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EDITORIAL

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COVID-19 in gastroenterology and hepatology: Where will we be?

In a review article on COVID-19 in gastrointestinal disease, Magro et al. discussed the main aspects of the practice of gastroenterology and hepatology impacted by the ongoing COVID-19 pandemic.[1] The authors summarized the gastrointestinal manifestations of COVID-19, the consequences for patients requiring immunosuppressive therapy, and subsequent vaccine strategies for these patients. Moreover, the decreased availability of endoscopy resources, digitalization of patient contact, and threatened education of gastroenterology trainees are discussed in detail. It is clear that the practice of our profession has changed and that we will face unique challenges the upcoming years when we recover from this pandemic. The question remains how we are going to cope with these changes and how practice will adapt to handle the challenges ahead.

First, it will be essential to realize the true repercussion on the prognosis of patients who were exposed to a postponed diagnostic evaluation and subsequent delay of initiating treatment due to the COVID-19 pandemic and related measures. Illustrative is the Dutch experience demonstrating a significant decline in the absolute number of gastrointestinal cancers detected during endoscopy in 2020.[2] Next to postponing or cancelling elective endoscopy, a decrease in patient referrals and temporary pause of the colorectal cancer screening program were suggested to be responsible for this decrease. It is expected that the consequence of the COVID-19-induced delay in diagnosis and treatment of gastrointestinal cancers will result in considerable loss of life-years and additional deaths.[3] Not only do we need to consider the time it will take to resolve the backlog of patients awaiting endoscopic evaluation, but also a potential increase in demand of patients that have awaited consulting their general practitioner for their complaints, and subsequently delayed their referral to a gastroenterologist. This increase in patients will increase the workload for the upcoming years even more, the so-called post-COVID recovery wave. Therefore, initiatives to improve patient selection for endoscopy will become even more imperative to solve the disequilibrium between supply or "capacity to serve" (available endoscopy resources) and demand (patients referred for endoscopy). Additionally, It has also crystallized that endoscopy is often overused, illustrated by a prospective study from Portugal which found that only 62% of patients had an appropriate indication for esophagogastroduodenoscopy.[4] A potential solution is the use of web-based patient education, which has shown to be an effective tool to decrease the need for esophagogastroduodenoscopy in uninvestigated dyspepsia.[5]

Second, who is going to diagnose and treat these patients when the COVID-19 pandemic has subsided? For example, we see that in the United Kingdom gastroenterology trainees reported a significant decrease in exposure to endoscopy procedures.[6] It is hypothesized that the effects of reduced training, and as a result reduced certification, will be expected to persist until the year 2022.[6] Equally, a survey amongst gastroenterology fellows in the United States showed that one-third of fellows were redirected to non-gastroenterology services during the pandemic and COVID-19 impacted all aspects of their training.[7] Endoscopy is a hands-on specialty, which cannot be compensated by the concept of home-office. Thus, initiatives amongst trainees to combat these challenges and create opportunities out of the challenges (ahead) are of great value.[8] Hence, as the influx of patients will increase in the upcoming years, we must prevent a decrease in the available number of well-trained gastroenterologists. This places us in a clinical conundrum, as training residents requires commitment, allocated time and guidance by trained professionals, who are needed more than ever to fulfill their clinical duties to mitigate the post-COVID wave waiting lists. This mandates innovative planning and management of available resources by healthcare policy makers and practice administrators. We also believe that a renewed focus on using simulators for hands-on training is now more pressing than ever.

Ultimately, to combat the challenges ahead we need to answer the "simple" question "why do we do things the way we do?" The COVID-19 pandemic showed us there is a great potential to optimize our communication with patients (telemedicine) and peers (digital conferences/meetings), to improve hygienic standards in our endoscopy units, to increase efficacy of triage when faced with limited endoscopy services and to improve international interdisciplinary collaborations (e.g., SECURE-IBD and COVID-Hep registries).[9,10] Time will tell if the changes made to our clinical practice will hold when restrictive measures are released. Ultimately, the weight of responsibility lies with us, because in the long run it is us professionals who need to derive full benefit from the lessons learned to ensure the best possible patient outcomes.

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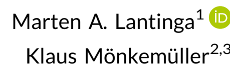
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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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