UMassMemorial Health Care

COVID-19 Clinical Care Council

GUIDELINES FOR GI ENDOSCOPY UTILIZAITON DURING COVID-19 PANDEMIC
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All endoscopic procedures (upper endoscopy, enteroscopy, colonoscopy, ERCP, etc.) are considered aerosol generating procedures (AGP) owing to the possibility of coughing and retching during upper endoscopy and the passage of flatus during colonoscopy. When these procedures are performed, all team members, including anesthesia should be outfitted with a full set of PPE including hair cover, eye covers, gown, and gloves. For the length of the procedure, all team members, anesthesia, and other individuals must be outfitted with a supervised fit-checked or fit-tested N95 mask.

General Recommendations:

1. Minimize all elective endoscopy. Use criteria in Table 1.
2. Use capsule endoscopy first for bleeding
3. All upper endoscopies are intubated to minimize retching during cases
4. All staff, except anesthesia, must leave the room for intubation and extubation
5. Level A mask guidelines (all providers wear a fit-checked/fit-tested N95 mask)
6. OR PPE for all staff (Refer to "PPE for Procedures" guidelines posted to COVID-19 Clinical Council Resources page).

Criteria for endoscopy during the COVID Crisis:

Table 1: Differentiating elective and urgent procedures.

Elective (Delay)	Semi-Elective (Perform)	Urgent (Perform)
• Screening or surveillance colonoscopy • Screening or surveillance EGD in a patient with asymptomatic upper GI disease • Evaluation of non-urgent symptoms (e.g. EGD for non-alarm symptoms, such as vague abdominal pain, nausea, GERD, or • Non-urgent endoscopic procedures • EUS for pancreatic cyst or small submucosal lesion). • All motility procedures (esophageal/anorectal manometry, pH studies)	• Severe iron deficiency anemia and suspected GI source (new onset and felt that endoscopy will change management) • Significant weight loss • PEG Placement • EUS/staging for malignancy • Prosthesis removal (luminal, pancreaticobiliary) where waiting would cause potential harm to patient • Any significant upper/lower GI symptom that will aid in diagnosis/management of suspected disease that the patient and physician believe cannot wait 3 months to evaluate.	• Upper and Lower GI bleeding • Dysphagia impacting oral intake • Cholangitis • Symptomatic pancreaticobiliary disease • Palliation of GI obstruction • Patients with a time-sensitive diagnosis (evaluation of suspected malignancy).

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