New York Society for Gastrointestinal Endoscopy
Guidelines for Endoscopy Units during the COVID-19 Pandemic
March 16, 2020

NYSGE continues to follow the evolving recommendations being presented by national GI societies regarding the practice of endoscopy amid the COVID-19 pandemic. On March 15, 2020 multi-society guidelines* were jointly published by AASLD, ACG, AGA and ASGE detailing updated information about presenting symptoms and GI symptoms in particular, diagnostic findings, and best practices for prevention. The leadership of NYSGE feels that more specific guidelines are needed for endoscopy practices regarding classification of elective procedures and the use of appropriate personal protective equipment (PPE).

The multi-society guidelines acknowledge that local and institutional recommendations may be evolving and should be closely monitored. NYSGE recognizes that the New York region is facing unique challenges compared to other areas of the country. We have learned from the solutions employed by our colleagues in other areas of the world who have, unfortunately, experienced the crisis that for us is now imminent.

NSYGE is known as a leader in endoscopic expertise, innovation, education, and research. In keeping with our commitment to members, our leadership in consultation with endoscopy unit leaders throughout the region have constructed adjunctive guidelines to address local needs and current restrictions. Most importantly, we hope that NYSGE's endorsement of these recommendations will help our members provide guidance to their institutions and facilitate measures to improve safety in the ongoing pursuit of optimal care for our patients.

Recommendations

A. NYSGE endorses the multi-GI society guidelines published on March 15, 2020 [https://www.asge.org/home/joint-gi-society-message-covid-19], as well as CDC and other federal guidelines as they evolve.

B. NYSGE recommends delaying elective procedures until the COVID-19 outbreak is considered over, using the following priority classification:

Elective Procedures that May be Delayed

1. Screening and surveillance colonoscopy in asymptomatic patients
2. Screening and surveillance for upper GI diseases in asymptomatic patients
3. Evaluation of non-urgent symptoms or disease states where procedure results will not imminently (within 4-6 weeks) change clinical management (e.g., EGD for non-alarm symptoms, EUS for intermediate risk pancreatic cysts)
4. Motility procedures - esophageal manometry, ambulatory pH testing, wireless motility capsule testing and anorectal manometry

Urgent/Emergent Procedures that May Not be Delayed

1. Upper and lower GI bleeding
2. Suspected GI bleeding
3. Dysphagia significantly impacting oral intake

4. Cholangitis or impeding cholangitis
5. Symptomatic pancreaticobiliary disease
6. Palliation of GI obstruction (UGI, LGI and pancreaticobiliary)
7. Patients with a time-sensitive diagnosis (evaluation/surveillance/treatment of premalignant or malignant conditions, staging malignancy prior to chemotherapy or surgery)
8. Cases where endoscopic procedure will urgently change management
9. Exceptional cases will require evaluation and approval by local leadership on a case by case basis

C. NYSGE recommends the following endoscopy unit workflow of urgent/emergent procedures with respect to personal protective equipment for patients and staff

Endoscopy Unit Staff Etiquette

1. All endoscopy staff should wear scrubs (endoscopists, nurses, techs, etc.) regardless of procedure type or duration. All staff should change from scrubs prior to leaving the hospital/AEC
2. All staff should have daily temperature checks on arrival at their endoscopy unit(s) and should follow institutional guidelines if febrile (>100.4F)
3. Front desk staff should wear surgical masks and gloves
4. Minimize the flow of staff throughout the unit, consider creation of kits for known positive patients and high-risk patients, minimize flow into large storage areas (consider assigning 1-2 individuals to staff these areas)
5. Restrict accompanying family members to 1 visitor (escort) and limit exposure in recovery areas
6. Enforce 6 feet separation between individuals in the waiting room or encourage family members to leave and return when finished
7. For endoscopy units in which bronchoscopy is performed, consider separating intake/recovery areas for these patients
8. NO vendors permitted

Patient Flow through Endoscopy Unit

1. All outpatients must be screened by CDC guidelines the day before by telephone
2. All outpatients will be warned of the possibility of exposure while in the endoscopy unit but that all protective precautions are being taken
3. Patients will get a temperature check (>100.4 considered febrile) by front desk staff on arrival to the endoscopy unit, followed by screening questions which will allow triage to “low risk” vs. “intermediate/suspicious risk”

Pre-Procedure

1. Patients classified as “low risk” to be admitted as per usual endoscopy practice, no mask required, maintain distance when possible such as while obtaining consent; maintain distance between patients in pre-procedure waiting area if possible
2. Patients classified as “intermediate/suspicious risk” should be admitted by staff wearing mask and gloves, using disposable pens if paper consent being obtained. When possible consider performing admission/consent/IV in procedure room (depends on unit resources for admission/recovery)

Procedural PPE recommendations stratified by infection risk and type of sedation

1. Anesthesia team to be encouraged to require that most skilled provider (i.e. Attending) perform intubation when required for the procedure (to minimize risk of aerosolization, shorten length of time for intubation, decrease the number of team members at risk of exposure)
2. Non-intubated, 'low-risk' patient: staff wear surgical mask, gown, gloves, face shield, hair net, shoe covers and scrubs
3. Non-intubated, "intermediate/high risk" patient: above plus N95 mask or equivalent
4. Intubated, "low-risk" patient: use surgical guidelines at institution
5. Intubated, "intermediate/high-risk" patient: as above plus N95 mask or equivalent
6. Known COVID-19 positive patients: follow institutional guidelines set forth by ID, DOH and CDC which call for intubation or procedures on these patients to be done in negative pressure rooms. Procedures on these patients should only be performed if emergent.

D. NYSGE recommends the following guidelines for trainee participation in procedures

1. Positive patients: no fellow participation (general or advanced)
2. "Intermediate/high risk" patients: no fellow participation (general or advanced)
3. Outpatient "low risk"' patients: fellow participation at the discretion of the Service
4. In-patient "low risk" patients: fellows may participate (rationale: they perform consults on same patient category)
5. At-risk fellows (personal medical conditions, pregnant, etc.): consider excusing them (defer to program directors)

E. NYSGE endorses the multi-GI society guidelines that stress strategic assignment of personnel to minimize simultaneous risk of exposure to as few team members as possible. Rotations should be considered for both interventional Attendings and general GI Attendings in order to limit number of team members at risk for simultaneous quarantine.

F. NYSGE recognizes that a distinction between hospital institutions and AEC/ASCs is not made in the multi-GI Society guidelines and it is understood that applicability of these recommendations may be difficult to transfer to the AEC/ASC setting. In general, however, NYSGE recommends following the same guidelines with respect to delaying of non-urgent cases and adherence to PPE standards. In addition, thought should be given to consolidation of resources and transferring cases to a hospital-based partner facility if available. Movement between facilities in which different precautions are being employed is not advisable.

G. NYSGE encourages our members to explore telehealth as an option for providing care to patients during these difficult times. Most insurance carriers and Medicare will cover telemedicine. Newer telehealth codes established for this year include 99441, 99442 and 99443. While these appear to be accepted by commercial carriers, Medicare does not yet recognize these codes. For Medicare, the standard E/M codes (with modifiers 95 or GT) are suggested.

Additionally, it is important to use the place of service code #2 (telehealth). More information can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf and https://www.mendfamily.com/telemedicine-billing-not-difficult-seems/

* https://www.asge.org/home/joint-gi-society-message-covid-19

Approved by the NYSGE Governing Council, March 16, 2020