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GUIDE FOR TRIAGE OF ENDOSCOPIC PROCEDURES DURING THE COVID-19 PANDEMIC

Introduction

The Gastroenterological Society of Australia (GESA) recently recommended that all endoscopists and health systems "Strongly consider limiting endoscopy services to Urgent and Emergency cases and deferring elective and semi-elective cases. This recommendation was to limit the number of patients attending hospitals and coming into contact with other patients and hospital staff. This also reduces the use of PPE in the context of possible supply gaps.

On 25 March 2020, Prime Minister Scott Morrison announced the suspension of all no-urgent surgery and procedures, with only category 1 and urgent category 2 cases continuing.

To support endoscopists and health systems in appropriately restricting endoscopic procedures, GESA provides the following triage guide. This guide considers the probably of detection of clinically significant pathology necessary to inform patient management in the short term, the potential role of endoscopic procedures causing staff and/or other patient exposure and resource utilisation, particularly of PPE. This guide is not exhaustive. It is implied that each case is considered on its merits, however a number of specific indications are flagged for "case-by-case assessment".

Context

In determining the appropriateness of any endoscopic procedure during this pandemic, it is essential that clinicians consider subsequent steps in that patient's clinical management algorithm. For example, if a colonoscopy or gastroscopy is being considered to confirm the diagnosis of a suspected neoplasm it may not be necessary or appropriate if that patient's wishes or co-morbidities are already known to preclude subsequent surgery or if it is unlikely that that patient will recover fully post-surgery or will only recover with extended Intensive Care Unit support.

Triaging colonoscopy cases poses the greatest challenge due to the varied presentations of clinically significant disease, including positive FOBT's in asymptomatic patients. As colonoscopy constitutes a major consumer of endoscopic resources, strict parameters are appropriate in selecting urgent cases. This results in a relatively greater number of indications requiring careful case-by-case assessment rather than mandated deferment.

Data assisting in the determination of a patient's risk for gastrointestinal neoplasia can be found on the Australian Institute of Health and Welfare website.

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Gastroscopy	**Emergency/Urgent Procedures:** **Reasonable to Proceed**	**Elective/Semi-elective Procedures:** **Defer**	**Case-by-case Assessment**
	Clinically Significant upper GI bleeding Upper GI obstruction Diagnosis and/or assessment of upper GI malignancy where patient management will be altered PEG placement/NGT/NJT placement when urgently required EMR/ESD of known upper GI neoplasm	Non-specific upper GI symptoms GORD Assessment Routine (non-dysplastic) Barrett's surveillance Diagnosis or follow-up assessment of Coeliac Disease Bariatric endoscopy Assessment of reflux oesophagitis/PUD healing Upper GI variceal screening and surveillance Achalasia endoscopic management eg Botox, pneumatic dilatation and POEM	First follow-up assessment of EMR/ESD/Ablative therapy (eg HALO) Severe abdominal pain – especially if admitted patient Dysphagia Marked weight loss Iron deficiency Anaemia (Except female <50 years) where no other cause likely on clinical assessment
Oesphageal Motility and pH Studies			
		All indications	

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Colonoscopy	**Emergency/Urgent Procedures:** **Reasonable to Proceed**	**Elective/Semi-elective Procedures:** **Defer**	**Case-by-case Assessment**
	Colorectal bleeding, considered not to be due to haemorrhoids Assessment and management of acute colonic obstruction Investigation of probable new diagnosis or flare of IBD where findings will direct management	Positive FOBT (Patient 50 years or older) but with high quality colonoscopy within 4 years Routine 1, 3 year or 5 year polyp or IBD surveillance Assessment of probable IBS or other functional GI disorders Bright red minor rectal bleeding likely of anal origin Repeat procedure for early assessment of multiple colonic polyps detected at a recent prior colonoscopy Follow-up post diverticulitis	Positive FOBT (Patient 50 years or older) without high quality colonoscopy within 4 years Iron deficiency with or without anaemia where no other cause likely on clinical assessment Surveillance for confirmed or suspected inherited colorectal cancer syndrome including Serrated Polyposis Investigation of abnormal imaging e.g. ileal/colonic wall thickening on CT Abdomen First reassessment of a recently performed EMR/ESD Large colonic polyps for endoscopic resection where occult submucosal invasive disease is possible Repeat procedures for prior inadequate colonoscopy preparation
Enteroscopy			
			Investigation and management of clinically significant GI bleeding

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ERCP	**Emergency/Urgent Procedures:** **Reasonable to Proceed**	**Elective/Semi-elective Procedures:** **Defer**	**Case-by-case Assessment**
	Cholangitis Biliary obstruction Post-operative or traumatic bile leak	Major papillectomy Management of recurrent acute or chronic pancreatitis Treatment of asymptomatic gallstones Management of Type 1 Sphincter of Oddi Dysfunction	Asymptomatic stent removal/revision
EUS			
	Diagnosis, staging and biopsy of neoplasia EUS -guided drainage of symptomatic or infected pancreatic fluid collections	Surveillance of stable pancreatic cystic lesions, sub-epithelial lesions Assessment of chronic pancreatitis Assessment of non-specific GI symptoms Screening/surveillance for pancreas cancer in high risk individuals	
Capsule Endoscopy			
	Overt small bowel bleeding with anaemia	Recurrent unexplained iron deficiency	Endoscopic capsule placement required Recurrent obscure significant IDA

The Gastroenterological Society of Australia (GESA) provides advice to endoscopists and endoscopy facilities during the COVID-19 pandemic. It should be noted that this advice is general in nature and thought to be correct at the time of posting. The user should have regard to any information, research or other material which may have been published or become available subsequently. It is recommended that this advice be considered in the context of the specific endoscopic facility and within the framework provided by the Departments of Health and Local Health Districts.