



**Joint Advisory Group  
on GI Endoscopy**



**BRITISH SOCIETY OF  
GASTROENTEROLOGY**

3 St Andrews Place  
Regent's Park  
London NW1 4LB

T 020 7935 3150  
F 020 7487 3734  
[www.bsg.org.uk](http://www.bsg.org.uk)

17.03.2020

Dear Colleagues,

### **Advice for Endoscopy Teams during COVID-19**

There is a clear and urgent need to plan for endoscopy activity over the coming weeks and months. It is very difficult in these challenging and uncertain times to decide what is best for patients, the population at large and healthcare staff, and there is balance of risks to consider. As a result of multiple discussions with key stakeholder groups we are publishing this advice to help Endoscopy Units and teams plan their activity during the COVID-19 outbreak. Be aware that this advice may change rapidly and we will update it as required, especially as further national updates and advice are announced.

This document has been developed with and is supported by:

- British Society of Gastroenterology (BSG)
- Joint Advisory Group (JAG)
- The Association of Coloproctology of Great Britain and Ireland (ACPGBI)
- Association of Upper Gastrointestinal Surgeons (AUGIS)
- Pancreatic Society of Great Britain and Ireland (PSGBI)
- UK and Ireland EUS Society (UKI-EUS)

It is also supported across the devolved nations by:

- Scottish Society of Gastroenterology (SSG)
- Welsh Association of Gastroenterology and Endoscopy (WAGE)
- Ulster Society of Gastroenterology (USG)

We have also shared it with the Irish Society of Gastroenterology (ISG).

## Introduction and background

Following conversations over the past 3 days, with some of the key stakeholders and opinion leaders involved in Endoscopy, there is agreement that there is an urgent need to plan for endoscopy activity over the coming weeks and months. Our assessment is that it will be too late if we wait for a central directive to tell us what to do regarding endoscopy activity.

Public Health England and their equivalent bodies across the UK, may produce their own advice soon about bowel screening. Bowel Scope flexible sigmoidoscopy may be officially suspended soon. FIT+ screened patients represent a more complex problem and we are waiting for advice from the UK Departments of Health, but nothing is available at present. It may be inevitable that we pause the colonoscopy screening programmes for a period of time but there are also arguments in favour of continuing at least in those <70 years old. FIT+ screened patients may represent a priority group, compared to the 2 Week Wait/suspected cancer, symptomatic referral patients, given the higher diagnostic yield and fitness of patients involved in the screening program. We discuss some of these issues later in the document.

The other group of patients causing concern are 2 Week Wait referrals and we are hoping for advice from NHS-England and the Devolved Administrations as quickly as possible. The BSG has been in contact with them and we await their response. The numbers of referrals *may* fall as patients who are already ill or who are self isolating, or who cannot see their GP, stay away from hospitals.

## Key Advice:

**In the absence of any specific instructions relating to gastrointestinal endoscopic procedures from the Government and the Devolved Administrations, and following the general strategic intent expressed by the UK Government to reduce any non essential exposure to the COVID-19 virus and to take all reasonable measures to limit its spread, the BSG now recommends that all elective and non-essential endoscopic procedures should stop, as soon as possible.**

## Discussion and Recommendations.

We believe, based on the evidence available to us at this time that this action is essential to:

1. Help flatten and delay the outbreak curve.
2. Minimise risk to other patients and staff. In particular it is essential to reduce the sickness absence rate and the need for staff to adopt forced self isolation.
3. The risk of faecal transmission is not clear at present but it is plausible and possible.

4. Asymptomatic COVID-19 infected patients are a known source of infection.
5. Stocks of standard and enhanced Personal Protection Equipment are limited and need to be prioritised, both for our own patients and for other areas of the hospitals.
6. Staff availability will decline as infection, self-isolating, childcare and redeployment are enforced. The available staff have to be deployed to procedures where endoscopy is essential and will change the management of patients.
7. The supply of devices and consumables (e.g. injection needles, banding kits, stents) may not be guaranteed as supply chains are placed under stress within the UK and abroad. These items need to be carefully husbanded over the coming weeks so they are used in the cases where they will be most effective.
8. Endoscopy is a major cancer diagnostic service, but patients with endoscopically detected cancers, who have completed their staging, may be unable to be listed for major surgery in the foreseeable future, because of the pressure on ICU and HDU beds for post-operative care. There is also likely to be a shortage of theatre staff.

For this reason, we suggest that urgent suspected cancer patients are assessed on a case by case basis and only endoscoped where the clinical need is felt to be a priority.

This list is not exhaustive and may have to be modified as the COVID-19 epidemic evolves, or new evidence becomes available.

The current situation has placed huge demands on politicians and those in medical leadership roles and the BSG therefore understands that official advice, specific to gastrointestinal endoscopy, may take time to emerge. For this reason, the BSG has consulted senior members of the GI community for advice and feels that in the absence of specific advice, we must now take a lead and consider what we should recommend to Health Boards and Trusts. Many organisations have already started to take the steps we are recommending.

## Decision making on Endoscopic Procedures

The BSG suggests that activity is prioritised under 3 categories:

- **Needs to continue;**
- **Defer until further notice;**
- **Needs discussion (possibly case-by-case, at consultant level)**

### Needs to Continue:

- Acute Upper GI bleeding
- Acute oesophageal obstruction – foreign bodies, food bolus, pinhole stricture/cancer where stenting is considered essential.
- Endoscopic vacuum therapy for perforations/leaks.
- Acute cholangitis/jaundice secondary to malignant/benign biliary obstruction

- Acute biliary pancreatitis and/or cholangitis with stone and jaundice
- Infected pancreatic collections/WON
- Urgent inpatient nutrition support – PEG/NJ tube
- Gastrointestinal obstruction needing urgent decompression/stenting

### Defer until further notice:

- **All routine symptomatic referrals**
- **Planned POEM, pneumatic dilatation for achalasia**
- **Other elective therapy/intervention** –PEG, stricture dilatation, APC for GAVE, RFA, pneumatic dilatation, ampullectomy etc
- **Bariatric endoscopy**
- **Low-risk follow-up** and repeat scopes – oesophagitis healing, gastric ulcer healing, ‘poor views’, check post therapy e.g. EMR/RFA/polypectomy (unless felt to be clinically high risk neoplasia still present) etc
- **Surveillance** -polyp FU, IBD, Barrett’s (unless felt to be clinically high risk neoplasia still present)
- **Routine/ non urgent Small bowel endoscopy**
- **EUS for ‘benign’ indications** – biliary dilatation, possible stones, submucosal lesions, pancreatic cysts without high-risk features
- **Other ERCP cases** - stones where there has been no recent cholangitis and a stent is in place; therapy for chronic pancreatitis; metal stent removal/change; ampullectomy follow up.
- **Bowel Scope flexible sigmoidoscopy should stop until there has been discussion with local commissioners.** This must include a proper risk assessment, which includes the likely benefits against the risks to staff and the maintenance of an emergency service.
- **Patients undergoing endoscopy / biopsy as part of clinical trials.**

### Needs discussion (possibly case-by-case)

- **2 Week Wait cancer referrals –to be assessed on an individual basis.** We recommend a group of consultants reviews and triage these referrals\*
- **FIT+ bowel screening colonoscopy should probably stop until there has been discussion with local commissioners or Boards.** This must include a proper risk assessment, which includes the likely benefits against the risks to staff and the maintenance of an emergency service. We recognise the significant difficulty surrounding this decision and will seek urgent advice from the UK Government and the Devolved Administrations. The arguments for and against the continuation of FIT+ bowel screening colonoscopy are discussed in the footnote.<sup>1</sup>

---

<sup>1</sup> It is difficult to know how best to advise for these groups of referrals – there are arguments in favour of pausing/suspending activity and arguments in favour of trying to carry on as best as possible. Arguments are possibly more in favour of continuing with colonoscopy screening over 2 Week Wait referrals, given the higher yield (10+%) and that many detected cancers may be eligible for surgery without ICU postoperatively. We do not have evidence on which to base a decision and

- **Planned EMR/ESD for complex polyps/ high risk lesions .**
- **New suspected IBD – acute colitis**
- **Cancer staging EUS – biopsy and/or staging**
- **SB endoscopy- ongoing transfusion dependent bleeding / suspected SB cancer on radiology/capsule endoscopy**

## Important Notes

- **This list is neither exhaustive nor prescriptive and is meant to serve as *a guide* to clinical teams when planning during the current emergency.**
- **The situation continues to evolve rapidly and this advice may change from day-to-day, so clinicians and managers need to check regularly and look for updates and briefings from the relevant Government agencies** in the four nations.
- **Teams need to consider resources- both staff and equipment** (PPE and endoscopy kit) – when planning and think well ahead as we get closer to the peak of the outbreak.
- **Systems need to be in place to keep records of patients who have been deferred or cancelled** so that either alternative arrangements (e.g. clinic follow up, radiological imaging) can be made or rebooking can occur when it is safe to resume normal activities. Local discussions with colleagues in Radiology may also be helpful when considering this.

## More general operational considerations

- **Restricting numbers of staff in rooms** for all procedures –e.g. limit trainees (may be redeployed anyway)
- **Limiting advanced endoscopy cases above to a smaller number of specialist consultants,** based in Endoscopy and ensuring that they are fitted appropriately for enhanced PPE
- **Assessing stocks of consumables and devices daily** - without panic buying. Keep in touch with suppliers and local representatives regarding the supply chain in coming weeks
- **Considering alternatives for diagnostic testing** –FIT/calprotectin; radiology (already hard pressed); telephone triage of e.g. 2WW referrals

We also believe that upper GI endoscopy of all kinds must be regarded as an aerosol prone procedure (AGP) and would urge the UK Government and Devolved Administrations to take action on this, by providing appropriate masks and personal protective equipment for staff. The risk in not taking these measures will be a potentially significant loss of staff due to illness with serious consequences for the provision of endoscopy services.

---

*hope that the situation will become clearer in the coming days. Until then, this should be discussed urgently with local commissioners and Endoscopy Leads.*

We understand how difficult these times are for everyone and that decision-making around endoscopy will be challenging. We wish everyone the best in the coming weeks and will continue to support you as much as possible throughout.



**Ian Penman**

**Vice-President Endoscopy, BSG**



**Cathryn Edwards**

**President, BSG**



**Mark Coleman**

**Chair, JAG Endoscopy**



**Alastair McKinlay**

**President Elect, BSG**

On behalf of:

- British Society of Gastroenterology (BSG)
- Joint Advisory Group (JAG)
- The Association of Coloproctology of Great Britain and Ireland (ACPGBI)
- Association of Upper Gastrointestinal Surgeons (AUGIS)
- Pancreatic Society of Great Britain and Ireland (PSGBI)
- UK and Ireland EUS Society (UKI-EUS)
  
- Scottish Society of Gastroenterology (SSG)
- Welsh Association of Gastroenterology and Endoscopy (WAGE)
- Ulster Society of Gastroenterology (USG)

DATE: 17.03.20