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Response:



We read the comments by Drs Tribonias and Paspatis¹ with much interest. We appreciate their comments regarding our article² and the details about their article.³ We would like to take this opportunity to clarify a few points that were raised.

Our study was unique, given the timing and complete change in practice of our ambulatory care center from moderate sedation with fentanyl and midazolam to deep sedation with propofol.² This allowed for a comparison between the 2 groups. However, as those authors have mentioned, we did not have the exact same endoscopists present for both groups. To limit this potential of bias, only the gastroenterology fellow differed between the 2 groups, and the attending physicians remained intact. In those authors' study, only 1 endoscopist participated for both groups.³ We applaud their efforts, but using only 1 endoscopist is difficult and has potential bias, especially when that 1 endoscopist is not blinded to the level of sedation. This is a reason why all the other studies on this topic have multiple endoscopists.⁴⁻⁷

Another reason for multiple endoscopists in a study is to have an increased number of patients to improve the statistical power. As the authors have mentioned, our statistical power may have not been ideal for small differences, and we fully agree. However, their study (n = 520) was smaller than our study (n = 585). Their statistical power calculation was based on the number of polyps identified per case, not adenoma detection rate (ADR) or polyp detection rate (PDR). Therefore, their randomized controlled trial may not have the statistical power to detect small differences in ADR or PDR as well.

With that information, and on the basis of the studies to date, we do agree that it is likely that deep sedation does not improve PDR or ADR as compared with moderate sedation of average-risk patients for colorectal cancer screening. As we mentioned in our article, a large randomized controlled trial specifically on the average-risk patient population would be beneficial. We thank Drs Tribonias and Paspatis¹ for their comments and interest in our article.

DISCLOSURE

All authors disclosed no financial relationships.

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Economic model to restart endoscopy practice needs to consider impact on health disparity in minority groups



To the Editor:

We read the timely article by Corral et al¹ on the economic analysis of COVID-19 polymerase chain reaction (PCR) testing before endoscopy with great interest. After initially choosing to postpone elective procedures, health-care facilities are seeking strategies to safely resume endoscopy to address the growing list of waiting patients.

The authors examined the impact of PCR testing based on endoscopy urgency. The results revealed that PCR testing for semiurgent and elective endoscopies for 1 week will require \$13 million and \$64 million, respectively, with a reimbursement of \$165 million and \$767 million.¹ Potentially, 65 and 325 workers, respectively, may become infected.¹ The authors conclude that PCR testing is an effective strategy to be implemented during the recovery phase.¹

Although we strongly agree that PCR is a good option, we should consider the impact of the turnaround time for obtaining PCR results (often several hours) and its effect on our patient populations. The strategy of using delayed testing will require 2 separate visits for patients: first a few days beforehand for testing and second for the procedure. This strategy may impose a significant burden for patients with already limited access to healthcare resulting from underlying inequalities, financial stress, or lack of transportation. These healthcare disparities have been well reported.²⁻⁵ Recent data from the Centers for Disease Control and Prevention reveal that the pandemic has disproportionately affected minorities.⁶ Furthermore, the

economic effect of COVID-19 in the community is significant. The most recent Bureau of Labor reports reveal 4.4% unemployment from recent exponential increases.⁷

We request that healthcare leaders consider socioeconomic and other disparities that are being magnified by the pandemic as they attempt to reinstate their practices. It will be imperative to implement individualized screening strategies, rather than a one-size-fits-all protocol, to ensure that we do not have a negative impact on our vulnerable patients who have the highest need for our services.

DISCLOSURE

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Response:



We thank Dr Badillo and colleagues¹ for their interest in our article.² The application of polymerase chain reaction (PCR) testing can be significantly limited by the geographic and socioeconomic conditions of each

community. Our model was initially designed for a single institution and then extrapolated to endoscopy needs in the United States. Assuming that all patients waiting for an endoscopy in the United States will have similar healthcare access is an oversimplification of our complex healthcare system.

To prevent infections between testing and endoscopy, we are requesting the nasal swab to be performed within 48 hours before the procedure. In rural and semirural areas, distance to a testing center may require 2 long trips. In our institution these have resulted in delays and have prevented a small number of candidates from completing their endoscopies. This impact is mitigated if the PCR test can be performed at the same time as other standard diagnostic and preprocedure laboratory tests 1 to 2 days before endoscopy. This will be further mitigated once point-of-care testing with rapid (≤ 1 -2 hours) is widely available and thus performed at the same session as endoscopy. Insurance coverage and funding is another concern for this and for all hospital-based measures. Even though Medicare announced that it will cover COVID-19 testing at no cost, specific requirements on clinical indications for the test may be added later (not covering asymptomatic individuals, as we propose).³ Overall, we agree that PCR testing is not a one-size-fits-all intervention but rather an additional piece of the roadmap to reopen endoscopy services, as described in Table 5 of our article.²

Broad policies like social distancing, face masks, and sanitation can minimize disparities in healthcare. Policies that require encounters with a healthcare provider (like PCR testing) will need multisectorial efforts involving public health officials, administrators, and policy makers to be implemented at a national scale.

DISCLOSURE

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