ENDOSCOPY GUIDELINES

To be used as guidelines for Endoscopy in the current COVID-19 environment

Intermountain® Healthcare

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INTRODUCTION

These guidelines were developed by a multidisciplinary team to include Gastroenterologists, Digestive Health Clinical Program, Surgical Operations, and Incident Command (Operations Section). Please note that guidelines are subject to change based upon epidemiological trends, supply status, hospital capacity, and absenteeism. Decision processes for the recommendations were also based upon those released by the ASGE, the NYSGE, as well as the British Society of Gastroenterology. The intent of limiting procedures to only those that are urgent/emergent include conservation of PPE and to reduce the risk of exposing patients, staff, and ourselves to SARS-CoV-2. Endoscopy managers and/or GI section chiefs will be reviewing all cases on a weekly basis to determine those that are urgent or can be delayed.

PPE INFORMATION LINKS

What PPE to wear to stay safe

PPE Instruction

How to safely reuse N95 masks, eyewear, and face shields

- Cover N95 with reusable face shield to prevent soiling
- Store N95 in paper bag between use to minimize humidity
- Clean hands before/after donning or doffing N95
- Do not reuse if nasal bridge or straps are no longer effective
- Do not reuse if visibly soiled

GUIDELINES FOR PRIORITIZATION OF ENDOSCOPY PROCEDURES IN THE COVID-19 ENVIRONMENT

The prioritization table at the end of the document is to serve as a guide. In general, the prioritization will likely correspond with the State color code of risk concern (P1 – during RED, P1-P2 – during ORANGE, etc.).

GUIDELINES FOR CONSERVATION OF RESOURCES/PPE

- PPE requirements in endoscopy will be guided by pre-procedural testing status.

PPE In OR and Endoscopy

COVID-19 CATEGORY	N95/PAPR during airway management	Post AGP Airborne Decontamination OR: 14 min Endo: 46 min	N95/PAPR During Case	Full COVID Protocol Runners, Full PPE OR Cleaning delay: 30 min Endo Cleaning delay: 69min
Known Covid-19 or PUI	USE N95/PAPR & FULL PPE THROUGHOUT CASE			YES
NEGATIVE TEST IN LAST 72 HRS	NO	NO	NO	NO
UNTESTED	YES	YES	ONLY IF AGP	NO

PUI-Patient Under Investigation AGP-Aerosol Generating Procedure PPE- Personal Protective Equipment

- For ***COVID-19 positive patients and Patients Under Investigation (PUIs),*** caregivers should wear PAPRs (preferred). An alternative when PAPR is not available may be an N95 mask and face shield. Please be aware of limited availability for fit-testing. When an N95 mask is issued, it is NOT to be discarded after one use (unless it has been soiled). Instruction points for proper reuse of an N95 mask are found HERE. Anesthesia should be involved if there is any suspicion of respiratory distress for outpatient and inpatient procedures, regardless of

SARS-COV2 status. For patients with COVID19 needing endoscopy, negative pressure rooms should be utilized if available. Following care of a COVID 19/PUI, an airborne decontamination time of 69 minutes should elapse before the next patient comes to the endoscopy suite.

- ***Patients with a negative COVID-19 test*** in the 72 hrs pre-procedure may be cared for in standard precautions (standard mask, gown, and gloves). No airborne decontamination is required after care of patients with a negative pre-procedural test.
- ***Patients who are untested*** may include those requiring urgent/emergent care when delay for testing could cause harm. Caregivers should wear PAPR or N95 when caring for untested patients. Airborne decontamination time of 46 minutes should elapse before bringing the next patient into the endoscopy suite.
- For outpatient urgent cases meeting above criteria or food impaction cases in the ER setting where the patient has no respiratory concerns for sedation, having an anesthesiologist is not necessary.
- Outpatient urgent cases (meeting the above criteria) should be done in the hospital endoscopy room due to limited PAPR / N95 supplies which are most likely stored in the hospital, rather than a detached outpatient endoscopic facility.
- Please consolidate all outpatient cases in as few days a week as possible and with one GI provider per day to reduce the overall risk. Your endoscopy manager and GI section chief will work with you on this. We should have as few people for each procedure as possible and this may mean spreading urgent outpatient cases to 1+ hour each.

We are all in this together and we need to keep ourselves and our staff protected. Please note that these guidelines are subject to change in the event of emerging information or escalation of crisis status.

Sincerely,

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PRIORITY 1 *URGENT – DO NOT DEFER*	PRIORITY 2 *FURTHER DELAY WILL LIKELY CAUSE HARM*	PRIORITY 3 *FURTHER DELAY MAY CAUSE HARM*	PRIORITY 4 *DEFERRAL WILL NOT LIKELY CAUSE HARM*
EXAMPLE INDICATIONS	EXAMPLE INDICATIONS	EXAMPLE INDICATIONS	EXAMPLE INDICATIONS
• Active/overt GI blood loss with anemia (in cirrhotic r/o suspected variceal hemorrhage) • Active/overt GI blood loss in cirrhotic patients (r/o suspected variceal hemorrhage) • New iron deficiency anemia (symptomatic) • Dysphagia (new onset, progressive, dysphagia resulting in food impaction/malnutrition) • Severe odynophagia • Food impaction/Foreign body removal • Imaging suggestive of new malignancy • Treatment of severe stenosis and strictures • PEG tube placement • Esophageal, gastric, duodenal, small bowel stents for palliation of obstruction • Treatment of esophageal precancerous lesions concerning for malignancy (EMR) • Suspected choledocholithiasis or biliary obstruction • Obstructive jaundice, Gallstone pancreatitis • Bile leaks, traumatic or surgical biliary injury • Evaluation of pancreatic cysts with alarm features/concerns for malignancy	• Noninfectious diarrhea with weight loss or malnutrition • Unexplained weight loss • New iron deficiency anemia (asymptomatic) • Change in bowel habits/stool caliber with concern for cancer • ED referrals in symptomatic patient with alarm symptoms • Needed semi-urgent stricture dilation • Prior PEG deferral in favor of NJ tube placement • Ongoing Variceal Banding Therapy after recent variceal hemorrhage • Treatment of esophageal pre-cancerous lesions (Barretts' ablation) • High risk gastric/duodenal EMRs (risk vs benefit to be reviewed by provider) • Surveillance colonoscopy after mucosal resection for large polyps with concerning features (i.e. incomplete resection of HGD) • Pancreatic fluid collection drainage/debridement (P1 if symptomatic) • IBD surveillance with prior dysplasia • Assessment of IBD in active disease/active symptoms with anticipated therapy change	• Acute/subacute abdominal pain w/u • ED referrals in stable patient with chronic symptoms w/o alarm features • Chronic GI symptoms w/o warning signs • Stable chronic anemia without risks factors • FIT®, Cologuard® in stable non-anemic patient • Barrett's surveillance (hx dysplasia) • IBD activity assessment (i.e. post-op) • Overdue surveillance colonoscopy • Surveillance colonoscopy after piecemeal polypectomy without concerning features • Evaluation of pancreatic cysts (common referrals for EUS – no alarm features/concerns for malignancy)	• Gastroesophageal reflux disease (GERD) • Routine dyspepsia • Average screening colonoscopy • Routine surveillance colonoscopy • Routine low risk surveillance (i.e. routine IBD, Barrett's) • Routine variceal screening • Colonoscopy in uncomplicated diverticulitis • Motility studies, pH monitoring, and anti-reflux mucosectomy (unless required as surgical or urgent evaluation)