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economic effect of COVID-19 in the community is significant. The most recent Bureau of Labor reports reveal 4.4% unemployment from recent exponential increases.<sup>7</sup>

We request that healthcare leaders consider socioeconomic and other disparities that are being magnified by the pandemic as they attempt to reinstate their practices. It will be imperative to implement individualized screening strategies, rather than a one-size-fits-all protocol, to ensure that we do not have a negative impact on our vulnerable patients who have the highest need for our services.

## DISCLOSURE

*Dr Guba is a consultant for Medtronic. Dr Thosani is a consultant for Boston Scientific, Pentax America, and Medtronic; the recipient of royalties from Uptodate, and a speaker for Abbvie. The other authors disclosed no financial relationships.*

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## Response:



We thank Dr Badillo and colleagues<sup>1</sup> for their interest in our article.<sup>2</sup> The application of polymerase chain reaction (PCR) testing can be significantly limited by the geographic and socioeconomic conditions of each

community. Our model was initially designed for a single institution and then extrapolated to endoscopy needs in the United States. Assuming that all patients waiting for an endoscopy in the United States will have similar healthcare access is an oversimplification of our complex healthcare system.

To prevent infections between testing and endoscopy, we are requesting the nasal swab to be performed within 48 hours before the procedure. In rural and semirural areas, distance to a testing center may require 2 long trips. In our institution these have resulted in delays and have prevented a small number of candidates from completing their endoscopies. This impact is mitigated if the PCR test can be performed at the same time as other standard diagnostic and preprocedure laboratory tests 1 to 2 days before endoscopy. This will be further mitigated once point-of-care testing with rapid ( $\leq 1$ -2 hours) is widely available and thus performed at the same session as endoscopy. Insurance coverage and funding is another concern for this and for all hospital-based measures. Even though Medicare announced that it will cover COVID-19 testing at no cost, specific requirements on clinical indications for the test may be added later (not covering asymptomatic individuals, as we propose).<sup>3</sup> Overall, we agree that PCR testing is not a one-size-fits-all intervention but rather an additional piece of the roadmap to reopen endoscopy services, as described in Table 5 of our article.<sup>2</sup>

Broad policies like social distancing, face masks, and sanitation can minimize disparities in healthcare. Policies that require encounters with a healthcare provider (like PCR testing) will need multisectorial efforts involving public health officials, administrators, and policy makers to be implemented at a national scale.

## DISCLOSURE

*Dr Corral is the recipient of a travel grant from Abbvie and of minor food and beverages from Boston Scientific and Cook Medical. Dr Wallace is a consultant for Virgo, Cosmo, Anx Robotica, Covidien/Medtronic, and GI Supply; the recipient of research grants from Fujifilm, Boston Scientific, Olympus, Ninepoint, and Cosmo/Aries; a holder of stock options in Virgo; and the recipient of minor food and beverages from Synergy, Boston Scientific, and Cook Medical.*

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## Endoscopy training during COVID-19



To the Editor:

Diagnostic and therapeutic procedures are among the core aspects of gastroenterology. We acknowledge that during the COVID-19 pandemic there have been diminished procedural volumes, as highlighted by the American Society for Gastrointestinal Endoscopy.<sup>1</sup> As trainees in gastroenterology we would like to advocate for our training by proposing solutions to this challenge.

First, hands-on procedures can be supplemented by the use of simulation endoscopy-based systems. Simulators are widely available and are often not used to their full potential. Simulation offers multiple advantages during times when traditional training cannot take place in the endoscopy unit. It is a tool for objective evaluation of competency,<sup>2</sup> which is of paramount importance for trainees who will be starting independent practice soon. It also allows for tailoring and continued proficiency for diagnostic and therapeutic purposes.

During the COVID-19 pandemic, telemedicine has been extensively used for ambulatory practice. In light of its potential benefits, incorporation of tele-endoscopy should be considered to account for reduced endoscopy volumes. Tele-endoscopy would involve real-time display of procedures as they are being performed by attendings, during which trainees observe these cases. Examples could include hemostasis for GI bleeding and complex endoscopic resection of lesions. Tele-endoscopy could also allow for real-time–based discussions, so trainees gain continued competence in decision making. From the patients' perspective, tele-endoscopy allows for a “second look” to take place to ensure that no lesions have been missed and hence provides further reassurance that the endoscopic examination has been done optimally.

COVID-19 has posed a significant challenge to endoscopic training. However, where there is a challenge there is also an opportunity. We hope that recognizing the training limitations we currently see will provide an impetus for alternative and improved training solutions.

## DISCLOSURE

*All authors disclosed no financial relationships.*

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## Patient anxiety and role of patient education during coronavirus disease 2019 epidemic



To the Editor:

We read with great interest the article by Hennessy et al<sup>1</sup> presenting recommendations for endoscopy centers on how to work during the COVID-19 epidemic. However, we suggest that this guideline could add a section about patient education to reduce patients' anxiety about COVID-19. This suggestion is based on a previous investigation by us.

A total of 222 patients who came to the gastroenterology clinic in our hospital were randomly divided into 2 groups and were asked to fill out our questionnaire from April 6, 2020, to April 30, 2020. Eighty-eight patients, who received and read a manual with basic knowledge about COVID-19 and prevention measures of the endoscopy center, were defined as the education group (EG). Another 134 patients without the manual were defined as the control group (CG). Our questionnaire was divided into 3 parts: demographic information, worries and willingness about undergoing endoscopy, and the Impact of Event Scale–Revised.<sup>2</sup> A preliminary survey was conducted; the overall Cronbach's  $\alpha$  of the second part was 0.819, and the construct reliability was 0.919.

We found that 48.51% of CG patients were worried or strongly worried about being infected by endoscopy, whereas the proportion reduced into 34.09% after reading the manual ( $P = .027$ ). Besides, only 38.81% of the CG patients were willing to undergo endoscopy during the epidemic, whereas after patient education, the proportion increased into 56.82% ( $P = .035$ ). The details of the investigation results can be seen in [Table 1](#).