Acta Biomed 2021; Vol. 92, N. 4: e2021258 DOI: 10.23750/abm.v92i4.10655

Rescheduling/scheduling of endoscopic procedures during "Phase-Two: which precautions should be taken?" Experience and results of a single Italian Endoscopic Unit

Damiano Bisogni, Luca Talamucci, Roberto Manetti

Interventional Endoscopy, Department of Oncology and Robotic Surgery, Azienda Ospedaliero Universitaria Careggi, Florence, Italy

To the Editor,

Coronavirus disease (COVID-19) large spread has deeply changed our lifestyle and working organization (1, 2). First cases in Italy were recorded in Milan during February 2020, leading to a quick diffusion across the whole peninsula. To date, in September 2020, COVID related-deaths and contagions are more than 35.000 and 240.000, respectively. During the maximum contagion period, endoscopic units carried out only urgencies, emergencies and some interventional procedures (such as selected cases of endoscopic retrograde cholangiopancreatographies, stenting for colonic or esophageal malignancies, etc. . .) (2, 3).

At the end of this contagion period (on June 3th), each endoscopic unit has faced the question of how rescheduling the normal work activity. The main questions were: how many exams per day? Is a phone triage enough, in order to exclude Coronavirus infection? Which individual protection devices (IPDs) are recommended to contain the risk of operators' contagion?

To date in Italy, no univocal statement concerning the reconversion of the endoscopic units in order to avoid infection transmission still exists (2, 3). Herein, each Italian region has adopted different rules both to reallocate the postponed exams and to schedule new to come procedures. These new endoscopic settings have the aim of obtaining low risk-based layouts, minimizing the infection risks (both for patients and for personnel) and identifying the suspected COVID-19 (2, 3). Most of the Italian institutions has adopted a preliminary phone-related triage model.

Despite common indications concerning disinfection rules, the use of IPDs, the healthcare professionals management and assessment of endoscopic procedures-related priority have been established, no univocal rule regarding the reschedulation still exists, so that each hospital institution adopts different models (3).

In this article, we report our single center experience concerning the rescheduling rules for endoscopic procedures. In order to reduce the infection risk and the personnel contagion, a preliminary nasopharyngeal swab is done 48 hours before the endoscopic procedure both in inpatients and in outpatients. During the last 3 months, 1297 nasopharyngeal swab have been performed: three outpatients resulted COVID-19 positive at the preliminary swab (0.23 %).

Parallel to this nasopharyngeal testing, a nursing triage is carried out just before entering the endoscopy unit, in order to minimize the infection risks. All the patients received a phone-call two weeks after the procedure, in order both to assess their healthcare and to find out any suspicious sign of SARS-CoV-2 infection: none developed the Coronavirus disease. To date, thanks to these rules, no COVID-19 infection was recorded for medical staff or nursing staff.

As well explained in Elli L and colleagues' article and along the line of some Chinese studies, estimating that up to 50-75% of subjects carrying Coronavirus

might be asymptomatic (thus representing insidious source of infection), we have adopted a surveillance protocol by nasal swab testing for every endoscopic procedure (1, 4). At the light of these findings, we consider every patient a potential carrier of SARS-CoV-2 unless proven otherwise (4).

In conclusion, as well explained by Chen N and colleagues, surveillance protocol by nasal swab testing allows to find out up to 75% of asymptomatic subjects carrying SARS-CoV-2 (4, 5). However, Yang Y et al. reported a positive rate of nasopharyngeal swabs between 30% and 60% at initial presentation, therefore giving importance to the low sensitivity of this method (5).

In our opinion, a well conducted phone-triage, a preliminary nasal swab testing and routinely personal protection equipment adoption, ensure the endoscopic personnel safety, limiting the person-to-person spread of the infection. We hope that, in the future, new studies and guidelines might assess univocal rules to regolate the access of outpatients and inpatients to the endoscopic units (3).

References

1. Elli L, Rimondi A, Scaramella L, et al. Endoscopy during the Covid-19 outbreak: experience and recommendations from a single center in a high-incidence scenario. Dig Liver Dis. 2020;52(6):606-612.
2. Repici A, Maselli R, Colombo M, et al. Coronavirus (COVID-19) outbreak: what the department of endoscopy should know. Gastrointest Endosc 2020; Journal Pr. https://doi.org/10.1016/j.gie.2020.03.019.
3. Manes G, Repici A, Radaelli F, Bezzio C, Colombo M, Saibeni S. Planning phase two for endoscopic units in Northern Italy after the COVID-19 lockdown: An exit strategy with a lot of critical issues and a few opportunities [published online ahead of print, 2020 Jun 19]. Dig Liver Dis. 2020;52(8):823-828. doi:10.1016/j.dld.2020.05.042.
4. Chen N, Zhou M, Dong X, et al. Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. Lancet 2020;;395:50713.
5. Yang Y, Yang M, Shen C, et al. Evaluating the accuracy of different respiratory specimens in the laboratory diagnosis and monitoring the viral shedding of 2019-nCoV infections. MedRxiv 2020:2020.02.11.20021493.

Conflict of interest: Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article.

Authors' contributions: Damiano Bisogni: data collection, substantial contributions to conception and design, writing the study, drafting the article, final approval of the version to be published. Luca Talamucci, Roberto Manetti: study design, data analysis, drafting the article, final approval of the version to be published. All authors read and approved the final version of the manuscript.

Correspondence:
Received: 1 September 2020
Accepted: 18 September 2020
Damiano Bisogni MD,
Interventional Endoscopy, Department of Oncology and Robotic Surgery, Azienda Ospedaliero Universitaria Careggi, Largo Brambilla, Florence of Tuscany (Zip Code 50134), Italy; ORCID number: 0000-0002-8086-3257;
E-mail: bisognifelice@libero.it