



Correspondence

Who comes first: Rescheduling endoscopic activity after the acute phase of the Covid 19 pandemic


Dear Editor

The current health emergency caused by the COVID19 pandemic has caused an abrupt reduction in all ordinary endoscopic activities [1]. Our endoscopy unit, usually overloaded with procedures, has reduced its activities to immediate urgencies only, as recommended by position statements of many scientific societies [2–4].

After the most critical phase of the emergency, the need to evaluate the relative urgency of the endoscopic procedures was addressed.

In our endoscopic academic tertiary referral unit, about 300 endoscopic procedures from March 16 to May 2 were suspended. According to local (hospital) and regional health department indications, outpatient services have been reorganised, by remodulating time slots for procedures, controlling and filtering patients' access to the unit and reviewing the indications for each single endoscopic procedure programmed but not performed. Procedures initially classified as urgent (by 48 hours, n. 77) and short (by 10 days, n. 68) were directly rescheduled and performed.

Furthermore, we decided to interview all the patients of postponed endoscopic procedures by phone calls carried out by trainees, tutored by a senior component of the endoscopy unit. A systematic questionnaire was developed based on the following items: demographic and clinical patient characteristics, current conditions, gastrointestinal signs and symptoms, exam indications and priority classes assigned by the general practitioner or other physicians, time and results of previous endoscopic examinations, laboratory tests, ongoing treatments. Results of the phone interview and any additional clinical documentation e-mailed by the patient was evaluated and archived including date and time of the interview with the patient's informed consent. Based on the results of the reassessment, patients were rescheduled stratifying the procedures in the following 4 priority classes, as suggested by the recent ESGE position paper (3):

- A: non-deferrable
- B: reschedule within 10 weeks
- C: reschedule within 12 weeks
- D: reschedule between 12 and 24 weeks

This reasoned attempt to reprogram endoscopic activity has confronted us with the gap often encountered between recommendations in scientific guidelines and their applicability in real-life clinical practice. Many new situations have been addressed, which we believe may be useful to share with the digestive endoscopy community who are struggling with similar issues. Firstly, during these telephone interviews we often found ourselves in the situation of having to provide advice, request blood tests or even mod-

ify/ recommend therapeutic interventions, in an attempt to provide the most complete medical assistance possible for a remote evaluation. We actually took responsibility for postponing or not the endoscopic procedures of patients that we never had the opportunity to evaluate in depth. Specifically, we had to convince patients that their symptoms or indication for endoscopy was more threatening than the risk of coming to the hospital during the pandemic. On the other hand, we had to convince patients that the condition they reported was not to be addressed urgently, being largely outweighed by the risks of contracting COVID-19.

In the absence of objective references, we often had to rely on the so called "common-sense medicine" rather than evidence-based medicine. In this situation, health workers had to personally modify the rules of access to medical procedures with rigid, although arbitrary selection criteria, with emotional and moral implications. This situation has profoundly changed the doctor-patient relationship. The condition of uncertainty in which doctors found themselves was perceived by the patients, who no longer attributed to the doctors feelings of omnipotence, paternalism and emotional detachment, but recognized a complicity that could prelude to a new therapeutic alliance. Just a few months ago, the physical attacks on health workers were in Italy in the daily news, while today the same health workers are applauded as heroes and represented as angels. Finally, the role of trainees in GI endoscopy in this evaluation and prioritization system should be stressed. In a phase in which endoscopic training was suspended as recommended by scientific societies [3], this daily activity nevertheless presented trainees with new tasks in which active decision-making and knowledge of guidelines are central, improving their knowledge and involvement.

In conclusion, exam rescheduling for the COVID-19 pandemic has confronted the endoscopic community with new and unforeseen issues. Once all rescheduled exams are performed, we will be able to evaluate the efficacy of the prioritization methodology we employed. These results will certainly be useful to obtain greater appropriateness for endoscopic procedures and for the reorganization in the subsequent stages of the COVID-19 pandemic.

Declaration of Competing Interest

The authors declare no conflict of interest.

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