

### **BAPO statement on SARS Cov2 and Paediatric Otolaryngology Provision**

This statement is to be read in conjunction with other guidance published by ENTUK, particularly those with respect to PPE, tracheostomy, endoscopy and aerosol-generating procedures, all of which are fully endorsed by BAPO. For avoidance of repetition, it is intentionally brief. As this is a rapidly evolving situation, updates of this document will be posted on the ENTUK Covid-19 resource page.

This statement is based on international expert opinion, published literature and guidance from other professional bodies. Many of the enquiries for paediatric otolaryngologists have been directed at the management of specific conditions. It would be impossible to address every possible permutation of primary pathology, Covid-status, comorbidity, local facilities and available multi-professional expertise. Recommendations herein have been made to ensure that the risk of spread of the life threatening COVID19 infection is minimised among patients, families and staff. They are also guided by the current knowledge of Covid-19 characteristics in the paediatric population, namely that 13% of infected children are asymptomatic and those symptomatic infected children have mild symptoms, that there are subpopulations at increased risk of more significant illness and that children may play a major role in community-based viral transmission including faecal-oral transmission.

#### **Management of elective and semi-elective paediatric out-patient clinic and surgery**

The majority of paediatric ENT conditions will not result in serious harm or life threatening situations over a period of 3 months, therefore operating and face-to-face clinics must cease to prevent harm. There is a recognition that a small amount of paediatric ENT pathology may rarely pose a risk to life or cause serious harm to health, including rapidly enlarging neck masses. These conditions must be recognised and treated.

The management of obstructive sleep apnoea related to adenotonsillar hypertrophy has been the subject of most enquiries and debate. There are no specific objective parameters which can be used to determine whether at this time, adenotonsillectomy can be justified. As a general rule, adenotonsillectomy should be delayed unless despite maximal medical treatment, delaying surgery would result in irreversible cardiopulmonary complications or necessitate endotracheal intubation. The chosen technique should depend on available expertise. In the absence of any evidence that intracapsular tonsillectomy causes any increase in aerosolisation over conventional dissection tonsillectomy, it would be the preferred method to adopt due to the considerably reduced incidence of secondary haemorrhage. Full AGP-PPE precautions should be taken during surgery.

#### **Management of paediatric otolaryngological emergencies**

In addition to the observations above, as capacity in hospitals reaches saturation, the management of emergencies in children should be directed at simultaneously minimizing admission and risk of harm.

### *Foreign bodies*

Retained button batteries remain an absolute emergency with respect to removal. Ingested foreign bodies causing absolute dysphagia will require removal. Otherwise, foreign bodies in the ear, nose and throat should be treated conservatively unless there is significant risk to the airway or may cause long term sequelae if removal is delayed (e.g. sharp objects). There will be many children who develop a cough and have a soft history of "playing with small toy parts/food etc". Unless they have stridor, dyspnoea or localizing signs these should be observed and the CXR repeated. If available, a local CT scan may help differentiate foreign body from other pathologies.

### *Periorbital abscess*

Where vision is at risk, and conservative measures have failed, an external approach is recommended. This is in line with recommendations by the SBNS.

### *Fractured nose*

In the absence of a nasal septal haematoma, it is recommended that manipulation of fractured nasal bones should not be carried out at the present time.

### *Acute mastoiditis*

Acute mastoiditis should be managed medically, and if appropriate by needle aspiration of a subperiosteal abscess and a CT scan acquired only if symptoms progress despite conservative management. A ventilation tube should not be used to manage intratemporal complications. If surgery is required due to life-threatening complications, it should be carried out in line with the BSO guidelines using curettage instead of drilling and after full Covid testing.

### *Neck abscess*

Infective neck masses should be managed as outpatients as far as it is possible to. Progressively enlarging cervical or retropharyngeal collections may require surgical treatment with full PPE.

### *Airway compromise*

Inevitably, a small number of children will require urgent endoscopic airway assessment. The infective risk of outpatient endoscopy is not likely to be justifiable and a telephone discussion with your local paediatric airway service would be more appropriate after maximal medical treatment which may include empirical treatment with anti-reflux medication and oral steroids

## **Management of children with tracheostomy**

In line with ENTUK guidance, elective tracheostomy should be avoided at this time. Unavoidable tracheostomy should be carried out with full PPE using a cuffed unfenestrated tracheostomy tube. Tracheostomy tube changes should be minimized. Tracheostomy training of parents of children who underwent tracheostomy prior to Covid-19 should have their training accelerated to permit discharge as soon as it is safe to do so.



**Michael Kuo (President)**



**and Steven Powell (Honorary Secretary)**

**on behalf of The British Association for Paediatric Otolaryngology**

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