

COVID-19

Provincial Guidance on the Management of Patients Requiring Gastrointestinal Endoscopy

Patient Coronavirus Screening prior to endoscopy

The following recommendations for screening of all patients who present for a surgery or procedure have been adopted provincially.

Update to Previous Guidance (Updated March 20 & 23, 2020)

1. Any patient who has returned to Manitoba from travel, including travel within Canada, should not have their procedure in the first 14 days following their return even if asymptomatic, except in emergency circumstances.
2. Any patient who has been in direct contact with a known positive COVID-19 patient should not have their procedure within 14 days of the contact even if asymptomatic, except in emergency circumstances.
3. Any patient who has been in direct contact with a person who is undergoing testing for COVID-19 should not have their procedure until the results are confirmed negative even if asymptomatic, except in emergency circumstances.
4. Any patient who has an influenza-like illness at the time they show up for their procedure should not have their procedure until they have recovered, except in emergency circumstances;
5. Any patient who has an unexplained new cough should have their procedure delayed until it has been investigated, even if they do not have a fever, except in emergency circumstances.

If any patient that meets any one of the criteria above and presents for elective outpatient endoscopy, they should be cancelled at the site, sent home and rescheduled as necessary. The most responsible MD for the patient can make that distinction. For physicians in Winnipeg, central intake should be notified of the cancellation and rebooking will occur at a later date. For rural and northern physicians, the local slating office should be notified of the cancellation.

Urgent cases or therapeutic cases for known diseases may continue as planned with appropriate PPE (as described below). Even when a procedure is relatively urgent, it may be reasonable to postpone the procedure for a short period until the patient can be cleared as a possible COVID-19 carrier. When possible, procedures should be avoided in those individuals over age 70 or with multiple comorbid conditions unless absolutely necessary in order to prevent hospital related acquisition of COVID -19.

The following will summarize recommendations concerning gastrointestinal endoscopy in the current setting of concerns over COVID- 19 and attempt to provide consistency in practice throughout all health regions in Manitoba. These recommendations are consistent with previous directives from Dr. Dana Moffatt at WRHA Central Endoscopy Intake.

At present, all provincial GI endoscopy sites should be moving toward booking only emergent and urgent non-elective cases. Elective cases are considered those that can wait longer than 3 months. Each endoscopy unit must review all presently planned endoscopic procedures to ensure that they comply with current recommendations. Regardless of the prioritization protocols used in a particular endoscopy unit, patient selection for urgent cases will include the following groups as per the “endoscopy referral form” that is used in all regions:

Endoscopy Patient Selection

As discussed in prior memos and emails, going forward ALL elective outpatient endoscopy is on hold and patients should be cancelled.

The remaining outpatient slates we have access to are reserved for:

- Urgent indications (essentially new cancer diagnosis or therapy) and ERCPs for ascending cholangitis
- Semi urgent indications including high risk rectal bleeding concerning for colon cancer, definite and significant iron deficiency anemia of unknown etiology, progressive dysphagia concerning for cancer, suspected ongoing upper GI bleeding not responsive to medical management, Endoscopic ultrasound (EUS) for oncologic diagnosis or pancreatic fluid collection drainage. ERCPs for symptomatic common bile duct stones, post-operative bile leaks, and to stent obstructed tumours can be considered semi urgent as well.
- Outpatients specifically selected by the endoscopist for indications outside of a) and b) that CANNOT wait 3 months for assessment and treatment
- PEG tube placements as outlined below

Procedures that should NOT be performed are EGD/ERCP/EUS for:

1. Dyspepsia investigation
2. Barrett’s esophagus screening/surveillance
3. H.Pylori status assessment
4. Abdominal pain
5. Iron deficiency anemia with low index of suspicion for UGI pathology
6. Weight loss
7. Non iron deficiency anemia
8. Assessment of chronic dysphagia
9. Confirmation of celiac disease
10. Evaluation or treatment of benign or low risk neoplasia
11. Chronic pancreatitis, recurrent pancreatitis, pancreas divisum, ampulla stenosis or abdominal pain
12. Screening for varices or routine banding of known varices
13. EUS for benign neoplasia or submucosal lesions, chronic pancreatitis or pancreatic cyst assessment

Peg Tubes:

Peg tubes placed endoscopically should be deferred whenever possible. Inpatients can safely have an NG in place for 6-8wks or more, and placement of a PEG should only be considered if failure of an NG tube occurs or if a PEG is required for disposition or if immediate enteral access is required for medication delivery that is not possible by other means.

PEG tube and button replacements at the bedside or by Interventional radiology can still occur with appropriate droplet precautions undertaken.

FOBT positive patients requiring Colonoscopy

Given the potential for significant pathology, it is reasonable to continue providing diagnostic colonoscopy for screening FOBT positive patients, at least in the short term. There is evidence that patients with a positive FOBT or FIT test that do not undergo diagnostic colonoscopy in a timely fashion have worse oncologic outcomes. At present ColonCheck CancerCare Manitoba has stopped FOBT screening. Regions are advised to stop all additional ad hoc colorectal cancer screening using FOBT or colonoscopy at this time.

Personal Protective Equipment

The following recommendations should be followed at all sites:

In the absence of widespread community transmission of COVID-19, use of a double lined surgical mask and eye shield for ALL upper and lower endoscopy procedures is recommended, as well as waterproof gown, gloves, hair net (Enhanced Contact/Droplet Precautions).

For patients that are COVID-19 positive or suspected to have COVID-19, follow provincial PPE recommendations including Enhanced Contact/Droplet Precautions and use of an N95 respirator for aerosol generating medical procedures (AGMPs). Any upper endoscopy should be performed in a negative pressure room, if possible. If a negative pressure room is not available, then the room requires a portable HEPA filter running for 60 minutes between cases, followed by a terminal clean. Please communicate with site IP and C documentation as well as MB Health directions for more information about this process.

Patients that are COVID-19 positive or suspected to have COVID-19 and require lower endoscopy should be scoped in a negative pressure room, or follow protocols for HEPA filtration and terminal cleaning of the room. Physicians and nurses are recommended to follow enhanced droplet protection for PPE.

- Use a mask and eye shield for ALL upper and lower endoscopy procedures, as well as gloves and waterproof gowns, and hair nets. COVID-19 has been found in upper and lower GI tract biopsies and secretions, in symptomatic and asymptomatic patient.
- Patients that are at risk for COVID-19 or have a history of contact with a COVID-19 patient should NOT undergo endoscopy of any kind, unless absolutely necessary. This includes both outpatients and inpatients. If these patients do require urgent/emergent upper endoscopy, N-95 respirators are recommended for all staff.

- Patients with confirmed COVID-19 that require upper endoscopy should be done in a negative pressure room, and if in Winnipeg at an acute care site. If your site does not have a negative pressure room for endoscopy, then you will need to follow IP and protocols for cleaning, with HEPA filtration of the room x 60 minutes between cases followed by a terminal clean.
- Patients with confirmed COVID-19 that require lower endoscopy should be done with extreme caution; use of N95 respirators for all staff is recommended but not mandatory. At the very least, enhanced droplet precautions are mandatory. Again, there should be a high threshold to perform endoscopy in these patients due to the risk to staff and the facility.

Future state:

If/when we have confirmed broad based community transmission of COVID-19 in Manitoba, we will have to adjust our standards again, as all upper endoscopy (including ERCP and EUS) will have to be treated as if they are potentially COVID-19 positive eg. Full PPE, N95 respirators, negative pressure room and terminal cleaning as outlined above.

NOTE: Prescreening with a negative COVID-19 test in asymptomatic patients is not an acceptable practice due to the imperfect sensitivity of the test, particularly in asymptomatic patients.

Therefore when community transmission is occurring broadly in Manitoba, upper endoscopy should only be reserved for emergent and life threatening indications.

This is an evolving situation. As recommendations change, they will be communicated.