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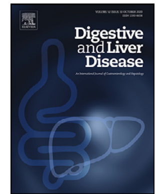
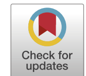


Correspondence

How endoscopy centers prepare to reopen after the acute COVID-19 pandemic interruption of activity



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1. Letter to the Editor

During the recent outbreak of COV-SARS 2 infection, most hospitals in Italy as well as in almost every country of the world have been forced to reallocate their resources to cope with the huge flow of patients in need of hospitalization and even intensive care for respiratory symptoms.

In this context, gastroenterology departments and endoscopy centers have significantly reduced their activity.

In a recent survey Repici et al. [1] documented that, following the COVID-19 epidemic, 39 out of 41 endoscopy units (EUs) in northern Italy (95.1%) continued to perform urgent procedures, while the same proportion warranted examinations to hospitalized patients, 28 EUs (68.3%) kept scheduling colorectal cancer screening colonoscopies (FIT+), 9 EUs (22.0%) ensured endoscopic therapeutic procedures, and 7 (17.1%) maintained all kind of endoscopic activities. In quantitative terms, this corresponded to a 75–99% reduction in activity in 28% of endoscopic units, and to a 50–75% reduction in 9% of units, with only a single unit maintaining its workload unchanged. Finally, most EUs limited their activity to urgent cases, including patients at high-risk of cancer, such as FIT+.

As a result, a formerly planned endoscopic procedure has been postponed or canceled for a large number of patients; the burden of this unmet demand will affect the booking lists as soon as hospitals resume their usual activities. Elective endoscopy activity must be restored for many reasons: first of all, with the mitigation measures that many countries have adopted, the duration of the pandemic is expected to increase by at least six months, leveling the incidence curve and making the prolonged deferral of elective procedures unsustainable [2]; in addition, routine endoscopy has a huge economic and health impact. In the United States alone, a hypothetical suspension of elective endoscopy for 6 months is expected to lead to the delayed diagnosis of over 2800 colorectal cancers and 22,000 high-grade adenomatous polyps with malignant potential [3]. The 6-month mortality rate for those who would eventually be diagnosed with colorectal cancer would increase by 6.5% [4].

The problem is how to restart elective endoscopy and how to reschedule the examinations that have been postponed. Inherently, as the COVID-19 epidemic is likely to persist, we should possibly reconsider the current indications for endoscopy, as only a revision of the indications could allow for a workload that must necessarily be significantly reduced, due to social distancing and other restrictive measures to be continued in the near future.

We would like to report a survey among 10 endoscopy centers in Northern Italy that had already participated in another study [5], related to patients' decision to undergo or cancel endoscopic procedures planned during the coronavirus epidemic, even if prescribed as relatively urgent by their General Practitioners. The purpose of the present survey was to ascertain whether endoscopic examinations, previously booked for the period of interruption of endoscopic activity, would simply be canceled or postponed and, if so, on what policy (i.e. based on a clinical decision, with a medical review of indications and priorities, or simply on an administrative one).

To gather information, we prepared a simple questionnaire which asked three simple questions relating to the interval between March 9 and April 30:

1) number of upper and lower endoscopies planned but not performed, due to the interruption of the activity connected to the global reorganizations of COVID-19 hospitals, precluding the performance of routine endoscopy;
2) policy adopted to "recover" these patients, if any;

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[1] See Appendix for the list of members in the Fast Track Endoscopy Study Group.

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3) percentage of rescheduled patients who agreed to undergo the procedure.

We collected data from 3079 patients regarding 1417 upper endoscopies and 1662 colonoscopies. In most centers, no reprogramming policy was adopted, and endoscopy units were given indications that all previously booked procedures should simply be rebooked by patients. In 6 EUs only, patients were contacted directly by the medical staff and asked if they wanted to reschedule the procedure or, conversely, if they wanted it canceled. Rescheduling was chosen by 27.5% to 85% of patients, cancelation by 10% to 57.5% of cases, the figures highlighting impressive differences among the participating EUs.

Patients who agreed to reassign the procedure were informed that the date could be adjusted according to a priority based on the indications and severity of the potential condition. In the remaining 5 EUs, patients were contacted by administrative staff and informed that the procedure would be automatically rescheduled, without any triage.

We do not know what corresponding percentage of patients contacted by administrative staff accepted or refused to undergo the endoscopic examination.

Globally, the burden of searching for a new appointment has been left to the citizen despite the fact that the choice not to provide endoscopic examinations during the COVID-19 peak was made by hospitals and health authorities in the two Italian regions, and not by the citizens.

The ongoing COVID-19 epidemic has been the cause not only of deaths, serious illnesses of previously healthy people and severe stress for hospitals and doctors, but it will likely have long-lasting negative consequences for people's health.

In order to safe reopening of EU, the AGA therefore suggested implementing a triage system, and all procedures to be reallocated should be reviewed by qualified medical personnel and classified as time sensitive or non-time sensitive by adopting a suggested framework [6]. However, we should understand that the COVID-19 epidemic is not close to extinguish but will remain with us for the foreseeable future (at least six months).

We must therefore resume routine (i.e. elective) outpatient endoscopy and we must recognize that the volume of endoscopic outpatient procedures will decrease compared to the past, due to persistent limitations (social distance and other practical measures that limit contact between people, to prevent spread of SARS-CoV2 infection). It means that we must actually make a significant selection of deferrable or non-deferrable endoscopic procedures, and this can only be done by experienced gastroenterologists.

Here we appeal to our health authorities to understand that COVID-19 does represent a great challenge, but it also offers an opportunity to try to reduce inadequacy in endoscopy, which has so far been a major global concern: for example, it is estimated that 56% of upper gastrointestinal endoscopy diagnostic procedures are considered inappropriate, i.e. not according to guidelines [7–10].

Conflicts of interest

None.

Appendix. Members of the Fast Track Endoscopy Study Group

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