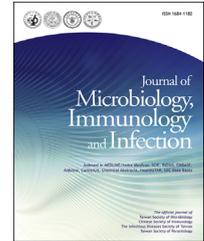




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Short Communication

Anosmia and olfactory tract neuropathy in a case of COVID-19



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Abstract Coronavirus Disease-19 (COVID-19) has been in a global pandemic currently and relating symptoms were reported variously around the world. We reported a previously healthy man of COVID-19 presenting with anosmia as the obvious symptom with relevant radiological findings on brain magnetic resonance imaging.

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In the current pandemic of Coronavirus Disease-19 (COVID-19), it is well known that the patients infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) may be asymptomatic or have diverse manifestations, mainly respiratory tract or flu-like symptoms. The first confirmed case of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection in Taiwan was imported from Wuhan, China on January 21, 2020. More concerns on sense

of smell related to COVID-19 were raised since March, 2020 around the world.¹ We describe the first adult with COVID-19 presenting with recent onset of anosmia in Taiwan, who raised the clinicians' attention to the newly recognized symptom of COVID-19.

Case report

A 21-year-old male without past medical history, presented with five-day of loss of smell without other respiratory tract discomfort or fever. He ever visited a local otolaryngology clinic, but the symptom persisted. Prior to his presentation to the hospital, he had visited Frankfurt, Osnabrück,

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Munster, Berlin, and München of Germany from February 24th to March 07, 2020. Upon his arrival of the quarantine station of the hospital on March 16th, fever up to 38 °C was detected, and chest X-ray (CXR) film showed infiltration over left lower lung near the cardiac apex. Given traveling history and pulmonary infiltration on chest film, he was admitted to the negative-pressure isolation room.

On examination, his oxygen saturation was 99% on ambient air and respiratory rate was 20 breaths per minute. Laboratory examinations showed white blood cell count 6500 per μL (normal 3400–9500 per μL) and lymphocyte count 1554 per μL . The patient received oral oseltamivir and gemifloxacin as empirical therapy for influenza and community-acquired pneumonia. COVID-19 was diagnosed by real-time reverse transcription polymerase chain reaction (RT-PCR) testing that detected SARS-CoV-2 from nasopharyngeal swab. Hydroxychloroquine (200 mg twice per day) was prescribed for seven days (from March 22nd to 29th, 2020), as shown in Table 1. He could smell the food (such as banana and oranges) and the cleansing detergent since March 22nd, 2020 (12 days after the onset of anosmia). Since March 28th, 2020, the RT-PCR test for SARS-CoV-2 was negative in four consecutive nasopharyngeal swabs. He was discharged after 23-day of hospitalization with partial recovery of sense of smell. At the day of discharge, brain magnetic resonance imaging (MRI) was done. The coronal 3D turbo spin echo MRI image disclosed smaller right olfactory bulb (Fig. 1A) and coronary T2-weighted MRI image with fat suppression revealed linear hyperintensities inside bilateral olfactory nerves (Fig. 1B), suggestive of bilateral olfactory neuropathy.

SARS-CoV-2 serology

We retrospectively tested this patient's serum for SARS-CoV IgG/IgM using 2019-nCoV IgG/IgM Rapid Test Cassette (Dynamiker Biotechnology Co., Ltd, Tianjin, China). Tests for serum SARS CoV-2 antibody on March 17 and March 20 showed negative results. The test from serum on March 23

started to show weak positive (13 days after the onset of anosmia), which was also compatible with the date of symptoms in recovery, as shown in Table 1. The following test from serum on April 4th revealed both positive results for IgG and IgM.

Discussion

Currently, the clinical symptoms and signs of COVID-19 were increasingly recognized and have been adapted to diagnostic criteria in many countries.^{2–4} However, in mid-March of 2020, as this case complained such “unusual” symptom and recalled no symptoms of upper respiratory tract infection, the diagnostic RT-PCR was conducted based on his traveling history and pulmonary infiltration on his CXR film. Afterwards, increasing cases of COVID-19 were noted to have anosmia, ageusia, or both in Taiwan, and the reporting criteria of COVID-19 were adopted to include anosmia and ageusia by the Center of Disease Control of Taiwan on March 30, 2020. In a recent multicenter study in Europe,⁵ as high as 85.6% and 88.0% of mild-to-moderate COVID-19 patients reported olfactory and gustatory dysfunction, respectively, if active surveillance was conducted.

The pathogenesis of anosmia and ageusia in the cases of COVID-19 was not well studied. Previous studies reported that decreased volume of the olfactory bulb in the patients with postinfectious olfactory loss might be related to the symptoms severity and the duration of olfactory loss.⁶ A patient with COVID-19 in Paris, France experienced acute loss of olfactory function without nasal obstruction, and was found to have bilateral inflammatory obstruction of olfactory clefts of nasal cavity on computed tomography and MRI.⁷ However, the anomalies of the olfactory bulbs and tracts, which were present in our case, were absent in the French's case. In addition to the radiological findings in central nervous system, the recently recognized olfactory receptor family on human airway smooth muscle cells, which are

Table 1 Clinical course, laboratory findings, and antimicrobial treatment in the case of COVID-19.

| | March | | | | | | | | | | | | | April | | | | | | | | | | | | | | |
|--|-------|----|----|----|----|-------|----|----|----|----|----|----|-------|-------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Hospital day | | | | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| RT-PCR testing of SARS-CoV-2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nasopharyngeal swab | | | | | | + | | | | | + | | - | - | | + | - | | - | - | - | | - | | | | | |
| SARS-CoV-IgM | | | | | | | - | | | | - | | + | | | | | | | | | | | | | | | + |
| SARS-CoV-IgG | | | | | | | - | | | | - | | + | | | | | | | | | | | | | | | + |
| Blood leukocyte count (μL) | | | | | | 6,500 | | | | | | | 6,200 | | | | | | | | | | | | | | | |
| Blood lymphocyte count (μL) | | | | | | 1,554 | | | | | | | 1,587 | | | | | | | | | | | | | | | |
| Symptoms/signs | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anosmia | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rhinorrhea | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oseltamivir | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gemifloxacin | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hydroxychloroquine | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mecobalamin | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

↓Sense of smell started to be improving

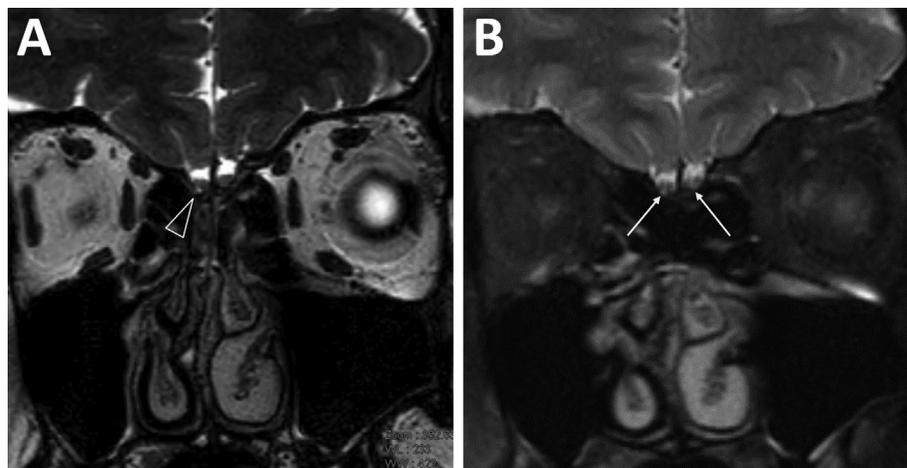


Figure 1. Magnetic resonance imaging of brain at 28 days after the onset of anosmia as the manifestation of COVID-19. The coronal 3D turbo spin echo image disclosed smaller right olfactory bulb (1A, hallow white arrowhead) and coronal 1 mm slice thickness T2-weighted MRI image with fat suppression revealed linear hyperintensities inside bilateral olfactory nerves (1B, white arrows), indicative of bilateral olfactory neuropathy.

impaired by the virus, may play a role of the development of anosmia.⁸ Meanwhile, SARS-CoV-2 belongs to genera Betacoronavirus, same as severe acute respiratory syndrome coronavirus (SARS-CoV) in 2003, which has been reported to cause olfactory neuropathy.⁹ Both virus have many similarities and also have differences in their genomic and phenotypic structure as well.¹⁰ The pathogenesis of SARS-CoV might be possibly applied to study current SARS-CoV-2 in terms of anosmia and ageusia.

A recent survey from China showed that the antibodies against SARS-CoV-2 could be detected in the middle and later stage of the disease.¹¹ The seropositivities of serum IgM and IgG were notably detected from the 9th day and 11th day after symptoms onset, respectively.¹¹ Hence, while real-time PCR assays from respiratory tract specimens currently remain the standard diagnostic tool for COVID-19, the serological testing could be able to serve as a supplemental tool and both testing results should be interpreted simultaneously to provide thorough disease course of COVID-19.¹² Besides, in our patient, we found his recovery from the symptoms consistent with the appearance of serum antibodies to SARS-CoV-2. The similar disease course could also be seen on a previously reported patient, who developed SARS-CoV-2 IgG right after her symptoms resolved.¹³

In conclusion, we reported a previously healthy man of COVID-19 presenting with anosmia as the obvious symptom with possibly relevant radiological findings on brain MRI. With viral clearance in nasopharyngeal swabs, anosmia partially improved. Clinical features and pathogenesis of anosmia and ageusia warrant more studies.

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Declaration of Competing Interest

The author declares no conflicts of interest.

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