Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

etiología inflamatoria-infecciosa se refiere, destacan la endometriosis y la enfermedad inflamatoria pélvica en mujeres[1,4], la enfermedad diverticular (particularmente de intestino delgado), la enfermedad de Crohn y la tuberculosis abdominal en zonas endémicas. La radioterapia abdominopélvica en el tratamiento de neoplasias ginecológicas, prostáticas, rectales o linfoproliferativas también puede generar adherencias, cuya severidad depende de la extensión del área tratada, el grado de fraccionamiento de la dosis y la dosis total de radiación[4]. Además, en autopsias de pacientes sin cirugía abdominal previa, se han detectado adherencias postinflamatorias hasta en el 28% de los casos[2]. En el caso presentado se realizaron una colonoscopia y una gastroscopia para descartar enfermedad inflamatoria intestinal, así como la prueba de la tuberculina para descartar exposición previa al bacilo de la tuberculosis, siendo los resultados negativos. Todas las demás causas fueron descartadas debido al sexo del paciente, a los antecedentes personales y al examen histopatológico del intestino resecado.

Por otro lado, las bridas congénitas se forman durante el desarrollo embrionario[2] y son una causa extremadamente infrecuente de obstrucción intestinal en adultos[5]. Se localizan con más frecuencia entre el íleon terminal o su mesenterio y el colon ascendente, el ligamento de Treitz, el lóbulo hepático derecho o la vejiga. En la mayoría de casos se componen de tejido conectivo que contiene vasos y nervios[5]. En el caso presentado, se excluyó la etiología congénita debido a la edad del paciente, a que las bridas eran múltiples, no contenían vasos sanguíneos ni nervios, y no se situaban en las localizaciones típicas descritas anteriormente.

Descartada cualquier etiología adquirida o congénita de las adherencias, se atribuyó un origen idiopático. En conclusión, la presencia de bridas idiopáticas debería tenerse en cuenta en el diagnóstico diferencial de la obstrucción intestinal en pacientes sin cirugía abdominal previa, sobre todo en los que no se demuestra ninguna lesión responsable en las pruebas radiológicas.

Conflicto de intereses

Declaramos que no existen aspectos de financiación o de cualquier otro tipo que puedan llevar a un conflicto de intereses.

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Endoscopy activity in a covid-19 high-risk area (Barcelona): Moving forward (or backwards) according to the necessary resources available

Reinicio de la actividad endoscópica en un área de alto riesgo de covid-19 (Barcelona): progresión (o regresión) según los recursos necesarios disponibles endoscopy

Dear Editor:

Endoscopy activity has been dramatically reduced to minimum due to COVID-19 outbreak consequences. Endoscopy Units are experiencing shortages in staff, personal protective equipment (PPE), medical equipment as respiratory ventilators and monitors, beds or even physical space. Moreover, cleaning rooms have gained a new role of PPE (i.e. goggles, or face shield) disinfection from different hospital areas. For this reason, it is convenient to be prepared on how to resume non-urgent and non-delayable endoscopy activity and adapt to the natural evolution of pandemic.

We recommend to progress to an adapted activity in a three-phase system.

For that, some minimum requirements are necessary to move forward on endoscopy activity, grouped in 3 basic needs: Workforce trained in endoscopic procedures, PPE availability and testing capacity for COVID-19 [Fig. 1]. The movement between the phases could be bidirectional depending on pandemic situation. So, the phases will be dynamic returning to a previous phase or progressing to an advanced phase.

With only one team available in the unit, it will be very risky planning to do semi-urgent endoscopy on a regular basis, considering the quarantine likelihood if health care workers get infected. On the other hand, to start assuming

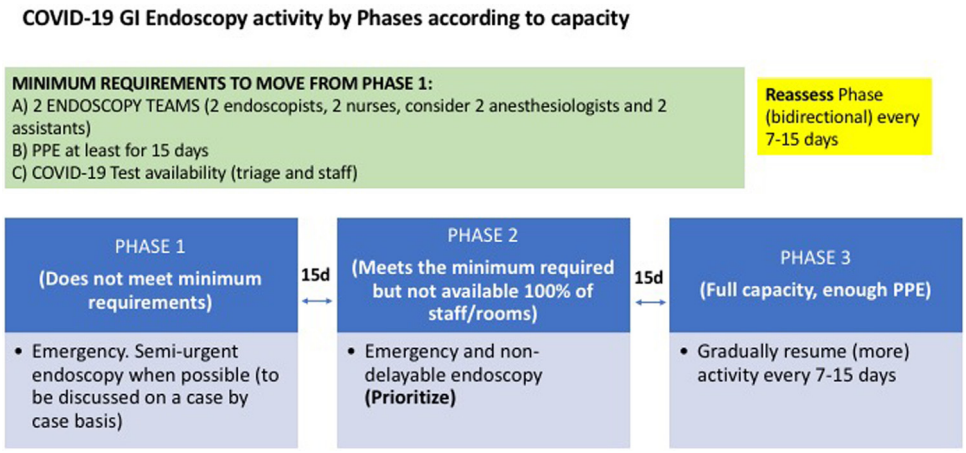

Figure 1 Dynamic phases of endoscopy activity in a high-risk area during covid-19 pandemic according to workforce, PPE availability and screening test capacity.

more schedule of procedures, it is necessary to expand the number of rooms depending on the capacity of the endoscopy unit. This may imply bringing personnel back from COVID-19 tasks.

Additionally, we are suffering shortages in PPE availability. PPEs are necessary for the COVID-19 era,[1–3] and they should be used for every gastrointestinal endoscopy specially in high-risk areas. As its availability for a long time may be difficult to predict, we suggest that supplies should be guaranteed for at least 2 weeks before resuming more activity.

Another concern is the screening of staff and patients. Testing capacity is not widely available right now, but it is recommended to test healthcare workers and patients. As circuits may differ on COVID-19 status, testing might be necessary to detect asymptomatic positive cases and prevent patient-to-patient, staff-to-staff, patient-to-staff and staff-to-patient transmission, taking into account the possible false positives and false negatives due to the variability of the tests.

Once those minimum requirements are met, we could move forward to a second phase, doing priority endoscopic procedures on a regular basis according to a case-by-case management and high/low priority as it has been recommended by ESGE,[1] SEED, SEPD, AEG[4,5] and other societies. Depending on the pandemic evolution, the adaptation of endoscopy staff to second phase, and the endoscopy unit is reaching a full capacity with enough PPE, it will be possible to gradually assume more activity.

Because epidemiology and sociopolitical measures are continuously changing, we should reassess every 1 or 2 weeks (suspected incubation period[6]) our local status. And we should be prepared to move not only forward but backwards when needed.

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