

Coronavirus (COVID-19) outbreak: what the department of endoscopy should know

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Coronavirus (COVID-19) outbreak: what the department of endoscopy should know

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Abstract

Italy recorded its first case of confirmed acute respiratory case due to Coronavirus on February 18, 2020, soon after the initial reports in China. Since that time, Italy and nations throughout the world have adopted very stringent and severe measures to protect populations from spread of infection. Despite these measures, the number of infected people is growing exponentially with a significant number of patients developing acute respiratory insufficiency. Endoscopy departments face significant risk for diffusion of respiratory diseases that can be spread via an airborne route, including aspiration of oral and fecal material via endoscopes. The purpose of this article is to discuss the measures, with specific focus on personal protection equipment and dressing code modalities, which have been implemented in our hospital to prevent further dissemination of COVID-19 infection.

Background:

Coronaviruses are nonsegmented, enveloped, positive-sense, single-strand ribonucleic acid (RNA) viruses [1]. Six coronavirus species are known to cause human disease. Most of them generally cause mild respiratory disease; however, fatal coronaviruses have emerged periodically in the last decades (severe acute respiratory syndrome coronavirus -SARS-CoV- in 2002 and the Middle East respiratory syndrome coronavirus -MERS-CoV- in 2012).

1 In December 2019, the World Health Organization (WHO) China office was informed of cases of
2 pneumonia of unknown etiology detected in Wuhan [2], and a new coronavirus called SARS-CoV-2
3 was extracted from lower respiratory tract samples of several patients.
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6 Since then, as of March 10, 2020, more than 100,000 cases have been confirmed worldwide [3],
7 with the infection spreading to many countries all over the world. Italy has one of the highest rates
8 with more than 10,000 confirmed infections[3]. As of March 11, 2020, the World Health
9 Organization has declared the infection a Pandemic, indicating significant worldwide involvement
10 of the disease. [[https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-
11 media-briefing-on-covid-19---11-march-2020](https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020)]
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19 The most common SARS-CoV-2 related disease (COVID-19) symptoms are fever, weakness,
20 cough, and diarrhea [4, 5]. More than half of patients report shortness of breath, with few
21 developing acute respiratory distress syndrome (ARDS). After septic shock, refractory metabolic
22 acidosis and coagulation dysfunction can lead to death with a case fatality rate reported to be 3.5%
23 [6].
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29 Human-to-human transmission occurs primarily via direct contact or through air droplets [7,8]. The
30 higher risk of transmission is within approximately 1 meter from the infected person; however, the
31 maximum distance is still undetermined [9].
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36 Even though health care personnel working in endoscopy units are not directly involved in the
37 diagnostic and therapeutic evaluation of COVID-19 positive patients, endoscopy should still be
38 regarded as a risky procedure. This risk of exposure and subsequent infection of endoscopy
39 personnel is, in fact, substantial in cases of patients with respiratory disease that can be spread via
40 an airborne route [10]. A recent study from Johnston et al [11] confirmed the significant and
41 unrecognized exposure of the endoscopist's face to potentially infectious biologic samples during
42 endoscopy. Endoscopy procedures demand short physical distance from patients to the personnel
43 and according to studies performed during the global SARS outbreak of 2003 droplets from infected
44 patients could reach persons located 6 feet or more from the source [12].
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53 Finally, we do believe that the risk of exposure of endoscopy personnel is not limited to upper
54 endoscopy procedures considering the recent detection of SARS-CoV in biopsy specimens and
55 stools, suggesting a possible fecal-oral transmission [13]. This could be even more relevant given
56 that the virus transmission can occur during the incubation period in asymptomatic patients.
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In general, establishing infection prevention measures and guideline within an endoscopy department is essential for creating a high-quality and extremely safe environment to protect both patients and personnel. In this new era of the COVID-19 outbreak, it is imperative that these measures be implemented and maintained to avoid further unrecognized spread of the disease.

SARS-CoV-2 infection definition

The median estimated incubation period of the virus is about of 5.5 days with a range from 0 to 14 days. Robust evidence coming from China and Italy confirms that about 80% of patients have asymptomatic or mild disease and that the median age of cases is below 60 years [4,5,7]. These data clearly show that a significant number of patients undergoing endoscopy procedure may fall in the category of asymptomatic carriers and preventive measures are necessary to avoid massive endoscopy-related diffusion of the virus.

A tricky issue in this epidemic context is patient risk stratification and definition of subgroups of patients. We believe it is important that we adopt a common definition of potential COVID-19 patients. According to several recently issued guidance, COVID-19 should be considered in anybody who has been in contact with confirmed SARS-CoV-2 infection or has returned from a high-risk country in the 14 days before the onset of following symptoms: fever (even without respiratory symptoms), cough, acute respiratory infection of any degree and severity (with or without fever), severe acute respiratory infection requiring hospital admission and clinical/radiological evidence of pneumonia. Contacts are defined as (1) those living in the same household of a confirmed infection; (2) those with direct or face-to-face contact (for any length of time) with an infected person or with their biologic fluids without an appropriate protective dressing code; or (3) those being within 2 meters from a person with a confirmed infection. With regard to the classification of high-risk countries, this is going to be a concept in constant evolution even though as of March 2, 2020 several countries have been categorized as highest-risk (category 1) and high-risk (category 2) according to the list in the box below (Figure 1). Given the rapidly evolving epidemiology, hospitals should stay up to date via their national disease control centers. For U.S. hospitals, the Centers for Disease Control (<https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>) provide up-to-date information. The World Health Organization provides similar information (<https://www.who.int/health-topics/coronavirus>).

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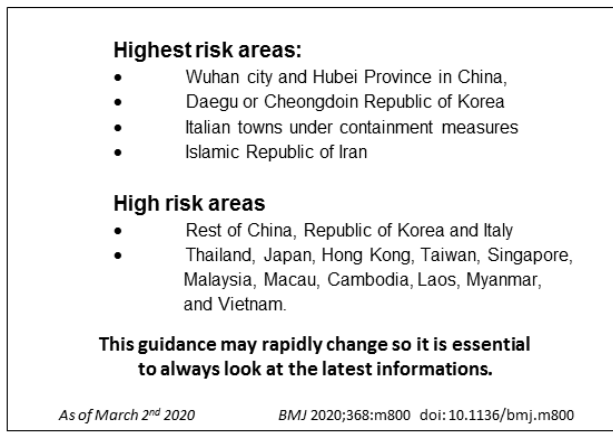


Figure 1: Country risk assessment.

Patient management and risk assessment

Once a patient is scheduled for an endoscopic procedure, the risk of COVID-19 infection should be checked and stratified individually. The day before the procedure, all patients are called ahead and surveyed about symptoms of a respiratory infection and are potentially rescheduled according to the specific patient’s disease and condition. When the patient reaches the hospital, use nurse-directed triage protocol to stratify the risk of COVID-19 (Table 1), using the following questions [14]:

- In the last 14 days have you had fever (>37.5°C), cough, sore throat, or respiratory problems?
- Have you had family or close contact with a suspicious or confirmed case of COVID-19?
- Do you come from areas at higher risk of COVID-19?

If a patient is referred by a different healthcare facility, the same triage protocol is delivered by phone the same day of the procedure before the patient leaves the facility. This is instrumental to allow endoscopy personnel to prepare for receipt of the patient.

We also suggest checking the patient’s body temperature before entering in endoscopy and to reclassify those patients with a temperature above 37 degrees. Based on this preliminary screening, patients can be classified as low, intermediate, and high-risk, which translates to different modalities of infection control precautions.

Classification of potential SARS-CoV-2 infection risk in patients undergoing endoscopic examination

Low-Risk	<ul style="list-style-type: none"> ▪ No symptoms (eg, cough, fever, breathlessness, diarrhea) ▪ No contact with someone SARS-CoV-2 positive ▪ Non-stay in high-risk area during the previous 14 days
Intermediate-Risk	<ul style="list-style-type: none"> ▪ Presence of symptoms with <ul style="list-style-type: none"> ○ No medical history for contact with someone SARS-CoV-2 positive ○ Non-stay in high risk area during the previous 14 days ▪ No symptoms but <ul style="list-style-type: none"> ○ Contact with someone SARS-CoV-2 positive ○ Stay in high risk area during the previous 14 days
High-Risk*	<ul style="list-style-type: none"> ▪ At least one symptom + one of the following: <ul style="list-style-type: none"> ○ Contact with someone SARS-CoV-2 positive ○ Stay in high risk area during the previous 14 days

Table 1: Potential SARS-CoV-2 infection risk in endoscopy patients

*in an emergency setting, all the procedures must be considered high risk if adequate patient history cannot be assessed.

Caregivers and relatives of the patients are strictly prohibited to enter the endoscopy department unless the patient requires specific assistance and translation service. We recommend regular phone follow-up with a dedicated triage at 7 and 14 days after endoscopy procedure for all patients undergoing endoscopic procedures until this infectious outbreak is completely resolved.

PPE description and recommendations

Personal protective equipment, known as PPE, is equipment worn to reduce exposure to hazards that cause workplace injuries and illnesses. PPE may include items such as gloves, goggles or face shield, gowns, and respiratory protective equipment [15].

One the most important pieces of protective equipment is the mask, whose primary function is to keep respiratory particles from the source such as splashes, saliva, or mucus from contaminating the work environment. Medical or surgical or facial masks are defined as loose-fitting, disposable devices that create a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. The standard facial mask may be effective in blocking splashes and large-particle droplets, but, by design, it does not filter or block very small particles in

1 the air that may be transmitted by coughs, sneezes, or certain medical procedures and does not
2 provide complete protection from germs and other contaminants.
3

4 Respirators, on the other hand, protect the wearer against potentially hazardous particles created by
5 the work environment. More specifically the N95/FFP2/FFP3 respirator is a protective device
6 designed to achieve a very close facial fit and extremely efficient filtration of airborne particles (up
7 to 0.3 microns), that can be inhaled through the nose or mouth) and germs. Note that the edges of
8 the respirator are designed to form a seal around the nose and mouth.
9

10 As a general measure, as of March 4, 2020, the World Health Organization recommends respiratory
11 protection for providers, with use of standard medical mask. This means that all of the personnel not
12 directly in close contact with the patients (those in charge of endoscope disinfection, etc) have to
13 constantly wear the medical mask for the time they stay in the hospital.
14

15 **Patient dress code**

16 All patients entering in the endoscopy unit should be invited to wear a surgical mask. In addition,
17 those classified as intermediate- or high-risk should wear a surgical mask and gloves. The surgical
18 mask has to be removed just before commencing the procedure. Because most endoscopic
19 procedures are performed with the patient under conscious or deep sedation, we adopted the policy
20 that the mask has to be replaced again once the patient has recovered from sedation sufficiently to
21 maintain oxygen saturation above 90% on room air.
22

23 **Endoscopy personnel precautions and dress code**

24 All staff involved in the endoscopy department are invited to follow standardized precautions as a
25 measure for optimal infection control among employers. We recommend that personnel keep a
26 reasonable distance from every patient during all the steps taken before the beginning of endoscopic
27 procedures (informed consent signature, vital signs recording, patient instructions for the procedure,
28 etc). It is mandatory to wash hands with soap and water or alcohol-based hand rub before and after
29 all patient interaction, contact with potentially infectious sources, and before putting on and upon
30 removal of PPE, including gloves. The minimal composition of a set of PPE for personnel in
31 endoscopy should be modified on the basis of risk stratification, as shown in Figure 2.
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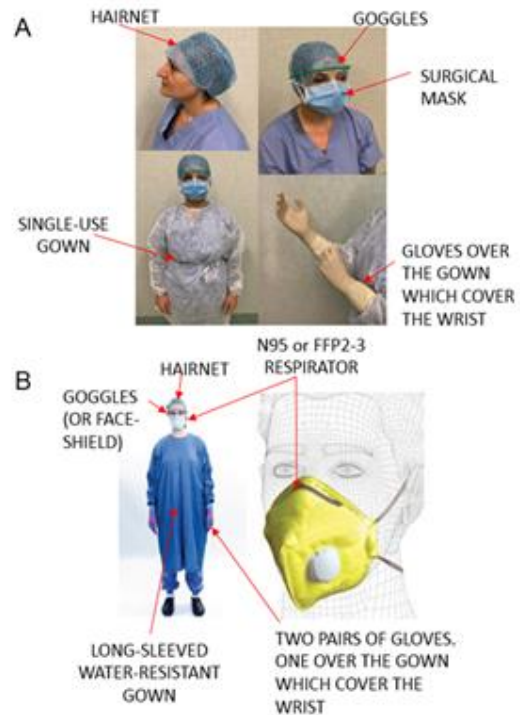
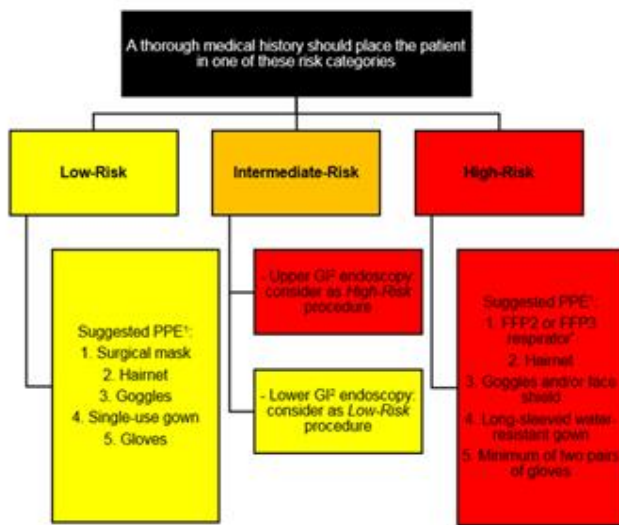


Figure 2: High- and low-risk dressing equipment. ¹PPE: Personal Protective Equipment; ²GI: Gastrointestinal; *FFP: Filtering Face-Piece. FFP2/3 are equivalent to N95 mask. A, Low-risk dressing equipment. B, High-risk dressing equipment.

We strongly discourage, also in a time when shortage of devices may happen, to reuse any disposable device. In case of shortages, alternatives to respirators should be considered, including other classes of FFRs, elastomeric half-mask, and full facepiece air purifying respirators.

How to wear the PPE

The U.S. Centers for Disease Control provide detailed, graphical instructions on proper use of PPE in the setting of COVID-19 (<https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf>). The first PPE to be donned is the hairnet. Always check that the equipment you are using has not expired because this will compromise their integrity. Then, proper hand hygiene should be performed using an alcohol-based solution. The second PPE to be worn is the gown; in case of a gown with back closure, a second operator should assist in closing up the back. After wearing the gown, it is recommended to proceed with the filtering face-piece (N95, FFP2 or FFP3) respirator; it is crucial to perform a fitting test after the equipment has been put on the face. In case of shortage of filtering face-piece respirators, the use of a surgical mask as substitution is recommended. Once the

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respirator has been correctly positioned, the next step is the goggles for eye protection. Gloves are next: users should consider 2 pairs of gloves, one inner pair of gloves covering the skin up to the wrist (eg, surgical gloves), and one outer pair of gloves, the real “working gloves.”

How to remove PPE

At the end of the examination, the removal of the PPE is an essential and crucial part of the entire procedure that needs to be carefully carried out in order to prevent ourselves from contamination, as long as the PPE could by now be contaminated. The gloves are removed first because they are now considered heavily contaminated. Use of alcohol-based hand disinfectant should be considered before removing the gloves. Once the removal of gloves has been completed, hand hygiene should be performed again; next, a new pair of gloves should be worn, in order to prevent self-contamination and to be able to continue the procedure safely. Having the new pair of gloves on, now the gown should be removed; if using a gown with back closure a second operator should assist. Eye protection should be removed next. When removing goggles or face shields, touching the front part, which can be contaminated by droplets or particles, should be avoided. Removal of respiratory protection comes next; it is important not to touch the respirator during its removal. After that, the hairnet should be taken off. The last PPE to be removed are the latest pair of gloves worn, which may now be contaminated. After glove removal, hand hygiene should be repeated.

Role of the negative-pressure room in the COVID-19 outbreak.

Despite ASGE suggestions to perform endoscopic procedures in a negative-pressure room [16], in most endoscopy facilities around the world, this is not available. Therefore, it would be advisable to urgently equip at least one endoscopic room with a negative-pressure system to be used for all patients with respiratory symptoms. When this is not feasible, we recommend performing endoscopy on patients who are high-risk or positive for SARS-CoV-2 in negative-pressure rooms located outside of the endoscopy department as long as this space is properly equipped to perform any endoscopy procedure safely and properly.

Reprocessing of flexible endoscopes and endoscopic accessories

The ASGE guidelines for infection control in the endoscopy unit can be found, and are available open access (https://www.asge.org/docs/default-source/default-document-library/51e78060-cd85-4281-b100-6abebcb04c49.pdf?sfvrsn=4c109450_0). Similarly, the 2018 European Society of Gastrointestinal Endoscopy (ESGE) Guidelines [17], recommend that all endoscopes and reusable accessories should be reprocessed with a uniform, standardized reprocessing procedure.

1 Disinfectants used for this purpose should be tested according to the European Standard EN 14885.
2 The product used must be as follows: bactericidal, mycobactericidal, fungicidal, and virucidal
3 against enveloped and nonenveloped viruses. Cases of hepatitis B and C virus transmission have
4 been reported in medical literature, but they have been related to an inappropriate cleaning and
5 disinfection. When all currently reprocessing guidelines are strictly followed, the risk of
6 transmission of any kind of viruses is extremely rare to nonexistent. This is why we have reinforced
7 training sessions and personnel meetings on the importance of strictly following endoscope
8 reprocessing policy as a safe and efficient method to prevent the spread of viral infection.
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17 **Decontamination policy for endoscopy rooms**

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19 Each endoscopy department should have a detailed plan addressing the cleaning of rooms, including
20 methods and chemical agents for cleaning and disinfecting the procedure space at the end of the
21 daily procedures. The cleaning process should include cleaning of all surfaces in the procedure
22 room in order to remove all soil and biofilm, followed by proper disinfection [16] as clearly
23 reported in the ASGE guideline. Data on the virucidal efficacy of chemical agents against SARS-
24 CoV-2 are not available; therefore, our recommendations are based on studies done for other
25 coronaviruses. SARS coronavirus is known to be stable in feces and urine for at least 1 to 2 days;
26 thus, surfaces might be a possible source of contamination and lead to infection. Until more precise
27 recommendations are available, noncritical environmental surfaces frequently touched by hand (eg,
28 bedside tables, bed rails) and endoscopy furniture and floor should be considered heavily
29 contaminated in case of patients with intermediate or high risk of COVID-19 and should be
30 thoroughly disinfected at end of each procedure. Standard room disinfection policy should be kept
31 in rooms where non-COVID-19 or low-risk patients undergo endoscopy. For surface and
32 noncritical patient-care equipment disinfection, we are currently using 1:100 dilution of household
33 bleach and water [18]. In case of negative-pressure rooms, a delay of about 30 minutes is suggested
34 before allowing a new patient to enter in the room. Because small particles remain airborne for
35 some period of time, in absence of negative pressure rooms alternative measures such as diluting
36 the air in a space with cleaner air from outdoors should be considered and the room kept empty for
37 at least 1 hour.
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58 **Conclusions**

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It is a challenging time for the whole world, and we as endoscopists and physicians have additional responsibility of protecting our patients and ourselves. It is really of paramount importance in the next months to enforce and strictly maintain these infection control measures using written protocols and dedicated meetings. The level of commitment and the amount of individual effort that everybody will contribute for preventing infection dissemination is like little grains of sand that together will help in creating a solid and durable barrier against this deadly virus.

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** **Type of relationship may include:** full-time or part-time employee, independent contractor, consultant, research or other grant recipient, paid speaker or teacher, membership on advisory committee or review panels, ownership interest (product royalty/licensing fees, owning stocks, shares, etc.), relationship of a spouse or partner, or any other financial relationship.



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x No financial relationships with a commercial entity producing health-care related products and/or services relevant to this article.

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Company	Type of Relationship**	Content Area (if applicable)

x **As corresponding author of this article,** I attest that I have received disclosure information from all participating authors as listed above and acknowledge that I am responsible for verifying the accuracy of and reporting completely the information provided to me. Financial relationships relevant to this article can be researched at <https://www.cms.gov/openpayments/>. I understand that typing my name below serves as an electronic signature for the purposes of this form.

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Highest risk areas:

- Wuhan city and Hubei Province in China,
- Daegu or Cheongdo in Republic of Korea
- Italian towns under containment measures
- Islamic Republic of Iran

High risk areas

- Rest of China, Republic of Korea and Italy
- Thailand, Japan, Hong Kong, Taiwan, Singapore, Malaysia, Macau, Cambodia, Laos, Myanmar, and Vietnam.

This guidance may rapidly change so it is essential to always look at the latest information.

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