is the first such reported case. Nasal septal abscess is an uncommon occurrence that typically results from trauma leading to septal hematoma and subsequent hematoma infection.\(^1,2\) The most common presenting symptom is nasal congestion.\(^1,3,4\) Additional common symptoms include nasal pain, purulent nasal discharge, headache, and fever.\(^1,3\) A CT scan with contrast can determine the location and size of the abscess, as well as evaluating for potential malignant disease.\(^4\) The most common organism detected in nasal septal abscesses is *Staphylococcus aureus*, followed by other aerobes such as *Streptococcus pneumoniae* and *Klebsiella pneumoniae*.\(^3,4\) Anaerobic, oral flora have been identified in rare cases, including *Prevotella* and *Peptostreptococcus* species.\(^3\)

In this patient with no history of trauma, poorly fitted dentures eroded the maxillary gingiva and established a communication between the oral and nasal cavities. Oral flora migrated through this pathway into the nasal cavity and subsequently developed into a septal abscess. Infection source was confirmed by culture results that exhibited oral anaerobic *Fusobacterium* and *Prevotella* species growth. Complications of nasal septal abscess can be severe, including meningitis, cosmetic deformity of the nasal bridge, osteomyelitis, cavernous sinus thrombosis, or intracranial abscess.\(^1,3,5\) Owing to the severity of potential complications, prompt treatment is necessary. Treatment consists of incision and drainage with subsequent antibiotic selection based on Gram stain and culture results of the drained fluid. A Penrose drain can be placed to facilitate resolution, whereas nasal packing may prevent blood and pus from recollecting in the tissue. Empirical antibiotic treatment is generally amoxicillin/clavulanate or clindamycin to provide sufficient *S aureus* coverage while awaiting culture results and susceptibilities.\(^1,3,5\)

In cases where trauma does not precede development of nasal septal abscess, infection source should be sought to direct treatment and prevent recurrence. The cornerstone of diagnosis remains a detailed history and physical examination. In an edentulous patient presenting with nasal septal abscess and no history of trauma, the oral cavity should be carefully examined to rule out a communication between oral and nasal cavities.

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**COMMENT & RESPONSE**

**Measuring Tracheotomy Risk in Patients With COVID-19: Time to Look Beyond Surgery and Surgeons**

To the Editor Avilés-Jurado and colleagues\(^1\) add another piece to the coronavirus 2019 (COVID-19) jigsaw puzzle with their investigation of 50 patients undergoing surgical tracheostomy for respiratory failure. The study affords insights on timing and reassurances regarding surgeon safety during bedside open tracheostomy in the intensive care unit. A lingering question remains, however, concerning safety of the rest of the health care team during surgery and afterwards.

Avilés-Jurado and colleagues\(^1\) reported that no surgeons contracted COVID-19 disease during the study period, but they do not report on other indispensable members of the team. Nurses, speech-language pathologists, and respiratory care clinicians bear a substantial burden of COVID-19 exposure risk.
Surgical opening of the airway during tracheotomy is brief in duration, and this critical step is typically performed with apnea—greatly reducing aerosol generation. In contrast, this margin of safety from apnea is seldom available to nurses and other allied health professionals. Notably, the investigation reports median time to tracheostomy of 9 days (interquartile range, 2-24 days), suggesting that many tracheotomies were performed before infectivity waned.2

Both the number of airway manipulations performed following tracheotomy and the duration of such exposures greatly exceeds that attributable to the index procedure. Examples of aerosolizing maneuvers, often accompanied by cough, include tracheotomy suctioning and stomal care, flexible endoscopic or videofluoroscopic evaluation of swallowing, cuff deflation, speaking valve evaluation, administration of nebulizers, high-resolution manometry, expiratory muscle strength training, and Iowa Oral Performance Instrument tongue strength diagnostics.

In this cohort,1 the timing of tracheostomy was primarily determined by intensivists, based on clinical condition, prognosis, and predicted tolerance to weaning; however, judging when patients will safely tolerate tracheostomy is difficult. Multidisciplinary collaboration enhances decision making, particularly amidst intensive care unit capacity strain. Such decisions should engage the relevant stakeholders bearing risk of aerosol generation during and after the procedure. A preprocedural apnea test in conjunction with the multidisciplinary team may help assess physiological reserve to tolerate tracheotomy and minimize complications.2

Long before the COVID-19 pandemic swept across countries and continents, the World Health Organization declared 2020 the Year of the Nurse and Midwife, the culmination of a global campaign to improve health by raising the profile of nursing worldwide. All frontline workers should be given due consideration not only in practice, but in reporting safety provisions and outcomes. High-quality tracheostomy care is predicated on purposeful interprofessional collaboration. We commend Avilés-Jurado and colleagues1 for their study, which adds to growing knowledge on assessment of safety, timing, and outcomes of tracheostomy.3-5

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In Reply After carefully reading the letter sent by McGrath et al, we thank the authors for their comment and compliments regarding our work.1 We totally agree with them on the importance of considering all professionals in charge of the treatment of the stoma, cannula, and the rehabilitation of the upper airway, at risk beyond the act of tracheostomy.

At the beginning of the pandemic, as surgeons we had to face a situation that presented many uncertainties and generated fear among the otolaryngologists, that of performing a tracheostomy in patients with coronavirus disease 2019 (COVID-19). Little was known about the degree of infectivity of mechanically ventilated patients and the risk associated with the procedure. It was also unclear where or when the tracheostomy should be performed or which was the best procedure. Scientific societies recommended a delayed tracheostomy (beyond 3 weeks of intubation) to avoid the risk of transmission and to avoid unnecessary tracheostomies in patients who could not overcome the disease. No one raised the fact that a delayed tracheostomy may have long-term consequences of difficult resolution, such as laryngotracheal stenosis.

Therefore, our first objective was to confirm that a surgical tracheostomy could be performed properly with the appropriate protection and following the recommendations at the time of tracheal entrance. It was a key point to monitor and analyze the possible infection of the surgical team.

As the authors mention, the infectivity of the rest of the team is equal to or more important than that of surgeons, especially with regard to nursing personnel. The period of greatest risk of infection is during the admission at the ward or in the intensive care unit. Several studies have shown a high percentage of infection and seroconversion in frontline workers.2 Unfortunately, in widely exposed personnel, it is difficult to know at what point they got infected along the process.

Knowing the risk of infectivity based on the time passed since the symptoms onset is of paramount interest. A recent meta-analysis established that although severe acute respiratory syndrome 2 (SARS-CoV-2) RNA shedding in respiratory and stool samples can be prolonged, duration of viable virus is relatively short-lived. SARS-CoV-2 titres in the upper respiratory tract peak in the first week of illness.3 More recently, a study
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evaluated the duration of culturable SARS-CoV-2 in hospitalized patients with COVID-19. The median time from the onset of illness to viral clearance in culture was 7 days (95% CI, 5-10 days), being the last positive viral culture 12 days after symptom onset.

We agree with the authors that it is time to look beyond surgery and surgeons and, for the sake of frontline workers, evaluate the infectiveness risk at the time of tracheostomy. Culture of tracheal secretions could be the next step. This knowledge may help us to determine the proper timing of the tracheostomy.

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Regarding Use of Povidone Iodine to Reduce Nasopharyngeal Viral Load in Patients With COVID-19

To the Editor We read with interest the recent article by Guenezan et al., “Povidone Iodine Mouthwash, Gargle, and Nasal Spray to Reduce Nasopharyngeal Viral Load in Patients With COVID-19: A Randomized Clinical Trial,” published in JAMA Otolaryngology–Head & Neck Surgery on the use of nasal and oral application of 1% povidone iodine (PVP-I) solution in non-admitted patients with COVID-19. We congratulate the authors for publishing this highly relevant clinical data pertaining to the ongoing pandemic. Despite the rollout of safe vaccination, the final outcome of SARS-CoV-2 remains to be seen. Until the definitive data emerges (possibly even beyond then), the importance of preventive strategies cannot be overemphasized. The wide availability and antimicrobial spectrum (including virucidal properties against SARS-CoV-2 demonstrated in the in vitro studies) make it an attractive agent for limiting the infection spread. The current pilot study provides important preliminary data and may boost larger-scale studies to reach more definitive conclusions. However, for the readers’ benefit and possible optimization of future study designs, we would like to gain more clarity regarding some of the facts presented in the study.

Though the detectable viral RNA can be recovered for many weeks to months from the upper aerodigestive tract mucosa, the viable viral particles cannot be recovered beyond the first few days of symptom onset. This was supported in the current article, which revealed that the viable virus could not be isolated in either group by the end of 3 days. However, the authors showed a 75% decline in the viral titer in the intervention group compared with a 32% decline in the control group at day 1 postintervention. It is unclear from the provided data whether the difference was statistically significant.

Although the protocol details the randomization process, the final attained imbalance in the age groups is striking. The intervention group chiefly comprised a young population with fewer comorbidities. It would be interesting to know if adjustment for the same was attempted and affected the final analysis. The authors had postulated a 66% decline in carrier state (as defined by RNA levels) in the intervention group to arrive at a sample size of 24. Though the absolute percentage decline (similar for the control and intervention groups) was not reported in the current article, the data will help determine the sample size for future studies besides strengthening the current results. Also, the trial seems to be composed of a relatively healthier population. Because the study involved patients treated on an outpatient basis only (despite a few patients presenting with chest pain and/or dyspnea), the applicability of the results to moderate-to-severe illness or those with significant comorbidities remains a potential area of further research.

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3. Cevik M, Tate M, Lloyd O, Maraolo AE, Schafera J, Ho A. SARS-CoV-2, SARS-CoV, and MERS-CoV viral load dynamics, duration of viral shedding, and

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