Although there is no well-defined treatment regimen for SNTCS, limited information in the literature suggests that a more aggressive treatment strategy with combined surgical resection and adjuvant therapy gives patients the best chance for survival. Further research is needed to better define the optimal treatment regimen for patients with this sinonasal pathology.

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Additional Contributions: We thank the patient for granting permission to publish this information.


COMMENT & RESPONSE

Use of Bookwalter Retractor to Create a Working Space for Tracheostomy During the Coronavirus Disease 2019 Pandemic

To the Editor The ongoing coronavirus disease 2019 (COVID-19)-related pandemic has created a challenge with performance of tracheostomy due to the high risk of aerosolization of potentially infectious materials. This creates a significant hazard for operating room staff and surgeons. Dr Bertroche and colleagues1 have described an excellent method for creating an enclosed negative-pressure environment for performance of tracheostomy, with the purpose of minimizing release of aerosol. We present a modification of this description (Figure).

Rather than the laryngoscope holder, our group has used the Bookwalter retractor as the arm for drape placement. This is a commonly used retractor system for abdominal surgery, and is placed after draping the patient. After the ring is positioned, a C-arm drape or radio frequency room scanner wand drape is used, with creation of working arm ports similar to the description provided by Bertroche and colleagues.1 The drape is held stable with towel clamps. For the purposes of tracheostomy, we find several advantages. The ring of the retractor creates a flat view of the operating field, which permits a similar view between surgeon and first assistant clinician. Second, the ring prevents collapse of the drape with application of negative pressure. We find that excessive collapse and folding amplify the glare issues that occur when working through a drape material. The major disadvantage of this setup is the restriction in vertical working room above the surgical field, depending on the placement of the ring on the Bookwalter arm. We overcame this by avoiding elongated instruments, specifically the Yankauer suction.

Given the high-risk aerosolization potential of tracheostomy, we completely agree with the creation of an enclosed working space over the surgical field. We hope this modification can assist with ease of performing the procedure.

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Conflict of Interest Disclosures: None reported.

In Reply It is certainly great to see the adaptation of our initial design with use of a Bookwalter retractor by Yarlagadda and Anderson. One of our aims in development of the negative pressure aerosol cover was to use materials and instruments commonly available at most medical centers. The use of the widely available Bookwalter retractor undoubtedly follows in the spirit of this goal. Key to our continued success in managing the current global pandemic is the responsiveness and resourcefulness of our community in identifying issues and developing solutions to these shared challenges. It is our hope that fellow otolaryngologists and the greater medical community continue to rise to adapt to these challenging times with ingenuity and vigor.

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Understanding COVID-19-Related Olfactory Dysfunction

To the Editor: We read with interest the article by Boscolo-Rizzo et al titled “Evolution of Altered Sense of Smell or Taste in Patients With Mildly Symptomatic COVID-19.” We would like to commend the authors for this important work in the documentation of the natural history of olfactory dysfunction in patients with COVID-19. We concur that the pattern of symptoms reported suggests a sensorineural cause of the olfactory dysfunction.

Postviral anosmia, most frequently investigated among patients with the influenza virus, is often attributed to infection and consequent apoptosis of olfactory neurons. In contrast, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has been hypothesized to affect olfactory function via infection of the sustentacular, perivascular, and stem cells in view of its affinity with the angiotensin-converting enzyme 2 (ACE2). These cells, and not the olfactory sensory neurons, have been shown to have high expressions of ACE2 and TMPRSS2. Bryce et al reported that SARS-CoV-2 infection of the sustentacular cells resulted in massive infiltration of immune cells and damage to the olfactory ciliary layer within a short period of 2 days in a golden Syrian hamster model. They further reported partial restitution of the ciliary structure at 14 days after infection, which is postulated to reflect differentiation of progenitor cells to sustentacular cells and mature olfactory receptor neurons. In contrast, other studies have shown functional recovery at 45 days and odorant receptor expression at 90 days after olfactory neuronal damage.

The authors have described a high proportion of recovery of olfactory function at 4 weeks from the initial diagnosis of COVID-19. However, the timing of onset and recovery of olfactory dysfunction was unclear in the article. Being able to establish a proper timeline of olfactory symptoms would help to further shed light on the pathogenesis of olfactory dysfunction. We would therefore like to suggest considering critical testing time points of 2 to 3 days, 14 days, and 1 to 3 months after infection.

To further complicate matters, recent data have emerged showing that SARS-CoV-2 may be able to infect apparently ACE2-negative cell types—either via other participative molecules such as BSG, neuropilin-1, and PIKfyve, or perhaps that very low-level ACE2 expression is sufficient to mediate infection.

Having a clear account of the symptomatology and evolution of olfactory dysfunction at regular intervals would allow researchers to compare and correlate post-COVID-19 olfactory dysfunction with other olfactory disorders on a cellular level. This may play an important role in furthering our understanding of the pathogenesis of SARS-CoV-2.

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In Reply We thank Chee and Wang for their appreciation of our original investigation titled “Evolution of Altered Sense of Smell or Taste in Patients With Mildly Symptomatic COVID-19.”

We agree that it would be useful to include more frequent evaluation of olfactory function; this was not possible in this current study owing to the overwhelming demands on clinicians at the peak of the pandemic, but hopefully future studies will be able to recruit patients and evaluate with both self-reported and psychophysical testing of olfactory function at more frequent intervals.

We encourage the self-reported evaluation of anosmia because it has as a baseline parameter of comparison to the sub-