end of 2020 or 2021, varying regionally or from country to country around the world.

Reports from China, but also from European countries and scientific institutions make it clear that ENT doctors and Phoniatricians are at an increased risk of contracting the coronavirus/SARS-CoV2 infection. As a group they are at risk of exposure to aerosol generation in particular due to the reported and detected presence of the virus in the nasal and pharyngeal cavities of infected individuals.
The currently available information on COVID-19 mandates the cessation of all elective Aerosol Generating Procedures (AGP*) and operations unless such procedures or operations cannot be delayed[1].

There is a potentially increased risk of infection during head and neck examinations, endoscopies and in general, during interventions in the upper airway and food passages [2-5]. This increase in risk likely relates directly to infectious aerosol either being directly inhaled or forming on contaminated surfaces during these procedures. Individuals who are asymptomatic may still have active infection with the virus and are potentially infectious.

Accordingly, personal protective equipment (respiratory FFP3 masks, eye protection, cap, gloves and gown) should be used even if the patient is totally asymptomatic as long as the procedures include examination or manipulation of the patient's throat, nose, larynx or upper airway. Use of such equipment is important whether examinations take place in community polyclinics, private clinics, hospital outpatient settings or wards, casualty, intensive care settings or operating theatres.

The UEP also recommends a rapid paradigm shift wherever possible away from face–to-face examination to the provision of diagnostics and therapy through solutions embracing telehealth and telemedicine.
Below are examples of what these recommendations mean in different clinical scenarios. Teletherapy in the text below means instances in which both the examiner/therapist and the patient are communicating through video and/or audio applications.

## Voice/ airway

**All laryngeal operations** should be cancelled/deferred except in cases where a malignancy is suspected and the need for biopsies or curative surgery is imperative, or when the airway itself is at risk. Jet-ventilation and high-flow humidified oxygen should be avoided. Tracheostomy entails significant risk and should be avoided whenever possible. Laser, micro-debrider and suction-cautery methods should be avoided whenever possible.

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* An aerosol generating procedure (AGP) is a procedure which potentially stimulates explosive expulsion of air via coughing, sneezing etc. and results in the release of airborne particles thereby increasing the risk of airborne transmissions of infections that are classically spread by droplet transmission. Such procedures include for example, but are not limited to:

1. Tracheotomy/tracheostomy operations including percutaneous dilatation tracheostomy
1. Intubation and extubation
3. Open suctioning, positive air way pressure, jet-ventilation, high-frequency ventilation, high-flow nasal oxygen
4. Bronchoscopy
5. Flexible or rigid endoscopic oral, trans-nasal and laryngeal examinations
6. Drainage of quinsy infection
7. Management of epistaxis
8. Removal of fishbone or other foreign body in the pharynx
9. Trans-oral or trans-nasal injections into or manipulation of the larynx
10. Trans-oral or trans- nasal oesophagoscopy or gastroscopy

In patients scheduled for surgical operations, if feasible, SARS-CoV2 tests should be undertaken soon prior to the operation date and then followed immediately by home-quarantine/isolation until the operation is carried out. One negative test should be enough in the absence of symptoms that can be attributed to SARS-CoV2. Testing or awaiting the result of a test should not be the reason for the delay of an emergency operation.

Patients with positive results, in absence of SARS-CoV2 symptoms, should be retested to avoid delays due to false positive results. A confirmed positive result mandates the delay of an elective operation for at least two weeks and until a further test is negative, as long as this delay does not entail marked danger to the patient's airway or life.

All emergency cases in which SARS-CoV2 testing is not possible due to time constraints, should be considered to be SARS-CoV2 positive. When operating on positive cases, PPE ideally includes[6] Powered Air-purifying Respirators (PAPR) for all personnel in the operation room.

**Laryngeal office procedures** (examination by flexible or rigid endoscopy) should be limited to instances in which malignancy or potential airway compromise are suspected based on the patient's medical history and symptoms.

**Telehealth** can be introduced in general for history taking. As we approach the peak of this pandemic, endoscopy should be reserved for emergency and urgent cases; thus, we recommend utilizing remote voice therapy for certain patient groups that may benefit therefrom.
The following patient groups represent some examples of patients who may be suitable for remote voice therapy while waiting for the definite endoscopic examination:

a) Transgender patients
b) Patients with obvious vocal fold paralysis/paresis symptoms following surgery, for example thyroid surgery.
c) Patients with symptoms clearly pointing to an occupational voice disorder in which the voice problem is directly attributed to voice over-use.

Similarly, ongoing face-to-face voice therapy should be changed to remote voice therapy. Smartphone apps should be utilized if available.

**Patients receiving regular botox injections for voice spasms, tremors or Vocal Cord Dysfunction (VCD):** (this guidance will vary depending on local, regional, Hospital or Trust guidelines) such injections, if undertaken with EMG guidance into the thyroarytenoid muscle via a cricothyroid approach can potentially continue during the pandemic under certain specified circumstances, for example where patients will suffer from marked disability if the injection is cancelled/delayed. Caveats include the following: that these injections only be done by extremely experienced individuals, that all personnel present, including the patient, should wear surgical masks if possible at FFP3 level; that injections through a fiberscope channel should be avoided, that injections likely to induce cough, for example those into the posterior cricoarytenoid muscle, or those through a trans-tracheal or trans-laryngeal route should be avoided.

**Swallowing**

It must be remembered that Functional Endoscopic Evaluation of Swallowing (FEES) and Videofluoroscopic Swallow Studies (VFSS) are Aerosol Generating Procedures (AGP), and as such should only be undertaken when absolutely necessary. All individuals present must wear full, protective equipment accordingly.
In cases in which there is **clear need for assessment of swallowing** to enable decisions such as relate to PEG placement it is better to use videofluoroscopy or modified-FEES with one or two consistencies in order to reduce the time of the actual procedure to a minimum.

For new referrals: Each department/team needs to determine the "time sensitivity", "urgency", and "preferred short protocol" on a case-by-case basis. They must take into account each patient's medical condition, social circumstances, and needs. Patients who are unsafe for oral feeding will need to be fed by nasogastric tube or - if unsafe for oral feeding for more than six weeks - by Percutaneous Endoscopic Gastrostomy (PEG) tube if feasible.
Swallowing examination and therapy can potentially be started through remote teletherapy options.
COVID-positive patients with swallowing problems on the ward should be managed, if possible, through indirect assessment and treatment provided by the health care personnel who are caring for them. Remote teletherapy and diagnostics should be used for such patients as much as possible

**Speech and language**

Speech and language assessment should be undertaken partially or wholly in a remote manner, if possible utilizing teletherapy, whenever possible. During the height of the pandemic, all invasive investigations should, if possible, be deferred. Routine questionnaires that can be completed prior to the actual consultation and be available to the examiner should be utilized to assist the examiners.

**Pediatric audiology**

Children with acute conditions necessitating a visit to the hearing center will still need to be seen on a face–to-face basis. It is recommended that the examination of the ears and hearing assessment be undertaken as expeditiously as possible. Screening questionnaires should be completed by the parent prior to the consultation in an attempt to assist the examiner, prioritize therapy, and if possible, defer the physical examination.

Screening of newborn hearing should be maintained. This includes the Early Detection of Hearing Impairment (EDHI) assessment for neonates suspected (from screening assessments) to have congenital hearing impairment.

In general, clinical face-to-face clinical time between clinician and child, and time spent waiting by the child in the clinic should be kept to the minimum, if possible with no waiting time at all.

Extensive attention should be given to disinfection of the examination rooms and the equipment within them. We recommend strict compliance with local health and safety regulations relating to sterilization and disinfection. Disposable equipment should be preferably used wherever possible.

**Reimbursement:** The UEP recommends that teletherapy and teleconsultations be recognized and reimbursed in accordance with local/ national policies during this COVID pandemic.

**Confidentiality:** Confidentiality is paramount. General data protection regulations (GDPR), local/ regional variants and appropriate legislation must be complied with. In particular, when undertaking a remote consultation, the examiner must introduce themselves thoroughly, must explain the rationale for the examination, and must obtain informed consent to proceed. They must document the examination in some form of contemporaneous manner and must send their findings (with permission of the patient/ carer) to the referring GP or physician and other appropriate individuals. The examiner must be aware of their duty of care, be alert to safeguarding issues, and understand the mechanism of escalation.

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