LETTER TO THE EDITOR

GESATA Statement on the timing of elective endoscopic procedures in patients with recent COVID-19 infection

To the Editor,

SARS-CoV-2 is currently widely prevalent in the Australian community. Rapid antigen tests (RATs) are being routinely used in several facilities in Australia for point-of-care testing of patients presenting for endoscopic procedures. Consequently, asymptomatic, or mildly symptomatic patients are being diagnosed with COVID-19 on the day of their scheduled procedure. Active COVID-19 infection has been associated with increased risk of post-operative morbidity and mortality in patients undergoing major surgery.1–3 This has led to local and international guidelines recommending delaying elective surgical procedures in patients with active COVID-19 infection where possible.4

Questions as to whether elective endoscopic procedures should be delayed, and the duration of delay, are therefore of contemporaneous importance. We reviewed the published current evidence to develop this guidance statement regarding timing of elective endoscopic procedures in patients with recent COVID-19 illness.

The appropriateness of point of care RATs on the day of endoscopic procedures is not reviewed in this document. We acknowledge that there is lack of evidence supporting routine use of COVID-19 screening tests prior to outpatient endoscopy procedures in asymptomatic individuals. However, as this is an evolving situation and depends on various factors such as local prevalence and community transmission rate, the use of RATs is left to the discretion of individual endoscopic/hospital facilities and health department jurisdictions.

There have been several large cohort studies that have assessed post-operative outcomes in patients with COVID-19. In a prospective cohort study from the Unites States involving patients undergoing elective major surgery, patients with recent SARS-CoV-2 infection (< 4 weeks before surgery) were found to be at increased risk of developing post-operative pneumonia and respiratory failure.1 In an international collaborative study by COVIDSURG group, patients with COVID-19 infection undergoing any surgery were found to have significantly increased risk of 30-day mortality up to 6 weeks after infection compared with COVID-19-negative patients.2 A previous COVIDSURG study assessing risk of COVID-19 infection on post-operative morbidity and mortality early in the pandemic reached a similar conclusion.3 Following an evaluation of the literature, Kovoor et al. recommended that minor surgery be delayed for 4 weeks and major surgery 8–12 weeks following laboratory confirmation of symptomatic SARS-CoV-2 infection.4

While these studies have been instrumental in risk-stratifying patients and informing timing of elective surgeries in patients with COVID-19, extrapolation of these data to endoscopy practice requires caution. Patients undergoing endoscopic procedures were excluded in all these cohort studies. Furthermore, there are no data directly assessing risk of post-procedure outcomes in patients with COVID-19 undergoing endoscopy procedures. Given that major surgeries require general anesthesia and involve a measurable inflammatory insult, these are not comparable with endoscopic procedures performed under intravenous sedation, where patients routinely return to their normal activity level within 12–24 h after the procedure. Significantly, all large cohort studies examined outcomes in unvaccinated patients. Since the highly effective vaccines became available in Australia in early 2021, over 93% of Australia’s population age 16 and over have now received at least two doses of vaccines.5

In summary, high-quality evidence informing endoscopy practice in the 2022 phase of the COVID-19 pandemic is lacking. The implications for patient health outcomes as a result of further delays in endoscopic management need to be assessed in the context of potential waiting list pressures due to legislated elective surgery restrictions. The recommendations below (Table 1) must be individualized and do not obviate the need for appropriate clinical judgment regarding risks and benefits for a given patient. The recommendations are intended to advise planning elective endoscopy procedures only. Any patient requiring an urgent endoscopic procedure should proceed based on the clinical indication with attention to local infection prevention and control policies.

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Table 1  Timing of endoscopic procedures for patients with a recent COVID-19 diagnosis

| Diagnosis                      | Endoscopic Procedure                                |
|--------------------------------|-----------------------------------------------------|
| Asymptomatic COVID-19 infection diagnosed + or within 2 weeks prior to scheduled procedure | Defer endoscopic procedure for ≥ 2 weeks after diagnosis |
| Asymptomatic COVID-19 infection diagnosed > 2 weeks prior to scheduled procedure | Proceed with endoscopic procedure as scheduled |
| Mild COVID-19 illness diagnosed on the day* of or within 2 weeks prior to scheduled procedure | Rebook endoscopy procedure ≥ 2 weeks after diagnosis |
| Mild COVID-19 illness diagnosed > 2 weeks prior to scheduled procedure | Proceed with endoscopic procedure as scheduled |
| Moderate COVID-19 illness diagnosed on the day* of or within 4 weeks prior to scheduled procedure | Rebook endoscopy procedure ≥ 4 weeks after diagnosis |
| Moderate COVID-19 illness diagnosed > 4 weeks prior to scheduled procedure | Proceed with endoscopic procedure as scheduled |
| Severe or critical COVID-19 illness within 6 months of scheduled procedure | Defer endoscopic procedure until cleared at medical review |

*Diagnosis made by rapid antigen test and/or PCR test.

Mild symptoms and signs of COVID-19 illness include fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, and loss of taste and smell.

Moderate symptoms defined as any of respiratory rate ≥ 30 breaths/min, SaO₂ < 92% on room air and lung infiltrates > 50%.

Severe or critical illness includes deteriorating respiratory function, respiratory failure, and other organ failure.

COVID-19 severity definition adapted from National COVID-19 clinical evidence taskforce. Available at: [https://www.nationalclinicalguidelines.com/covid-pdg](https://www.nationalclinicalguidelines.com/covid-pdg)

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References

1 Deng JZ, Chan JS, Potter AL et al. The risk of postoperative complications after major elective surgery in active or resolved COVID-19 in the United States. Ann. Surg. 2022; 275: 242–6 Epub 2021/11/19.
2 Collaborative CO, GlobalSurg C. Timing of surgery following SARS-CoV-2 infection: an international prospective cohort study. Anaesthesia 2021; 76: 748–58 Epub 2021/03/11.
3 Collaborative CO. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. Lancet 2020; 396: 27–38 Epub 2020/06/02.
4 A multidisciplinary consensus statement on behalf of the Association of Anaesthetists C, for Perioperative Care FoSSA, Royal College of Anaesthetists RCoSoE. SARS-CoV-2 infection, COVID-19 and timing of elective surgery. 2021.
5 Surgeons RACo. Guidance on delay to elective surgery post recovery from SARS-COV 2 infection. 2020.
6 Anaesthesiologists ASo. ASA and APSF joint statement on elective surgery and anesthesia for patients after COVID-19 infection. 2021.
7 Kovoor JG, Scott NA, Tivey DR et al. Proposed delay for safe surgery after COVID-19. ANZ J. Surg. 2021; 91: 495–506. [https://doi.org/10.1111/ans.16682](https://doi.org/10.1111/ans.16682)
8 Australian Government DoH. COVID-19 vaccination daily rollout update. 2022.