

bleeding. We had concentrated on gastrointestinal bleeding with marginal ulcer because the patient showed only hematemesis without a sign of intra-abdominal hemorrhage. However, hemobilia was progressed into gastrointestinal tract because hemorrhage could easily go to the hepaticojunostomy site and go upward to the stomach (Fig. 1d). It became a painful lesson to us and every surgeon. In conclusion, the possibility of hemorrhage on unusual site including nonsurgical causes should be kept in mind after PPPD.

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For Disclosures, see page XXX.

## Conflicts of interest

There is no conflict of interest.

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## COVID-19 and celiac disease – concerns to be addressed

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Coronavirus disease 2019 (COVID-19) was initially reported in China but rapidly spread around the world and caused a serious threat to global public health [1]. In face of the current situation, the celiac community raised a lot of concerns regarding celiac disease (CD) susceptibility and risk for severe COVID-19. Hence, we aimed to briefly review the impact of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection in celiac patients.

CD is an autoimmune disorder that affects the small bowel in genetically predisposed individuals precipitated

by the ingestion of gluten [2]. Celiac patients, in general, are not considered to be immunocompromised. Indeed, the immune system of those under a strict gluten-free diet and with controlled disease is similar to the rest of the population. However, the small proportion of patients with refractory CD are usually under immunosuppressive or ablative treatments, which makes them more susceptible to a wide range of infections.

Hyposplenism or functional asplenia in association with CD may result in impaired immunity to encapsulated bacteria. In fact, it has been reported an increased risk of severe diseases due to pneumococcal bacteria [2]. Celiac patients are also predisposed to a number of other infections such as influenza and *Clostridium difficile*. Most CD-related organizations encourage vaccination for *Streptococcus pneumoniae* during the pandemic because of the risk of co-infection in COVID-19 [3].

CD is often associated with other autoimmune diseases, such as thyroid disorders, rheumatoid arthritis and type 1 diabetes mellitus [2]. This last one has particular importance since mortality seems to be threefold higher in people with diabetes compared with the general mortality of COVID-19 [4]. Moreover, while there have not been many studies looking at respiratory complications of COVID-19 in patients with autoimmune diseases or in those under immunosuppressive therapy, there have already been case reports of other types of coronaviruses causing pneumonia in immunocompromised individuals.

Handwashing is one of the best ways to reduce spread of coronaviruses. The Centers for Disease Control recommends hand hygiene with soap and water or, alternatively, hand sanitizer with at least 60% alcohol [5]. There is a constant concern in the celiac population to inadvertently ingest gluten after using a cleaning product. Gluten cannot be absorbed by the skin and the basic active ingredients in an alcohol-based hand sanitizer do not contain gluten. Nevertheless, some disinfectants may contain ingredients derived from gluten, such as wheat germ oil. Thereby, it is recommended careful reading of the label, as with all other products.

There have been no studies suggesting severe illness from COVID19 in patients with CD, however, there is still little experience of SARS-CoV-2 infection in celiac patients. It is suggested to keep close surveillance of these patients and encourage control of their disease, as well as take preventive measures against COVID-19.

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Guarantor of the article: I.G. I.G. drafted the manuscript. All authors have critically revised and finalized the manuscript. All authors have approved the final version of the manuscript.

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## Is emergency endoscopic retrograde cholangiopancreatography safe in COVID-19 pandemic?

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Coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus-2 is now a pandemic worldwide and clinicians have many questions about the safety of interventional procedures, even in an emergency [1]. Here, we will present an endoscopic retrograde cholangiopancreatography (ERCP) case safely performed in emergency situations in a case known to be COVID-19 positive. An 81-year-old male patient was admitted to the emergency department with right upper quadrant pain, jaundice and fever of the last 2 days. In his evaluation, obstructive jaundice due to cholelithiasis and cholangitis was determined. ERCP was performed by duodenoscope (Olympus, TJF-150) with needle-knife sphincterotomy (Microtech) and precut. The procedure was completed without acute complications, after ERCP his bilirubin levels and complaints improved. On the fourth day of ERCP, he had an acute coronary syndrome, coronary angiography was performed and a coronary stent was inserted. Due to stent insertion, 600 mg clopidogrel, 300 mg acetylsalicylic acid, and 6000 IU enoxaparin were given to the patient. On the fifth day of ERCP, he had melena, with a 2 g/dl decrease in hemoglobin levels. Because he was having a 38.5°C of fever and cough, COVID-19 rapid blood test (OVIOS<sup>®</sup>) determining the serology of Corona virus-19 was performed which was positive. We performed ERCP again, with maximum protection using appropriate equipment (Fig. 1). On the sphincterotomy line, there were blood clots and they were cleaned with serum physiologic. Coagulation was achieved with the tapered tip sphincterotome (Microtech), choledoch was selectively cannulated, and 10F 10 cm plastic stent (10F, 10 cm; Microtech) was inserted. Two hemoclips (Sureclip, MicroTech) were inserted, and at the end of the procedure, there was no bleeding. After ERCP, because COVID-19 rapid blood test was positive, the real-time PCR



Fig. 1. Maximum protection before the procedure.

test for nucleic acid determination in respiratory samples for COVID-19 was sent to the laboratory which was positive and thorax computerized tomography was performed which revealed bilateral ground-glass opacities in basal parts of the lungs. Instantly, COVID-19 treatment including hydroxychloroquine (2 × 400 mg loading and 2 × 200 mg maintenance) and azithromycin (1 × 500 mg loading and 1 × 250 mg maintenance) started [2]. On follow-ups, his hemoglobin levels did not decrease and his vital signs were stable. After 7 days of treatment for Coronavirus-19 in ICU, his real-time PCR test for nucleic acid determination in respiratory samples (NCOV-19) was negative and he was discharged. Due to the contact history, rapid test results and PCR in healthcare workers in this team were negative, and no COVID symptom was observed during the 14-day follow-up. In conclusion, if adequate precautions are taken, emergency ERCP procedures can be performed safely without any harm to the healthcare workers and patients.

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## Conflicts of interest

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