

Irish Head and Neck Society Considerations on H&N during COVID-19

March 20, 2020

This document is intended as general guidance for clinicians in Ireland dealing with Head and Neck Cancer during the current COVID-19 outbreak, as at the date above. This guidance is subject to change with the evolving situation.

1. Referrals and outpatient clinics

It is recognized that many outpatient clinics are currently cancelled.

Where a facility does exist to see patients at clinic, then at the present time, patients should only be seen who are considered highly likely to have malignancy, and who are likely to have significantly compromised outcome by a delay in assessment of same.

Other patients, including new referrals with “red flag symptoms”, may be telephoned and the urgency of the referral re-triaged according to same.

Patients with recent cough or fever (>38 C) or respiratory symptoms within the preceding 1 week should not attend the outpatient clinic under any circumstance.

Flexible laryngoscopy should be performed only where it is considered critical that this examination be performed immediately and will influence immediate management. See section 2.

2. Flexible laryngoscopy

Levels of novel coronavirus (SARS-CoV-2) are highest in the nose and nasopharynx soon after the onset of symptoms. Furthermore, asymptomatic patients appear to have similar viral load to symptomatic patients [1]. In addition, coughing or sneezing during the performance of flexible laryngoscopy may lead to aerosolization of virus particles [2].

Flexible laryngoscopy should thus be considered a procedure associated with high risk of virus transmission to the clinician performing the procedure, which may occur even in patients with minimal or no symptoms.

At the time of preparation of this statement, there is significant community transmission of novel coronavirus in Ireland. Thus we recommend that all patients should be considered as possibly having SARS-CoV-2 in nasopharynx.

At the time of preparation of this document, there is also documented very high demand for personal protective equipment (PPE), and difficulty procuring same.

In view of the above, we recommend that at the present time, laryngoscopy should be performed only when this is considered an essential step in the diagnostic procedure, in patients considered highly likely to have malignancy, or it is otherwise necessary to inform immediate management of the patient. In patients where laryngoscopy is not considered time critical, we are recommending that this procedure be deferred until such time as reliable supplies of adequate PPE are restored, and more data regarding the risk of the procedure and steps to minimize same.

Laryngoscopy should not be performed in any patient with recent cough or fever (>38 C) or other respiratory symptoms within the preceding 1 week, unless it is immediately required for emergent evaluation of the airway.

Procedures around performing laryngoscopy should be agreed with local infection control committee.

Full personal protective equipment (PPE) should be worn by the clinician performing the procedure, including PPF3 mask, and eye protection. Clinicians performing the procedure must be trained in donning and removing PPE.

While there is a shortage of PPE in the hospital, the clinician should strongly consider deferring the laryngoscopy until such time as supplies of PPE are restored, unless the performance of laryngoscopy is time critical.

Laryngoscopy should be performed using a screen with camera attached to laryngoscope, so that the operator's head is as far as possible from the patient's head, and not facing the patient. We recommend that laryngoscopy not be performed with the clinician's looking through the eyepiece.

No other person should be within 2m of the patient undergoing laryngoscopy.

The laryngoscope should be sterilized according to hospital protocol.

Surfaces within the vicinity of the procedure should be wiped down with alcohol prior to seeing next patient.

If the procedure is considered to have generated a high degree of aerosolization (e.g. copious sneezing / coughing), consideration should be given to vacating the examination room for 1 hour prior to cleaning.

These guidelines may change as further information comes to light regarding risk of coronavirus transmission during flexible laryngoscopy.

3. MDT meeting

As far as practicable, physical attendance at MDT meetings should be kept to bare minimum of essential personnel only, with all attendees sitting at least 2m apart.

Videoconferencing, dialling-in, and /or use of teleconferencing platforms such as zooms should be facilitated.

4. Surgical treatment

It is recognized that there is currently reduction in operating theatre capacity, and space for in-patients in hospitals. It is also recognized that surgery for patients with Head and Neck Cancer currently carries additional risks to the patient, including risk of nosocomial Covid-19 transmission, and lack of the usual specialist postoperative care due to absence or redeployment of specialist personnel, as well as risks of virus transmission to healthcare staff.

Decisions regarding open surgery on mucosal cancers should take into consideration, among others, the goals and likely outcomes of surgery, the likelihood of curing the cancer, safety considerations

for theatre personnel and those delivering postoperative care, the consequences of delaying surgery, and alternative non-surgical modalities of treatment.

When considering risks, consideration should also be given as to whether the surgery involves intraoral/ open pharyngeal surgery; likelihood of having to use electrocautery or other energy devices which may increase risk of aerosolization, likelihood of requiring tracheostomy, and anticipated length of hospital stay.

Where patients do undergo surgery, full PPE should be performed by all staff. Consideration should be given to reduce the length of surgery where possible, e.g. by performing primary closure or pedicled flaps instead of free flap reconstruction.

5. Radiotherapy

Where patients are undergoing radical non-surgical treatment, consideration may be given to reducing treatment times (e.g. with hypofractionation), and/or withholding of chemotherapy in favour of radiotherapy alone, where appropriate. Examples of SIB IMRT hypofractionation schemes as alternative to 70/63/56 in 35 fractions include 65/60/54 Gy in 30 fractions, or, where volume is not large 60/50 Gy in 25 fractions. Certain head neck cancer patients are high risk for treatment such as patients with tracheostomies and laryngectomy patients who have secretions and cough, and patients having mouthbites inserted for radiotherapy such as oral cavity cancer patients. Full PPE should be used in caring for these patients. Use of mouth bites should be limited where possible. Full PPE should be performed by staff caring for these patients. Where radiotherapy capacity is limited patients receiving definitive radiotherapy will be prioritised over adjuvant radiotherapy. Oral care of patients with mucositis by staff should be performed with full PPE.

6. Tracheostomy

Tracheostomy is of particular concern during the COVID-19 outbreak as it is one of the highest aerosol generating procedures. It should be thus considered both a high risk procedure for staff performing the tracheostomy, as well as presenting an ongoing risk to those nursing and caring for the patient afterwards due to the frequent expectoration of droplets and aerosolized particles. This risk may be even higher due to frequent need to suction through the tracheostomy; need for cleaning and changing of inner tube; and risk of displacement of tracheostomy tube with forceful coughing or positional changes. Further issues include the anticipated need for high volumes of PPE to be worn by all staff, with meticulous donning and doffing, due to the higher aerosolisation risk; and increased risk of tracheostomy complications due to patients not being nursed by staff experienced in tracheostomy management. Based on these risks, it is advised that tracheostomy should be a rare event in COVID-19 patients.

Emergency tracheostomy may be required in as a life saving measure in patients with upper airway obstruction who are not known to have COVID-19. The decision to intervene should be rapidly evaluated by the most Senior Clinician available in close consultation with Anaesthetic/ICU staff with due regard for resources available at that time. In all cases, patients should be regarded as having COVID-19 and managed using full PPE.

Need for elective tracheostomy in patients who are being considered for major head and neck resection during the COVID-19 outbreak should be a consideration in deciding whether to proceed

with surgery, taking account of availability of resources (nursing, ICU, PPE) required for safe management of the patient in the postoperative period.

Currently, there no data showing evidence of benefit for elective tracheostomy in ventilated COVID-19 patients. It is recommended that individual decisions regarding tracheostomy in these cases should be made in a multidisciplinary fashion including head and neck surgical and ICU/anaesthetic colleagues based on their unique set of circumstances and resources available. We recommend that tracheostomy should only be considered in patients where this is likely to bring about a clear benefit for the patient that outweighs the risks of performing the procedure. Tracheostomies are not recommended in patients with poor prognosis or with anticipated continued need for ventilation. Where tracheostomy is performed, this should be delayed as long as possible, allowing reduction in viral load. As far as practicable, percutaneous tracheostomies should be performed over open tracheostomies (preferably without bronchoscopic control). Open surgical tracheostomy is strongly discouraged given the increased soft tissue dissection and aerosolisation risk.

These guidelines will be reviewed weekly and are subject to change with the evolving situation

References:

1. SARS-CoV-2 viral load in upper respiratory specimens in infected patients. N Eng J Med
2. Consensus statement: Safe airway society principles of airway management and tracheal intubation specific to the COVID-19 adult patient group. Medical Journal of Australia *preprint version* 17 March 2020. <https://www.mja.com.au/journal/2020/212/10/consensus-statement-safe-airway-society-principles-airway-management-and>