is not isolated to the pediatric population. Nasal chondromesenchymal hamartoma is generally considered a benign tumor because there has only been 1 reported case of malignant transformation. Nine instances of recurrence have been reported, most likely thought to be from incomplete surgical excision.

An association of NCCH and the autosomal dominant DICER1 familial tumor susceptibility syndrome has been unfortunately reported. DICER1 is an endonuclease that plays a role in post-transcriptionally modifying gene expression; this syndrome confers an increased risk of pleuropulmonary blastoma most commonly, but also cystic nephroma, Sertoli-Leydig tumors, and thyroid goiter. In current literature, most of the reported cases of NCCH have not been tested for DICER1 variations.

Nasal chondromesenchymal hamartoma is a very rare benign tumor that usually presents in childhood. Treatment is complete surgical excision, but consideration for genetic testing given potential syndromic implications should be undertaken for these patients and their families.

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COMMENT & RESPONSE

Overcoming Operator-Generated False-Negative Results in SARS-CoV-2 Testing

To the Editor  I share the concerns of Higgins et al regarding the low sensitivity of the gold standard for detecting severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and thank them for their detailed description of how to properly obtain nasopharyngeal swabs. However, the rejection by Higgins et al of nasal swabbing as a valid method for coronavirus disease 2019 (COVID-19) testing is inconsistent with current understanding. Most peer-reviewed publications comparing nasal vs nasopharyngeal swabbing for COVID-19 specimen collection have demonstrated noninferiority between methods.

A recent letter to the editor by Tu et al, covering one of the largest clinical multicenter studies to date, was published in the New England Journal of Medicine and summarized data collected from over 500 individuals. The authors confirmed the clinical usefulness of tongue, nasal, or mid-turbinate samples collected by patients compared with nasopharyngeal samples collected by health care workers. Correspondingly, the Centers for Disease Control and Prevention (CDC) adapted their COVID-19 testing guidelines, stating that a self-administered nasal swab is similar to a nasopharyngeal swab in detecting COVID-19. Furthermore, the CDC emphasizes that nasal sampling is less invasive and results in less patient discomfort, and that it is less technically complex, so it can reduce the risk of spread of infection to health care providers by reducing the duration of the procedure and allowing the patient to perform self-collection under supervision. In addition, the CDC highlights that such an approach lessens personal protective equipment utilization.

While medical guidance regarding COVID-19 treatment is constantly evolving, as of September 2020, the literature recommends nasal over nasopharyngeal swabbing for the detection of SARS-CoV-2.

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To the Editor We read with interest the article by Higgins et al on false-negative results from anatomical misconceptions regarding nasopharyngeal anatomy. The recruitment of swabbers unfamiliar with nasopharyngeal anatomy, both medical and especially nonmedical, has resulted in the employment of incorrect specimen collection techniques. Efforts have been made at institutional, national, and even international levels to educate swabbers, though with mixed results. Given the large heterogeneity of swab administrators, it may be difficult to enforce consistently accurate techniques. Furthermore, nasopharyngeal swab testing has further disadvantages of risk of exposure to the swabbers and use of valuable personal protective equipment.

A possible alternative would be to pursue use of saliva testing, which can be self-collected, eliminating operator variations in collection technique. A recent meta-analysis has shown comparable sensitivity for saliva tests (91%) and nasopharyngeal swab tests (98%), with moderate interstudy heterogeneity. Coupled with advances in point-of-care testing, this may enable reliable and safe autonomous testing, requiring minimal medical supervision and minimizing operator-generated false negative rates. Further prospective studies are needed and should be aimed at validating salivary testing as a suitable alternative to nasopharyngeal swab testing.

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In Reply We thank Dr Chee for the comments about our Viewpoint. Saliva testing may have reasonable clinical acceptance in certain situations. It should be noted that it remains a less accurate method, and therefore we would not recommend it for critical situations such as preoperative testing or to determine coronavirus disease 2019 (COVID-19) status during a hospital admission. However, saliva tests might be useful in estimating the rate of positivity in a population as in children and parents in certain school districts in the US. The nasopharyngeal swab test is actually not difficult to perform if proper education is provided and, for facilities opting for nasopharyngeal testing, the purpose of our Viewpoint was to highlight the proper anatomy.

We also thank Dr Landegger for interest and comments on our Viewpoint. He is certainly right that our knowledge of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) assessment is evolving. He also makes reasonable points regarding nasal swabs and that the Centers for Disease Control and Prevention (CDC) has now accepted nasal swabs as an alternative to nasopharyngeal swab testing. Pérez et al performed a very small study of 44 participants comparing nasopharyngeal and nasal swab testing with a 9% false-negative rate compared with nasopharyngeal swab testing. The study was not designed to demonstrate noninferiority, cannot be generalized to a large population, and the clinical relevance of this false-negative rate should be considered. The referenced study from Altamirano et al compared nasal swabs with oropharyngeal swabs, not nasopharyngeal swabs. Tu et al studied a larger sample (approximately 500 patients) of health care worker-performed nasopharyngeal swabs and were able to show a 94% sensitivity for nasal swabs and 96% sensitivity for midturbinate swabs under controlled settings. As in any other area of research, further larger, multicenter studies to confirm these findings would be helpful to ensure validity and generalizability.

A few other caveats should be considered. These studies used special foam-tipped swabs for nasal specimen collection and flocking swabs for oropharyngeal swab testing. Anecdotally, we have seen the standard polyester-tipped swabs used in nasopharyngeal testing being used for nasal and oropharyngeal testing, which is not recommended by the CDC. Therefore, much higher false-negative rates are possible when the intent is to perform a nasopharyngeal swab using a standard polyester-tipped swab yet only the midturbinate or nasal areas are reached. In addition, the clinically acceptable rate of false negative results in different settings should be considered. Nasopharyngeal swab testing remains the gold standard, so each facility can consider what is acceptable. For instance, we would encourage the most accurate testing techniques for preoperative testing before aerosol-generating procedures in which a false-negative result could result in high-risk exposure to the health care workers caring for the patient.

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