unit populations described in a recent meta-analysis from Brodsky et al3 detailing 775 patients. Most importantly, the patients who evidenced laryngeal injury at extubation reported worse breathing at 10 weeks compared with their uninjured counterparts, even when controlling for comorbid disease, the etiology of critical illness, and procedural factors (length of intubation and endotracheal tube size).

The 10 patients with ALgI described in our recent article4 all had clinical signs and symptoms of severe laryngeal functional impairment on initial evaluation. This contrasts with the previously reported 57 patients with ALgI incidentally detected during surveillance endoscopy.2 None of these 57 required a delayed tracheostomy for recalcitrant posterior glottic scar. We currently lack a validated severity grade for laryngeal injury after intubation; however, it is possible the 10 patients requiring surgical intervention (described in this work)5 possessed a more severe mucosal injury leading to more severe physiologic impairment at initial consultation. Questions persist over which patients in the intensive care unit to screen for ALgI, which patients with ALgI require intervention, and what therapy to offer. However, published data support the idea that ALgI detected at extubation, when unaddressed, is associated with impaired breathing after recovery from critical illness.4

The open questions for the otolaryngology and critical care community distilled from the letter by Aretha et al relate to (1) Can we lower the rate of ALgI though selection of smaller endotracheal tubes without negatively affecting clinical care? (2) How do we optimize clinical protocols to surveil patients at high risk for ALgI after intubation? (3) Is there a role for medical therapy when ALgI is detected6 (ie, inhaled corticosteroids improve subjective dyspnea and objective laryngeal mobility 3 months after extubation)? (4) How do we select patients with ALgI who will derive the most benefit from surgical therapy?

It is clear that more work is required to address important questions about rehabilitating the larynx after prolonged mechanical ventilation. However, given the real clinical effect of laryngeal injury (coupled with our limited ability to rehabilitate laryngeal contracture once established), we hope our work encourages all physicians participating in critical care to be mindful of the implications of laryngeal injury, be diligent in selecting an endotracheal tube, and triage those who may be at highest risk for injury. The critical care community has worked diligently to improve survival from critical illness. Their culture of rigorous scientific study has made these efforts possible. The rapid progress in clinical care for patients critically ill with COVID-19 is a testament to the value of that culture. We believe continued study of the laryngeal effects of mechanical ventilation, along with integration of otolaryngologists into the critical care culture of discovery, can improve the quality of life lived after critical illness.

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Conflict of Interest Disclosures: None reported.


Investigations of Malfunctions of the Vestibular System

To the Editor We read with great interest the article by Cao et al, titled “Association of Balance Function With All-Cause and Cause-Specific Mortality Among US Adults.”1 The authors concluded that balance disorder was associated with an increased risk of all-cause, cardiovascular disease, and cancer mortality.1

This prospective, population-based cohort study by Cao et al of a nationally representative sample of 5816 adults older than 40 years was based on the modified Romberg test of Standing Balance on Firm and Compliant Support Surfaces (modified Romberg test).

The subjective nature of individual test conditions 1 to 4 of the modified Romberg test is noteworthy. The definitions contained in the study required to determine the presence of vestibular balance disorders or visual and/or proprioceptive disorders confirm the observational nature of the study design.

The modified Romberg test is a test that does not allow for assessment of the efficiency of the equilibrium system fully. During its performance, no devices were used to objectively assess the condition of proprioceptors (static or dynamic posturography), visual efficiency, the sense of deep sensation, or the efficiency of the otolith organs.

There are known opinions about the diagnostic limitations of the Romberg test. Longridge et al2 claim that some versions of the Romberg test may not be effective at determining the presence of newly developed vestibular disease. Jacobson et al3 concluded that modified Romberg test should not be used as a screening measure for vestibular impairment.

The overall conclusion of the study by Cao et al was that there is a risk of increased mortality with balance disorders.

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Published Online: July 1, 2021. doi:10.1001/jamaoto.2021.12392

Conflict of Interest Disclosures: None reported.
In Reply Narozny et al raise an interesting observation about our article,¹ which highlights the need for research in sensory impairments. Balance disorder is a major public health concern in the US and significantly contributes to the onset of falls and hip fractures. Balance testing was incorporated in the National Health and Nutrition Examination Survey (NHANES) from 1999 to 2004 to estimate the prevalence of balance problems in the US general population using the modified Romberg Test of Standing Balance on Firm and Compliant Support Surfaces (the modified Romberg test). Based on this national surveillance, Agrawal and colleagues² reported an estimated 35.4% of US adults aged 40 years or older (69 million Americans) experienced vestibular dysfunction in northern Poland—the first Polish neurootologic survey of the general population. Ann Agric Environ Med. 2017;24(3):502-506. doi:10.5604/12329666.1228401

Current clinical practices commonly adapt crude balance testing (eg, 1-leg standing test) as a part of physical performance assessments made in adults to screen for balance problems that require targeted interventions for fall prevention.³ However, crude balance testing provides limited information on sensory impairments, which may impede the effectiveness of interventions to improve balance function. We acknowledge the limitations in the modified Romberg test as a screening measure for vestibular diseases and visual/proprioceptive disorders; it remains a simple tool that provides additional information on balance problems related to multiple sensory impairments that is better than crude balance testing.

Sensory impairments contribute to a wealth of unfavorable health outcomes. Emerging epidemiologic data suggest that deficits in the sensory system were associated with an increased risk of mortality and other diseases.¹,⁴,⁵ Because the prevalence of sensory impairments is increasing, accompanied by population aging and certain diseases (eg, coronavirus disease 2019),⁶ enhanced diagnostic assessments of the sensory system should be considered in clinical and research settings. Such assessments will facilitate investigations into the effects of sensory deficits and loss on long-term health outcomes at the population level and facilitate referrals of patients to specialists for targeted interventions.

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Published Online: July 1, 2021. doi:10.1001/jamaoto.2021.1291

Conflict of Interest Disclosures: None reported.


CORRECTION

Error in Figure 3: In the Original Investigation titled “Evaluation of the Video Ocular Counter-Roll (vOCR) as a New Clinical Test of Otolith Function in Peripher al Vestibulopathy,”¹ published online March 25, 2021, and in June print, there was an error in the key to Figure 3. The blue dot with “Average of 2 sides/controls” should have been a gray dot, and the gray dot with “Nonlesion side/patients” should have been blue. This article was corrected online.


Error in the Confidence Interval: In the Research Letter titled “Incidence of Bell Palsy in Patients With COVID-19,” which published online June 24, 2021,¹ a decimal point was misplaced in the 95% CI reported in the Results section. The correct 95% CI is 3.5-13.2. This article was corrected online.


Error in Author Name in Byline: In the Observation titled “A Spontaneous Chyle Leak,” published online on June 10, 2021, in JAMA Otolaryngology–Head & Neck Surgery, one of the author’s names was misspelled in the byline. Where it previously read “Shane Davey,” it now correctly reads “Shane Davy.” This article was corrected online.