

# World Journal of *Clinical Cases*

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## Contents

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## OPINION REVIEW

- 11665 Combined use of lactoferrin and vitamin D as a preventive and therapeutic supplement for SARS-CoV-2 infection: Current evidence

*Cipriano M, Ruberti E, Tovani-Palone MR*

## REVIEW

- 11671 Role of adherent invasive *Escherichia coli* in pathogenesis of inflammatory bowel disease
- 11690 Emerging potential of ubiquitin-specific proteases and ubiquitin-specific proteases inhibitors in breast cancer treatment

*Zheng L, Duan SL, Dai YC, Wu SC*

*Huang ML, Shen GT, Li NL*

## MINIREVIEWS

- 11702 Overlap of diabetic ketoacidosis and hyperosmolar hyperglycemic state

*Hassan EM, Mushtaq H, Mahmoud EE, Chhibber S, Saleem S, Issa A, Nitesh J, Jama AB, Khedr A, Boike S, Mir M, Attallah N, Surani S, Khan SA*

## ORIGINAL ARTICLE

## Case Control Study

- 11712 Comparing the efficacy of different dexamethasone regimens for maintenance treatment of multiple myeloma in standard-risk patients non-eligible for transplantation

*Hu SL, Liu M, Zhang JY*

## Retrospective Cohort Study

- 11726 Development and validation of novel nomograms to predict survival of patients with tongue squamous cell carcinoma

*Luo XY, Zhang YM, Zhu RQ, Yang SS, Zhou LF, Zhu HY*

## Retrospective Study

- 11743 Non-invasive model for predicting esophageal varices based on liver and spleen volume

*Yang LB, Zhao G, Tantai XX, Xiao CL, Qin SW, Dong L, Chang DY, Jia Y, Li H*

## Clinical Trials Study

- 11753 Clinical efficacy of electromagnetic field therapy combined with traditional Chinese pain-reducing paste in myofascial pain syndrome

*Xiao J, Cao BY, Xie Z, Ji YX, Zhao XL, Yang HJ, Zhuang W, Sun HH, Liang WM*

- 11766** Endothelial injury and inflammation in patients with hyperuricemic nephropathy at chronic kidney disease stages 1-2 and 3-4

*Xu L, Lu LL, Wang YT, Zhou JB, Wang CX, Xin JD, Gao JD*

### Observational Study

- 11775** Quality of life and symptom distress after cytoreductive surgery and hyperthermic intraperitoneal chemotherapy

*Wang YF, Wang TY, Liao TT, Lin MH, Huang TH, Hsieh MC, Chen VCH, Lee LW, Huang WS, Chen CY*

- 11789** Development and validation of a risk assessment model for prediabetes in China national diabetes survey

*Yu LP, Dong F, Li YZ, Yang WY, Wu SN, Shan ZY, Teng WP, Zhang B*

- 11804** T-cell immunoglobulin mucin molecule-3, transformation growth factor  $\beta$ , and chemokine-12 and the prognostic status of diffuse large B-cell lymphoma

*Wu H, Sun HC, Ouyang GF*

### META-ANALYSIS

- 11812** Prostate artery embolization on lower urinary tract symptoms related to benign prostatic hyperplasia: A systematic review and meta-analysis

*Wang XY, Chai YM, Huang WH, Zhang Y*

### CASE REPORT

- 11827** Paraneoplastic neurological syndrome caused by cystitis glandularis: A case report and literature review

*Zhao DH, Li QJ*

- 11835** Neck pain and absence of cranial nerve symptom are clues of cervical myelopathy mimicking stroke: Two case reports

*Zhou LL, Zhu SG, Fang Y, Huang SS, Huang JF, Hu ZD, Chen JY, Zhang X, Wang JY*

- 11845** Nine-year survival of a 60-year-old woman with locally advanced pancreatic cancer under repeated open approach radiofrequency ablation: A case report

*Zhang JY, Ding JM, Zhou Y, Jing X*

- 11853** Laparoscopic treatment of inflammatory myofibroblastic tumor in liver: A case report

*Li YY, Zang JF, Zhang C*

- 11861** Survival of a patient who received extracorporeal membrane oxygenation due to postoperative myocardial infarction: A case report

*Wang QQ, Jiang Y, Zhu JG, Zhang LW, Tong HJ, Shen P*

- 11869** Triple hit to the kidney-dual pathological crescentic glomerulonephritis and diffuse proliferative immune complex-mediated glomerulonephritis: A case report

*Ibrahim D, Brodsky SV, Satoskar AA, Biederman L, Maroz N*

- 11877** Successful transcatheter arterial embolization treatment for chest wall haematoma following permanent pacemaker implantation: A case report

*Zheng J, Tu XM, Gao ZY*

- 11882** Brachiocephalic to left brachial vein thrombotic vasculitis accompanying mediastinal pancreatic fistula: A case report  
*Kokubo R, Yunaiyama D, Tajima Y, Kugai N, Okubo M, Saito K, Tsuchiya T, Itoi T*
- 11889** Long survival after immunotherapy plus paclitaxel in advanced intrahepatic cholangiocarcinoma: A case report and review of literature  
*He MY, Yan FF, Cen KL, Shen P*
- 11898** Successful treatment of pulmonary hypertension in a neonate with bronchopulmonary dysplasia: A case report and literature review  
*Li J, Zhao J, Yang XY, Shi J, Liu HT*
- 11908** Idiopathic tenosynovitis of the wrist with multiple rice bodies: A case report and review of literature  
*Tian Y, Zhou HB, Yi K, Wang KJ*
- 11921** Endoscopic resection of bronchial mucoepidermoid carcinoma in a young adult man: A case report and review of literature  
*Ding YM, Wang Q*
- 11929** Blue rubber bleb nevus syndrome complicated with disseminated intravascular coagulation and intestinal obstruction: A case report  
*Zhai JH, Li SX, Jin G, Zhang YY, Zhong WL, Chai YF, Wang BM*
- 11936** Management of symptomatic cervical facet cyst with cervical interlaminar epidural block: A case report  
*Hwang SM, Lee MK, Kim S*
- 11942** Primary squamous cell carcinoma with sarcomatoid differentiation of the kidney associated with ureteral stone obstruction: A case report  
*Liu XH, Zou QM, Cao JD, Wang ZC*
- 11949** Successful live birth following hysteroscopic adhesiolysis under laparoscopic observation for Asherman's syndrome: A case report  
*Kakinuma T, Kakinuma K, Matsuda Y, Ohwada M, Yanagida K*
- 11955** What is responsible for acute myocardial infarction in combination with aplastic anemia? A case report and literature review  
*Zhao YN, Chen WW, Yan XY, Liu K, Liu GH, Yang P*
- 11967** Repeated ventricular bigeminy by trigeminocardiac reflex despite atropine administration during superficial upper lip surgery: A case report  
*Cho SY, Jang BH, Jeon HJ, Kim DJ*
- 11974** Testis and epididymis-unusual sites of metastatic gastric cancer: A case report and review of the literature  
*Ji JJ, Guan FJ, Yao Y, Sun LJ, Zhang GM*
- 11980** t(4;11) translocation in hyperdiploid *de novo* adult acute myeloid leukemia: A case report  
*Zhang MY, Zhao Y, Zhang JH*

- 11987** Sun-burn induced upper limb lymphedema 11 years following breast cancer surgery: A case report  
*Li M, Guo J, Zhao R, Gao JN, Li M, Wang LY*
- 11993** Minimal change disease caused by polycythemia vera: A case report  
*Xu L, Lu LL, Gao JD*
- 12000** Vitreous amyloidosis caused by a Lys55Asn variant in transthyretin: A case report  
*Tan Y, Tao Y, Sheng YJ, Zhang CM*
- 12007** Endoscopic nasal surgery for mucocoele and pyogenic mucocoele of turbinate: Three case reports  
*Sun SJ, Chen AP, Wan YZ, Ji HZ*
- 12015** Transcatheter arterial embolization for traumatic injury to the pharyngeal branch of the ascending pharyngeal artery: Two case reports  
*Yunaiyama D, Takara Y, Kobayashi T, Muraki M, Tanaka T, Okubo M, Saguchi T, Nakai M, Saito K, Tsukahara K, Ishii Y, Homma H*
- 12022** Retroperitoneal leiomyoma located in the broad ligament: A case report  
*Zhang XS, Lin SZ, Liu YJ, Zhou L, Chen QD, Wang WQ, Li JY*
- 12028** Primary testicular neuroendocrine tumor with liver lymph node metastasis: A case report and review of the literature  
*Xiao T, Luo LH, Guo LF, Wang LQ, Feng L*
- 12036** Endodontic treatment of the maxillary first molar with palatal canal variations: A case report and review of literature  
*Chen K, Ran X, Wang Y*
- 12045** Langerhans cell histiocytosis involving only the thymus in an adult: A case report  
*Li YF, Han SH, Qie P, Yin QF, Wang HE*

**LETTER TO THE EDITOR**

- 12052** Heart failure with preserved ejection fraction: A distinct heart failure phenotype?  
*Triposkiadis F, Giamouzis G, Skoularigis J, Xanthopoulos A*
- 12056** Insight into appropriate medication prescribing for elderly in the COVID-19 era  
*Omar AS, Kaddoura R*
- 12059** Commentary on "Gallstone associated celiac trunk thromboembolisms complicated with splenic infarction: A case report"  
*Tokur O, Aydın S, Kantarci M*
- 12062** Omicron targets upper airways in pediatrics, elderly and unvaccinated population  
*Nori W, Ghani Zghair MA*

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## Omicron targets upper airways in pediatrics, elderly and unvaccinated population

Wassan Nori, Muna Abdul Ghani Zghair

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### Abstract

Omicron, a severe acute respiratory syndrome coronavirus-2 variant, has spread around the globe, causing dramatic increases in infection rates. Viral mutant antigens were responsible for the strong infectivity, fast replication, and high reinfection rates reported from all ages. Omicron causes clinical symptoms mostly related to the upper respiratory tract with minimal symptoms from the lower respiratory tract besides an urgent presentation of cases that resembled a fatal illness, epiglottitis. Not to mention the long coronavirus disease 2019, which rises exponentially in the Omicrons era. Apparently, the disease has a less aggressive course than earlier variants with lower death rates; however, the infection is not trivial. Severe infection was raised among pediatrics, unvaccinated, and the elderly. Complete vaccine protection is urgently needed to protect the most vulnerable community members. Additionally, self-protective strategies such as wearing a mask and safe social distancing cannot be omitted.

**Key Words:** Omicron; SARS-CoV-2; Upper respiratory tract; Epiglottitis; Pediatrics; Unvaccinated

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**Core Tip:** Omicron, a severe acute respiratory syndrome coronavirus-2 variant, showed a special predilection for the upper airways. It caused a clinically different scenario, affecting pediatrics as a croup-like syndrome and urgent presentation in adults by causing alarming symptoms that resemble epiglottitis. Exponential Omicron infectivity and spread are higher than an earlier variant, yet it has lower death rates. High-risk groups for having severe forms of infection were the elderly and the unvaccinated population, which reinforces the importance of the vaccine in breaking the disease chain together with self-protective techniques such as masking and safe social separation that cannot be overlooked.

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## TO THE EDITOR

With interest, we read Al-Ani *et al*'s study published in *World J Clin Cases* 2022, which discussed ear, nose, and throat manifestations of coronavirus disease 2019 (COVID-19)[1]. Al-Ani *et al*[1] addressed the emerging virus's point of strength; its ability to mutate to form a new variant. In November 2021, South Africa was the first to identify a new severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) variant (Omicron-B.1.1.529) late in November 2021[2]. New viral variants had different transmission, infectivity, clinical presentation, diagnostic tests, and, last but not least, different resistance to vaccines [1,2].

Omicron variants have multiple mutations, enabling them to spread faster and infect people with naturally gained or vaccine-induced immunity. Fortunately, it causes a less severe mortality rate than earlier variants[3]. Omicron is not a trivial infection; cases that are elderly, immunocompromised, or unvaccinated continue to suffer from a more severe form of the disease[4,5,6]. Furthermore, the potential immunological role of gender and sex hormones has not been entirely ruled out[6,7].

What is unique about Omicron is that it has a particular predilection for the upper respiratory tract, presenting mainly with nasal discharge, sore throat, acute laryngitis, and less olfactory or taste disturbances. Some patients suffered from acute odynophagia, severe sore throat, and fever, a triad that became a typical presentation of the Omicron variant. A rapid examination with laryngoscopy is highly indicated to exclude epiglottitis. The latter is a life-threatening differential diagnosis where inflammatory edema occurs in the upper airways[8].

Omicron in pediatric patients showed a higher incidence of croup syndrome, a serious obstruction of the upper airways at ages less than four years. This implies that the Omicron targets the larynx. Thus, in the Omicron era, upper airway obstruction should be considered among pediatric patients[9].

Brogna *et al*[3] reported a seventy-year-old woman who suffered from a severe chest infection with an Omicron variant owing to pneumonia. The authors discussed how this variant causes concerns in geriatrics.

Chang *et al*[10] assessed the hematological and inflammatory biomarkers that define the severity of COVID-19 in the Omicron infected group *vs* the non-infected.

Omicron cases suffer from lower white blood cells, neutrophils, lymphocytes, eosinophilia, and platelets. Besides a lower lymphocyte multiplied by neutrophil counts (LYM \* NEU) compared to the non-infected group, this reduction was attributed to a depressed immune system by the invading virus. They recommended using the LYM \* NEU count as a reliable early and rapid diagnostic biomarker for Omicron.

Interestingly, C-reactive protein and serum amyloid failed to distinguish confirmed patients showing a non-significant reduction. Likewise, assessing the disease severity by blood oxygen saturation has not been useful in Omicron cases[10].

Regarding the Computed tomography (CT) scan, the Omicron variant showed fewer and less severe changes. Patients had more thickening of the bronchial walls, but the disease was less severe, and they had better hospital outcomes (including admission to critical care or death within 30 d of CT pulmonary angiography) than earlier versions[11].

What makes Omicron more likely to escape vaccine-induced immune protection is that the variant mutations add to the decline in the protection provided by the vaccine. Taken together, the complete vaccine bootstring cannot be overestimated. Patients who were already vaccinated with a booster dose had fewer odds of severe disease, less transmission risk to others, and lower CT changes than unvaccinated patients[5,12].

Lee *et al*[13] discussed that only vaccine schedules with at least one mRNA vaccine and a booster dose would trigger a sufficient neutralization response against Omicron.



Birol *et al*[14] study declared a lower severity of COVID-19 and less likely to need oxygen supplementation among fully vaccinated *vs* unvaccinated pregnant women with Omicron variants.

It is worth mentioning that the vaccine was not licensed for children under four years, which might explain the higher incidence of Omicron among pediatrics and the urgent need for vaccine approval.

In June, 2022. America's Center for Disease Control and Prevention and Canada's National Advisory Committee on Immunization recommended that:

Children aged (6 mo - 4 years) should have two doses of the Pfizer vaccine at 3-8 wk intervals, and children aged (6 mo - 5 years) should take 2 doses of Moderna shots at six weeks intervals[15].

In conclusion, protective vaccine schedules alongside protective measures have changed the face of COVID-19 pandemic[16]. The previous vulnerable group, as pregnant, showed less severe infection post-vaccination. In contrast, pediatrics suffered a higher infection rate with Omicron before licensing vaccines for them. However, Omicron in vaccinated elderly and unvaccinated individuals carries significant morbidity.

Increasing awareness about the importance of vaccinating household members to protect vulnerable groups and self-protective strategies such as wearing masks and safe social distancing cannot be overestimated.

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