

**GASTROENTEROLOGY PROFESSIONAL SOCIETY
GUIDANCE ON ENDOSCOPIC PROCEDURES
DURING THE COVID-19 PANDEMIC**

Below is guidance regarding how to manage the clinical procedural needs of patients during the COVID-19 pandemic. Any decisions should be informed by the local situation and available resources. There may be state, local and institutional rules in place that must be considered as well. This guidance is offered until more definitive data-driven information becomes available.

For those patients for whom a procedure or appointment is not deemed immediately necessary, each practice should implement mechanisms to assure appropriate follow-up once the immediate impact of the COVID-19 pandemic has eased or passed.

All Elective Procedures Should Be Delayed

1. Screening and surveillance colonoscopy in asymptomatic patients
2. Screening and surveillance for upper GI diseases in asymptomatic patients, including surveillance for esophageal varices in patients with cirrhosis.
3. For patients needing interval endoscopy for obliteration of esophageal varices post-acute bleeding, the individual circumstances of the patient need to be taken into account to determine safety of delay (i.e., size of varices, red wale markings, CTP status of the patient, acute bleed characteristics).
4. 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)
5. Motility procedures - esophageal manometry, ambulatory pH testing, wireless motility capsule testing and anorectal manometry

Urgent/Emergent Procedures Should Not Be Delayed

1. Upper and lower GI bleeding or suspected bleeding leading to symptoms
2. Dysphagia significantly impacting oral intake (including EGD for intolerance of secretions due to foreign body impaction or malignancy (stent placement))
3. Cholangitis or impending cholangitis (perform ERCP)
4. Symptomatic pancreaticobiliary disease (perform EUS drainage procedure if necessary for necrotizing pancreatitis and non-surgical cholecystitis, if patient fails antibiotics)
5. Palliation of GI obstruction [UGI, LGI (including stent placement for large bowel obstruction) and pancreaticobiliary]
6. Patients with a time-sensitive diagnosis (evaluation/surveillance/treatment of premalignant or malignant conditions, staging malignancy prior to chemotherapy or surgery)
7. Cases where endoscopic procedure will urgently change management (e.g., IBD)
8. Exceptional cases will require evaluation and approval by local leadership on a case by case basis

Key Clinical Frequently Asked Questions

Q. How do I treat a patient who presents with a positive FIT or Cologuard® who is asymptomatic?

A. In most cases, a colonoscopy should be considered non-urgent and can be delayed by at least 4-6 weeks and reassessed.

Q. If a patient had an upper GI bleed (PUD, non-variceal), has been put on a PPI and is due for follow-up surveillance, should this patient have an EGD?

A. A follow-up EGD to assess large gastric ulcer healing, etc. should be able to be delayed 4-8 weeks absent any other alarm symptoms.

Q. Should all emergent EGD patients be intubated?

A. Absent other reasons that present a threat to the airway, intubation is not indicated for all EGDs. Proper use of PPE, including N95 masks is paramount.

Q. Does a septic patient with an unknown and not obvious respiratory cause undergoing EUS or ERCP require use of an N95 mask?

A. All EGDs require proper PPE, including use of N95 masks.

Q. Should procedures be performed on patients with intermediate level cases such as Iron Deficiency Anemia (IDA) or mild dysphagia?

A. Decisions regarding cases such as these will need to be made on a case by case basis, taking into account resource availability, level of community infectivity and risk to the patient.