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established clinical prediction scores that identify critically ill patients at the greatest risk for death, such as the Acute Physiologic Assessment and Chronic Health Evaluation or the Simplified Acute Physiology Score. These scores are based on readily available clinical data and do not require stool samples.

In sum, our study found that the presence of gastrointestinal symptoms (diarrhea with or without nausea/vomiting) predicted a positive test for SARS-CoV-2 among patients with respiratory symptoms at the height of the COVID-19 pandemic. At this time, we do not believe that there is a diagnostic or prognostic role for stool-based testing among patients with known or suspected COVID-19.

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References

1. Nobel YR, et al. *Gastroenterology* 2020;159(1):373–375 e372.
2. Sultan S, et al. *Gastroenterology* 2020;159(1):320–334 e327.
3. Zhao Y, Cao Y, Wang S, Cai K, Xu K. COVID-19 and gastrointestinal symptoms. *Br J Surg* 2020. Online ahead of print.
4. Han C, et al. *Am J Gastroenterol* 2020;115:916–923.
5. Granville LA, et al. *J Clin Microbiol* 2004;42:1254–1256.
6. Gupta A, et al. *JAMA Intern Med* 2018;178:1155–1156.
7. Ashraf H, et al. *Digestion* 2007;76:256–261.

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 Most current article

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Striving to Protect Patients and Health Care Professionals in Endoscopy Units During Pandemics: From SARS to COVID-19



Dear Editors:

We would like to begin by commending Professor Repici and all Italian health care professionals for their hard-fought efforts in curbing the rise of coronavirus disease-2019 (COVID-19). In their article entitled “Endoscopy units and

the COVID-19 Outbreak: A Multi-Center Experience from Italy,”¹ we get a glimpse of real-world data from 41 endoscopy units in a part of the world that was heavily afflicted by the novel coronavirus.

Despite the surge of COVID-19 cases causing a huge burden to health care systems worldwide, it is reassuring that policies to enhance patient safety, avoid nosocomial outbreaks, and ensure rational use of personal protective equipment² can protect patients and health care professionals alike. All but 1 surveyed endoscopy unit decreased their normal endoscopy activity owing to COVID-19 and 70% of units adopted a triage for risk stratification. Urgent endoscopies were still being performed confirming that emergency services were not hampered even at the height of the pandemic, although it would be informative if the authors could elaborate more on the procedure types. In Italy, only 6 of 968 (0.006%) endoscopy health care professionals required hospitalization for severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) in the units surveyed, and none of these were attributable to endoscopy performed in COVID-19–positive patients. These numbers are even more remarkable given that 22% of these units performed procedures on COVID-19–positive patients with only surgical masks.

Despite these heartening results, there are several points we would like to highlight. First, we find the minimal number of endoscopy units prohibiting the accompaniment of caregivers slightly concerning. In Hong Kong, our public health authority has activated the Emergency Response Level since January 25, 2020; among other measures, this provision suspends visiting in all public hospitals except on compassionate grounds to mitigate the risk of cross-infection. Exceptions should be made only for patients who require specific assistance and translation services.³ It would be interesting to know the reasons behind such a low uptake for this measure in Italy. Second, the intention to follow-up patients after endoscopy seems difficult to implement in actual practice, with only one-quarter of endoscopy units doing so for suspected cases and only 1 unit doing so for asymptomatic patients. Third, approximately 70% of units were still performing screening colonoscopy for fecal immunochemical test positive patients. This issue is contentious, with the American Gastroenterological Association⁴ and European Society of Gastrointestinal Endoscopy/European Society of Gastroenterology and Endoscopy Nurses and Associates⁵ statements differing somewhat, with the former providing evidence to support a delay of ≤ 6 months and the latter opting for an individualized risk stratification that considers the risk of COVID-19 infection and disease-related mortality and/or morbidity. When our unit became the epicenter of the SARS outbreak back in 2003, all elective endoscopy was essentially stopped. Based on our prior experience, we now limit endoscopy only to potentially life-threatening situations, such as gastrointestinal bleeding and cholangitis, but allow some flexibility for clinical teams to decide on a case-by-case basis for time-sensitive cases such as in patients with cancer. Ultimately, whether fecal immunochemical test positive patients should have endoscopy performed would depend

on the prevalence of COVID-19, local guidelines, and the available resources.

Fourth, we read with interest the significant proportion of Italian endoscopy units performing endoscopy using only surgical masks. We would like to emphasize that the sample size is small, we are unsure of the endoscopic procedures performed, and that this practice deviates from what is recommended by most guidelines.^{2,4-6} Before more evidence is made available, we believe that N95 respirators or equivalent should still be mandated. Last, policymakers should be made aware of the shortages in negative pressure facilities for endoscopy to plan ahead and enhance preparedness for future pandemics.

The holy grail for endoscopy units should be to attain zero percent infection rates among health care professionals while providing essential services to patients.⁷ To succeed, general measures such as social distancing, adequate hand hygiene, and universal masking,⁸ at least in health care settings are equally important. Future studies should explore the safety of measures such as the extended use or reuse of N95, the infective risk of different endoscopic procedures, and softer but equally important issues, such as the effects of COVID-19 on endoscopy training. Lessons learned from this study and others can pave the way and guide best practices when endoscopy and clinical services gradually return to normal in a stepwise manner.⁶

In facing COVID-19, only one thing is certain. The global community must come together in solidarity as we are all in this together. We must try our best to stay safe and healthy, to protect our patients and our loved ones. This is not a time for complacency.

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References

1. Repici A, et al. *Gastroenterology* 2020;159: P363–366.
2. Lui RN, et al. *J Gastroenterol Hepatol* 2020; 35:749–759.
3. Repici A, et al. *Gastrointest Endosc* 2020;92:192–197.
4. Sultan S, et al. *Gastroenterology* 2020;159:739–758.
5. Gralnek IM, et al. *Endoscopy* 2020;52:483–490.
6. Chiu PWY, et al. *Gut* 2020;69:991–996.
7. Soetkno R, et al. *Gastrointest Endosc* 2020;92:176–183.
8. Leung NHL, et al. *Nat Med* 2020;26:676–680.

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COVID-19 Transmission among Gastrointestinal Endoscopists



Dear Editors:

We read with interest the paper by Repici et al on the North Italian experience of gastrointestinal endoscopy practice during the coronavirus disease-2019 (COVID-19) pandemic.¹ Based on a 1-week survey among 42 endoscopy centers 1 month after the first confirmed case in Italy, the authors describe the changes in the organization and case-load of the endoscopy units related to the COVID-19 outbreak. Additionally, they report confirmed COVID-19 infections among nurses and physicians in 12 endoscopy units, and 6 health care workers (HCW) requiring hospital admission. In further report from the same survey, only 4.3% (42/968) of the HCW had a confirmed COVID-19 infection.² The authors conclude that the risk of patient to HCW transmission is limited.

Although the Italian GI-COVID19 Working Group provides a detailed investigation on the burden of COVID-19 on endoscopic activity in a high-risk area, we would like to question the message they convey on the low risk of COVID-19 transmission to HCW.

During the last week of March, at the peak of the COVID-19 circulation (from March 23–27 2020, 23 days after the 100th confirmed case) the French Society of Digestive Endoscopy (Société Française d'Endoscopie Digestive, SFED) conducted a web-based survey on the impact of the pandemic on gastrointestinal endoscopic activity. The questionnaire had 35 items, including the number of endoscopic procedures performed and their indications, and the rate of COVID-19 cases among gastroenterologists, and the use of protective measures at the beginning of the COVID-19 infection in France. The recommendations of the SFED on the protective measures for HCW in endoscopy units were published on March 10 on the SFED website.

Accounting for 21% of the 3300 French Gastroenterologists, 694 gastroenterologists took the survey. Thirty percent worked in areas with a high prevalence of COVID-19 infection (East of France and Paris area), comparable with that of Northern Italy. Thirteen percent of all gastroenterologists presented symptoms consistent with a COVID-19 infection during March 2020. A polymerase chain reaction test for COVID-19 was performed in only 37% of them, because few laboratories were able to perform the test in France at this time. The polymerase chain reaction test was