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Bronchoscopist's perception of the quality of the single-use fiberoptic bronchoscope (Ambu aScope4™) in conventional bronchoscopies. A multicenter study in 21 Spanish pulmonology services.

Keywords:

Bronchoscopy, quality, CUSUM analysis, aScope4TM, bronchoalveolar lavage

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Authors list:

Flandes Aldeyturriaga J 1, Giraldo-Cadavid L 2, Alfayate J 1, Fernández-Navamuel I 1, Agustí C 3, Lucena C 3, Rosell A 4, Andreo P 5, Centeno C 5, Montero C 6, Vidal I 6, García-Alfonso L 6, Bango A 7, Ariza M 7, Gallego R 8, Orta M 8, Bello S 9, Mincholé E 9, Torrego A 10, Pajares V 10, González H 11, Wangüemert A 12, Pérez-Izquierdo J 13, Disdier C 14, de Vega B 14, Cordovilla R 15, Cascón J 15, Cruz A 15, García J 16, Puente L 16, Benedetti P 16, García-Gallo C 17, Díaz Nuevo G 17, Aguado S 17, Partida C 18, Díaz-Agero P 18, Luque E 19, Pavón M 19, Páez F 20, Cases E 21, Martínez R 21, Briones A 21, Fernández C 22, Martín C 22, Uribe-Hernández A 23, Robles J 24

Institutional affiliations:

1. Bronchoscopy and Interventional Pulmonology Unit, University Hospital "Fundación Jiménez Díaz", Madrid, Spain
2. Universidad De La Sabana; Fundación Neumológica Colombiana, Bogotá DC, Colombia
3. Pneumology Service, Hospital Clinic Universitari, Barcelona, Spain
4. Pneumology Service, Hospital Universitari de Bellvitge, Barcelona, Spain
5. Pneumology Service, Hospital Universitari Germans Trias i Pujol, Badalona, Barcelona, Spain
6. Pulmonology Service, Complexo Hospitalario Universitario, A Coruña, Spain
7. Pneumology Service, Central University Hospital of Asturias, Oviedo Asturias, Spain
8. Pneumology Service, Hospital San Pedro de Alcántara, Cáceres, Spain
9. Pneumology Service, Miguel Servet University Hospital, Zaragoza, Spain
10. Pneumology Service, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain
11. Pneumology Service, University Hospital of the Canary Islands, Santa Cruz de Tenerife, Spain
12. Pneumology Service, Hospital San Juan de Dios, Santa Cruz de Tenerife, Spain

Preprints are preliminary reports that have not undergone peer review. They should not be considered conclusive, used to inform clinical practice, or referenced by the media as validated information.
13. Pneumology Service, Galdakao University Hospital, Bilbao Vizcaya, Spain
14. Pneumology Service, Hospital Clínico Universitario, Valladolid, Spain
15. Pneumology Service, University Assistance Complex, Salamanca, Spain
16. Pneumology Service, Hospital Universitario Gregorio Marañón, Madrid, Spain
17. Pneumology Service, Puerta de Hierro University Hospital, Madrid, Spain
18. Thoracic Surgery Service, Hospital Universitario La Paz, Madrid, Spain
19. Pneumology Service, Virgen de Macarena University Hospital, Seville, Spain
20. Pneumology Service, Carlos Hay Regional University Hospital, Malaga, Spain
21. Respiratory Endoscopy Unit, Hospital Universitari i Politècnic La Fe, Valencia, Spain
22. Pneumology Service, General University Hospital, Alicante, Spain
23. Fundación Neumológica Colombiana, Bogotá DC, Colombia
24. Industrial Electronic Engineering, GHS SL, Madrid

Authors’ email addresses

JFlandes@quironsalud.es
Javier Flandes
Javier Aldeyturriaga
lfgiraldo@neumologica.org
Luis Fernando Giraldo-Cadavid
javier.alfayate.sanchez@gmail.com
Javier Alfayate
lfgiraldo@neumologica.org
Iker Fernández-Navamuél
lfgiraldo@neumologica.org
Carlos Agustí
lfgiraldo@neumologica.org
Carmen M. (CM) Lucena
lfgiraldo@neumologica.org
Antoni Andreo
lfgiraldo@neumologica.org
Felipe Centeno
lfgiraldo@neumologica.org
Carmen Montero
lfgiraldo@neumologica.org
Iria Vidal Garcia
lucia.garciaalfonso@hotmail.com
Lucía García Alfonso
abango@telecable.es
Antonio Bango
ariamiguel@hotmail.com
Miguel Ariza
rociga@gmail.com
Rocío Gallego Dominguez
h62orcam@gmail.com
Marta Orta Caamaño
shello@salud.aragon.es
Salvador Bello
elichilla@hotmail.com
Elisa Mincholé
torregosantpau.cat
Alfons Torrego
fandreo@separ.es
Virginia Pajares
fandreo@separ.es
Carmen González
luciagarciaalfonso@hotmail.com
Julio Pérez-Izquierdo
jcascon@saludcastillayleon.es
Blanca de Vega Sanchez
antoniovicruz@hotmail.com
Juan Cordovilla
jjaviergarcial@gmail.com
Antonio Cruz
lpunte@separ.es
J. Javier García-López
paolaantonella.benedetti@salud.madrid.org
Luis Puente
paolaantonella.benedetti@salud.madrid.org
Paola Benedetti
Corresponding author:

Luis Fernando Giraldo-Cadavid, MD, PhD, FCCP
ORCID ID: 00-0002-7574-7913
Interventional Pulmonology, Fundacion Neumologica Colombiana
Department of Epidemiology and Biostatistics, Faculty of Medicine, Universidad de la Sabana
Professor of Medicine at the Universidad de la Sabana
Autonorte de Bogota Km 7, La Caro, Chía, Colombia
E-mail: luisf.giraldo@unisabana.edu.co; lfgiraldo@neumologica.org
Bronchoscopist's perception of the quality of the single-use fiberoptic bronchoscope (Ambu aScope4™) in conventional bronchoscopies. A multicenter study in 21 Spanish pulmonology services.

Summary

Background:

The disposable bronchoscope is an excellent alternative to face the problem of SARS-CoV-2 and other cross infections, but the bronchoscopist’s perception of its quality has not been evaluated.

Methods:

To evaluate the quality of the Ambu-aScope4 disposable bronchoscope, we carried out a cross-sectional study in 21 Spanish pulmonology services. We use a standardized questionnaire completed by the bronchoscopists at the end of each bronchoscopy. The variables were described with absolute and relative frequencies, measures of central tendency and dispersion depending on their nature. The existence of learning curves was evaluated by CUSUM analysis.

Results:

The most frequent indications in 300 included bronchoscopies was bronchial aspiration in 69.3% and the median duration of these was 9.1 minutes. The route of entry was nasal in 47.2% and oral in 34.1%. The average score for ease of use, image, and aspiration quality was 80/100. All the planned techniques were performed in 94.9% and the bronchoscopist was satisfied in 96.6% of the bronchoscopies. They highlighted the portability and immediacy of the aScope4TM to start the procedure in 99.3%, the possibility of taking and storing images in 99.3%. The CUSUM analysis showed average scores> 70/100 from the first procedure and from the 9th procedure more than 80% of the scores exceeded the 80/100 score.
Conclusions:
The aScope4™ scored well for ease of use, imaging, and aspiration. We found a learning curve with excellent scores from the 9th procedure. Bronchoscopists highlighted its portability, immediacy of use and the possibility of taking and storing images.

Keywords:
Bronchoscopy; quality; CUSUM analysis; aScope4TM; bronchoalveolar lavage; disposable
**Background:**

Fiberoptic bronchoscopy is a widely used procedure in most hospitals around the world, especially for the diagnosis of infectious, inflammatory and tumor lung diseases. It is estimated that 92,000 bronchoscopies are performed annually in Spain, with a tendency to growth. Unfortunately, bronchoscopy can spread infections by spreading an infection in the same patient, by cross-infection between patients, or by infecting the personnel involved in the procedure.\(^1\)

The effects of cross infection can be severe for the patient and the health system and include complications of the infection and its consequences in terms of laboratory tests, medications, hospital stay, disability, and direct and indirect costs. For this reason, it is necessary to take extreme care and precautions in the decontamination and cleaning of equipment.\(^2\) Despite complex and advanced endoscope cleaning and disinfection systems, disinfection is often inadequate\(^3-5\), with the consequent risk of cross infection.\(^5-7\)

A disposable bronchoscope could decrease the risk of cross infection and increase accessibility to bronchoscopy in centers of less complexity or with limited resources and has been recommended by most respiratory societies for bronchoscopies during the SARS-COV-2 pandemic.\(^8-11\) Patients on mechanical ventilation,\(^12\) immunosuppressed or with infectious contagious diseases are those with the highest risk for cross infections and where these devices may have a more relevant role. These bronchoscopes are also desirable for procedures with a high risk of damage the bronchoscope (e.g. bronchoscopy by orotracheal tube), to reduce repair costs.\(^13\)
The utility of single-use bronchosopes has been extensively studied in anesthesiology, where they have been compared with reusable bronchosopes in terms of ease of use. In the field of pulmonology, there are not publications listing the perception of pulmonologists when using these bronchosopes for conventional diagnostic and therapeutic techniques.

This study seeks to evaluate the perception of the bronchoscopist about the quality of the Ambu® aScope™ 4 bronchoscope and the existence of a learning curve during the performance of conventional bronchoscopies of low complexity in the usual practice in pulmonology services of university hospitals of third level of care.

**Methods:**

**Design**

A prospective, observational, multicenter, cross-sectional study was conducted of an approved disposable bronchoscope (Ambu® aScope4 ™) with European certification (CEA) and used according to the product data sheet.

The study was carried out between February and August 2018, in tertiary care university hospitals with experience in performing bronchoscopies. The study was approved by the ethics committees of each institution and all the participants signed the informed consent both for their participation in the study and for the bronchoscopy.

The inclusion criteria were patients over 18 years with indication for the performance of a diagnostic bronchoscopy and that the procedure be approved by signing the informed consent. Exclusion criteria were bronchoscopies that required flexible interventional bronchoscopies or in which highly complex equipment was to be used. 300 subjects were recruited prospectively and consecutively in 21 Spanish pulmonology services.
Bronchoscopists had an experience of more than 500 bronchoscopies. The bronchoscopies were only diagnostic bronchoscopies with bronchial aspiration and bronchoalveolar lavage (BAL) and therapeutic bronchoscopies that involved the aspiration of secretions or hematic remains.

The bronchial aspirate (BAS) consisted of collecting the secretions found during the examination by means of simple aspiration or by using instillations of small volumes of physiological serum (5-10 cc) to favor the collection or try to carry away cellularity or microbiota of the airway.

BAL was performed by interlocking in a segmental or subsegmental bronchus (depending on the bronchial anatomy), three 50-cc aliquots of 0.9% saline were instilled and successively aspirated and processed for study. It was assumed that the first aliquot would collect a sample from the bronchial area, while the last volume instilled would carry distal airway and alveolar contents.

In the cases included in the study, the bronchoscopy was performed by two observers, the main operator who operated the bronchoscope and a collaborator who analyzed the exploration during its development. A video of each bronchoscopy was recorded and saved in the memory of the Ambu® aView™ device for later visualizations. The videos were labeled according to the order number and date of the examination, without the patient data being included. All procedures were anonymous in storage and confidentiality and privacy regulations were respected.

A search of the literature was carried out on questionnaires that measured the quality of the fiberoptic bronchoscopes for the performance of diagnostic bronchoscopies and none was found, so a new questionnaire was constructed on the Bronchoscope Quality Questionnaire (BQQ) by means of an expert consensus to establish the relevant items and domains to evaluate in the quality of the bronchoscope. A pilot test was carried out to
adjust the questions and the psychometric measures of the final instrument were evaluated.

The BQQ was assessed independently and masked by the two bronchoscopists after the bronchoscopy at two different times. Both questionnaires were archived and after a period of 1-15 days from the bronchoscopy, one of the two bronchoscopists viewed the video of the bronchoscopy, and completed the questionnaire again.

**Statistic analysis**

The qualitative variables were described with absolute and relative frequencies, the quantitative ones by means and standard or median deviations, and interquartile range (25th percentile to 75th percentile) depending on their distribution. The internal consistency of the questionnaire was measured with the Cronbach's alpha coefficient. To unify the item scores and to be able to compare them, the standardized scores were calculated using the following equation:

\[
\frac{\text{score obtained on the item}}{\text{maximum possible score on the item}} \times 100
\]

In this way, the standardized score was left with a range from 0 (worst possible score) to 100 (best possible score).

To assess the bronchoscopies quality related to the number of procedures performed with the aScope4 and the existence of learning curves, we used the binary CUSUM analysis method. We describe the details of this method in the supplemental appendix, which we summarize below. We consider an acceptable failure rate \((p_0\) 10% (90% of the scores in the evaluated aspect \(\geq 80 / 100\)) and an unacceptable failure rate of 20% \((p_1\) ) (less than 80% of the scores in the evaluated aspect \(\geq 80 / 100\)); we defined a type I error (probability
of falsely qualifying the bronchoscope as inadequate, designated as $\alpha$) of 0.1 and a type II
error (probability of falsely qualifying the bronchoscope as excellent, designated as $\beta$) of
0.1 (15–17). We plotted the CUSUM graph by plotting the index number of each case
(bronchoscopy) on the x-axis versus the cumulative sum score after that case on the y-
axis. Consecutive failures drive the CUSUM curve upward while consecutive successes
drive the CUSUM curve downward.

The CUSUM chart includes horizontal lines called decision limits ($h_1$ y $h_0$), which are the
limits of an acceptable or unacceptable error rate. When the CUSUM curve crosses a
decision boundary from above, it is inferred that the failure rates were within the
predetermined acceptable rate of 10% (excellent performance); when the CUSUM curve
crosses a decision limit from below, it is inferred that failure rates have reached the
unacceptable failure rate of 20% (inadequate performance); If the CUSUM curve is stable
between two decision limits, stable performance is inferred within good levels. Therefore,
good performance is assumed when the CUSUM curve slopes downward or remains
stable, but when the curve slopes upward it indicates a lower than acceptable success
rate. Decision limits ($h_1$ and $h_0$) were calculated based on the risk of type I errors ($\alpha$) and
II ($\beta$). In our case, as $\alpha = \beta = 0.1; p_0 = 10\%$ and $p_1 = 20\%$; therefore $h_0 = h_1 = 2.71$. For
this reason, we mark the decision limits of our CUSUM charts as horizontal lines starting
from the axis and at intervals of 2.71. Software used Microsoft Excel 2016 (Microsoft
Corporation, Redmond, WA, USA) and STATA vs 14.0 (StataCorp, Texas, USA).

Assuming a confidence of 95%, a margin of error of 6% and an average proportion of 50%
for the qualitative variables (more demanding scenario in terms of sample size), a sample
size of 267 bronchoscopies was deemed necessary for the study, to compensate possible
losses it was decided to increase to 300 bronchoscopies.

Results
A total of 300 bronchoscopies were performed, 15 procedures were made by each Spanish pulmonology services, 36 bronchoscopist participated with a median of 4 bronchoscopies (IQR: 2.1 - 8.4). The most frequent indications were BAS in 69.3% of all cases (208/300; 95% CI: 63.9% -74.3%) and BAL in 125 of all bronchoscopies (41.7%; 95% CI: 36.2% -47.3%) (Table 1 and figure S1). The nasal route of entry was used in 47.2% (141/300; 95% CI: 41.6% -52.8%) and the oral one in 34.1% of cases (95% CI: 29.0% -39.7 %) (Table 1 and figure S2). The duration of the bronchoscopy had a median of 9.1 minutes (IQR: 6.0-13.0) (Table 1). The reliability of the questionnaire measured by Cronbach’s alpha was 0.88.

The average in user-friendliness, image and aspiration quality was 4 out of a maximum score of 5 (standardized score: 80/100; for a maximum score of 100 and a minimum of 0). The average standardized score for ease of use, image quality, and aspiration was 80/100 (Table 2 and Figure 1). In 6% of the cases it was necessary to change the aScope 4, the most frequent reasons were limitation to reach the goals of the procedure and damage to the bronchoscope. 54.4% considered that the aScope had lower image quality than reusable video endoscopes. In more than 90% of the cases, all the pulmonary segments could be reached and all the planned techniques could be performed, for a general satisfaction with the team of 86.4% and a recommendation for its use in similar cases in 86.4% of the cases (Table 3).

The analysis by the CUSUM Analysis graphical method to detect if there was a learning curve in the use of the Ambu® aScope4 ™ showed the following learning points (point in which the scores exceeded 80/100 in more 80% of bronchoscopies): ease of passing the fiberoptic bronchoscope to the trachea (intubation) in the 3rd procedure, ease of maneuvering during the bronchoscopy in the 4th procedure, and image quality during the
bronchoscopy in the 9th procedure (Figure 2). Before these learning points the average scores for these aspects were between 70/100 and 80/100. The assembly of the equipment and the quality of aspiration of the bronchoscope obtained standardized scores higher than 80/100 from the first procedure.

The most outstanding characteristics of the bronchoscope were its portability and immediacy to start the procedure in 99.3% (296/300; 95% CI: 97.6% -99.8%), its sterility in 96.3% (287 / 300; 95% CI: 93.5% -97.9%), the possibility of taking and storing images and videos of the procedure in 99.3% of cases (298/300; 95% CI: 97.6% -99.8 %) and 88.6% (263/297; 95% CI: 84.4% -91.7%) considered that the images and videos were of sufficient quality. 93% of bronchoscopists considered it useful that the bronchoscope be disposable and for single use (277/300; 95% CI: 89.5% -95.3%). In one of the units of non-invasive mechanical ventilation where this study was conducted, highlighted the usefulness of the aScope 4 left at the bedside of a patient who presented dyspnea due to severe accumulation of secretions, by allowing them to aspirate them under direct vision more effectively than with the aspiration probe at blind.

**Discussion**

Our study provides as novel aspects the evaluation of the bronchoscopist's perception of the quality of the aScope4™ disposable bronchoscope through a standardized questionnaire and the measurement of its learning curve. The aScope4TM was very well evaluated in terms of ease of use, imaging and aspiration, obtaining an average score of 80/100 and a high degree of satisfaction in the bronchoscopist. After the 9th procedure, the scores exceeded 80/100 in more than 80% of the bronchoscopies. They highlighted its portability, immediacy to start the procedure and the possibility of storing the images.
New bronchoscopes have recently been introduced that offer advantages over existing ones. The quality assessment of these bronchoscopes should be done in the most objective way possible, to validate their functionality. The measurement of the bronchoscopist’s perception using standardized questionnaires that include the most relevant domains is a key element for the validation of these devices. In the absence of a questionnaire with these characteristics, we designed one by a panel of expert bronchoscopists, which included questions related to the route of entry, ease of assembly of the equipment, ease of operation, image quality and aspiration, robustness of the equipment to maintain full functionality and to allow the planned sampling, in addition to the degree of general satisfaction.

The evaluation of the psychometric properties of the BQQ showed a very good internal consistency as measured by Cronbach’s alpha, with a value of 0.88\(^{(18)}\). It is noteworthy that the Cronbach’s alpha coefficient can have values between 0 and 1, 0 indicates absence of consistency and 1 total consistency. Values between 0.8 and 0.9 are considered very good, values less than 0.7 are considered low and values greater than 0.94 are considered indicative of redundancy in the questions. The participation of a panel of experts in the construction of the questionnaire and the values obtained in Cronbach’s alpha gave us the necessary support in aspects related to the validity of appearance, content and construct to apply the questionnaire in our study.

A single-use disposable bronchoscope has significant advantages related to reducing the risk of cross infection, ease of compliance with non-working cleaning and disinfection regulations, and reducing costs related to trauma repairs during use or reprocessing of the equipment. Studies on the effectiveness of reprocessing techniques have shown failures that can occur even when current regulations are followed\(^{(4)(5)}\). This makes single-use
bronchoscopes preferable for patients at increased risk of infection, such as immunocompromised patients, or those at risk of spreading infections by resistant or virulent germs (e.g., hepatitis B and C, HIV, multi-resistant bacteria and tuberculosis, among other). Particularly, during the current COVID-19 pandemic most respiratory societies have recommended disposable bronchoscopes to decrease transmission of the SARS-CoV-2 to other patients and to the health care providers\(^{(8–11)}\). However, these advantages would be of little value if the bronchoscope did not fulfill its functions with quality.

Given their high sensitivity to detect changes in positive or negative trends, the cumulative checksum graphs (CUSUM) are probably the most appropriate method to evaluate the introduction of new technologies, study learning curves and assess the quality of the results\(^{(15–17, 19)}\). This analysis showed that the aScope4 did not require a learning curve in aspects related to equipment assembly and aspiration quality, probably because it works similarly to reusable bronchoscopes. The disposable covers, also designed to reduce the risk of cross infection, had some difficulties in these aspects\(^{(20)}\), the advantage of the single-use bronchoscope may be due to not needing to couple an external sheath with a second working channel. Image quality, ease of tracheal intubation and maneuvering had standardized scores ≥ 80/100 from the 9th procedure, with previous scores between 70/100 and 80/100, these results show a good performance of the aScope4 from the first procedure and excellent performance from the 9th procedure. However, like previous studies on the quality of single-use bronchoscopes\(^{(14,21,22)}\) or disposable covers\(^{(20)}\). They did not evaluate the existence of learning curves by methods validated for this purpose, nor did they use standardized questionnaires. Their comparison with our results has these limitations.
In a study done with a previous version of aScope 4, aScope$^{2(21)}$, authors observed lower image quality and greater difficulty in maneuverability. In our study, the scores in the domains related to image quality, maneuverability, aspiration, ease of assembly and general satisfaction were good, which is probably due to the technical improvements made in this new version of the device. Our study has as limitations not having included more complex procedures such as taking biopsies or punctures and not having included a control group, so that it does not allow us to establish the usefulness of aScope 4 for such procedures or the superiority or inferiority of aScope 4 versus other video bronchoscopes.

Among the advantages of the aScope 4 they highlighted the fact that it is sterile, that it is for single use, the portability and immediacy to start the procedure, the possibility of taking and storing videos and photos of the procedure. Taking and storing images can be particularly useful when the equipment is used in intensive care units, where fiberoptic bronchoscopes are often not used, and therefore the exploration is only visualized by the bronchoscopist who performs it. This device also constitutes an advantage in the training of specialists because it allows them to visualize the examination or teach the bronchoscopic findings to the members of the medical team and could also reduce the costs related to the damage of such equipment due to the trauma they receive when entering through tubes, orotracheal or non-invasive ventilation masks. In addition, the characteristics of the aScope 4 allow it to be kept permanently at the patient's bedside when there are serious problems with airway obstruction due to abundant secretions, so that they can be aspirated under direct vision in a way that is probably more effective than blindly.

**Conclusions**
The aScope 4 scored very well in terms of ease of use, image quality, and aspiration. We observed a learning curve with excellent scores from the 9th procedure. They highlighted its portability, immediacy of use and the possibility of taking and storing images.

**Abbreviations**

Cumulative checksum graphs CUSUM

European certification (CEA)

Bronchoalveolar lavage (BAL)

Bronchial aspirate (BAS)

Bronchoscope quality questionnaire (BQQ)

Interquartile range (IQR)

**Declarations**

- Ethics approval and consent to participate

The study was approved by the ethics committees of each institution and all the participants signed the informed consent both for their participation in the study and for the bronchoscopy

- Consent for publication

Not applicable for that section.

- Availability of data and material
To share our data in the follow link:
https://docs.google.com/spreadsheets/d/1s3TZklwXO0UX_93PbxN7Oij3OmwGhX7j1ZmhJ6lcxME/edit?usp=sharing

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• Competing interests

The authors declare that they have no competing interests.

• Authors' contributions

Flandes Aldeyturriaga J, Alfayate J, Fernández-Navamuel I, Robles J: contributed to the study design, patient recruitment, collection of clinical data, analysis of results, writing of the manuscript and final approval of the manuscript.

Giraldo-Cadavid L: Contributed to study design, patient recruitment, clinical data collection, statistical analysis, analysis of results, writing of the manuscript and final approval of the manuscript.

Agustí C, Lucena C, Rosell A, Andreo F, Centeno C, Montero C, Vidal I, García L, Bango A, Ariza M, Gallego R, Orta M, Bello S, Mincholé E, Torrego A, Pajares V, González H, Wangüemert A, Pérez-Izquierdo J, Disdier C, de Vega B, Cordovilla R, Cascón J, Cruz A, García J, Puente L, Benedetti P, García-Gallo C, Díaz Nuevo G, Aguado S, Partida C,
Díaz -Agero P, Luque E, Pavón M, Páez F, Cases E, Martínez R, Briones A, Fernández C, Martín C: contributed to the recruitment of patients, collection of clinical data, analysis of results, writing of the manuscript and approval end of this.

Uribe-Hernandez A: Contributed to writing the entire manuscript, statistical analysis and final approval of the manuscript.

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| Table 1. General characteristics.            | N   | %   | 95% CI     |
|---------------------------------------------|-----|-----|------------|
| Indication for bronchoscopy                 |     |     |            |
| Bronchial lavage or bronchial aspirate      | 208 | 69.3% | 63.9%—74.3%|
| Bronchoalveolar lavage                      | 125 | 41.7% | 36.2%—47.3%|
| Therapeutic aspiration of secretions        | 30  | 10.0% | 7.1%—13.9% |
| Bronchial biopsy                            | 17  | 5.7%  | 3.6%—8.9%  |
| Route of entry for bronchoscopy             |     |     |            |
| Nasal                                       | 141 | 47.2% | 41.6%—52.8%|
| Oral                                        | 102 | 34.1% | 29.0%—39.7%|
| Otracheal tube                              | 27  | 9.0%  | 6.3%—12.8% |
| Tracheostomy                                | 26  | 8.7%  | 5.1%—14.6% |
| VMNI mask                                   | 1   | 0.3%  | 0.1%—1.9%  |
| Other:                                      | 2   | 0.7%  | 0.2%—2.4%  |
| Bronchoscopy duration                       |     |     |            |
| time in minutes, median (IQR)               | 9.1 (6.0—13.0) |

Notes: 95% CI: 95% confidence interval; IQR: interquartile range
Table 2. Quality of the aScope 4 bronchoscope.

|                                             | Median | IQR\(^a\) | Score standardized (%)\(^b\) |
|---------------------------------------------|--------|------------|-----------------------------|
| Complexity to assemble the device           | 4.0    | 4.0—5.0   | 80%                         |
| Intubation facility                         | 8.0    | 8.0—9.0   | 80%                         |
| Ease of maneuvering in the tracheobronchial tree | 8.0    | 7.0—9.0   | 80%                         |
| Vasculature image quality                   | 4.0    | 3.0—4.0   | 80%                         |
| Mucous image quality                        | 4.0    | 3.0—4.0   | 80%                         |
| Image quality of subsegmental bronchi from the segmental bronchi | 4.0    | 3.0—4.0   | 80%                         |
| Image quality for pathological mucosal alterations | 4.0    | 3.0—4.0   | 80%                         |
| Image quality in case of bleeding           | 3.0    | 2.0—3.0   | 75%                         |
| Global image quality                        | 8.0    | 7.0—8.0   | 80%                         |
| Quality to suction secretions               | 4.0    | 4.0—4.0   | 80%                         |
| Quality to suction blood clots and debris   | 4.0    | 4.0—4.0   | 80%                         |
| Capacity to suction blood in active bleeding | 4.0    | 3.0—4.0   | 80%                         |
| Global suction quality                      | 8.0    | 8.0—9.0   | 80%                         |

Notes: \(^a\)IQR: interquartile range; \(^b\)Standardized score: calculated by dividing the score obtained by the maximum possible score and multiplying by 100, the best possible standardized score is 100% and the worst is 0%. 95% CI: 95% confidence interval.
Table 3. Capacity of the aScope 4TM bronchoscope to perform the planned techniques.

| Loss of functionality or deterioration during the procedure | n   | %     | 95% CI     |
|------------------------------------------------------------|-----|-------|------------|
| Yes                                                       | 287 | 97.0% | 94.3% —— 98.4% |
| It was not necessary to change                             | 283 | 94.3% | 91.1% —— 96.4% |
| Changed due to rupture or damage to the bronchoscope       | 2   | 0.7%  | 0.2% —— 2.4%   |
| Changed for bad aspiration                                 | 1   | 0.3%  | 0.1% —— 1.9%   |
| Changed for limitation to reach procedure goals            | 3   | 1.0%  | 0.3% —— 2.9%   |
| It was changed for a bad image                             | 1   | 0.3%  | 0.1% —— 1.9%   |
| It was changed for another reason                          | 10  | 3.3%  | 1.8% —— 6.0% |

| Need to change bronchoscope during the procedure           | n   | %     | 95% CI     |
|------------------------------------------------------------|-----|-------|------------|
| It was not necessary to change                             | 283 | 94.3% | 91.1% —— 96.4% |
| Changed due to rupture or damage to the bronchoscope       | 2   | 0.7%  | 0.2% —— 2.4%   |
| Changed for bad aspiration                                 | 1   | 0.3%  | 0.1% —— 1.9%   |
| Changed for limitation to reach procedure goals            | 3   | 1.0%  | 0.3% —— 2.9%   |
| It was changed for a bad image                             | 1   | 0.3%  | 0.1% —— 1.9%   |
| It was changed for another reason                          | 10  | 3.3%  | 1.8% —— 6.0% |

| Compared to other video-endoscopic equipment how did you find the Ambú | n   | %     | 95% CI     |
|-----------------------------------------------------------------------|-----|-------|------------|
| Much better quality                                                   | 9   | 3.1%  | 1.6% —— 5.7% |
| More quality                                                          | 35  | 11.9% | 8.7% —— 16.1% |
| Equal quality                                                         | 90  | 30.6% | 25.6% —— 36.1% |
| Less quality                                                          | 152 | 51.7% | 46.0% —— 57.4% |
| Much less quality                                                     | 8   | 2.7%  | 1.4% —— 5.3% |

| Were you able to reach all lung segments?                        | n   | %     | 95% CI     |
|------------------------------------------------------------------|-----|-------|------------|
| Yes                                                              | 272 | 91.9% | 88.2% —— 94.5% |
| No                                                               | 19  | 6.4%  | 4.1% —— 9.8%   |
| Does not apply                                                    | 5   | 1.7%  | 0.7% —— 3.9%   |

| Ability to perform all the techniques provided                    | n   | %     | 95% CI     |
|------------------------------------------------------------------|-----|-------|------------|
| Yes                                                              | 280 | 94.9% | 91.8% —— 96.9% |
| No                                                               | 12  | 4.1%  | 2.3% —— 7.0%   |
| Does not apply                                                    | 3   | 1.0%  | 0.3% —— 2.9%   |

| General satisfaction with the bronchoscope                       | n   | %     | 95% CI     |
|------------------------------------------------------------------|-----|-------|------------|
| Very satisfied                                                   | 3.  | 11.6% | 8.4% —— 15.7% |
| Satisfied                                                        | 102 | 34.7% | 29.5% —— 40.3% |
| Neutral                                                          | 118 | 40.1% | 34.7% —— 45.8% |
| Somewhat unsatisfied                                             | 39  | 13.3% | 9.9% —— 17.6% |
| Dissatisfied                                                     | one | 0.3%  | 0.1% —— 1.9% |

| I would recommend using this bronchoscope for similar procedures | n   | %     | 95% CI     |
|------------------------------------------------------------------|-----|-------|------------|
| I would recommend that it always be used                         | 3.  | 11.6% | 8.4% —— 15.7% |
| I would recommend that it be used in most cases                  | 102 | 34.7% | 29.5% —— 40.3% |
| I would recommend that it be used in an acceptable number of cases | 118 | 40.1% | 34.7% —— 45.8% |
| I would recommend that it be used only in very select cases      | 39  | 13.3% | 9.9% —— 17.6% |
| I would recommend that it never be used                          | 1   | 0.3%  | 0.1% —— 1.9% |

Notes: 95% CI: 95% confidence interval.
Figure 1. Image of the proximal third of the trachea obtained with aScope 4 of a patient showing an osteochondroplastic tracheobronchopathy
Figure 2. Plots of cumulative checksums (CUSUM Analysis)

Notes:
Intubation: passing the bronchoscope through the vocal folds into the trachea. When the CUSUM curve is directed upward it indicates inadequate performance (less than 80% of procedures were scored with a standardized score ≥ 80/100), when the curve stabilizes indicates that between 80% and 90% of the procedures were rated with a standardized score ≥ 80/100, when the curve is directed downwards indicates that more than 90% of the procedures were scored with a standardized score ≥ 80/100. The assembly of the equipment and the quality of aspiration obtained standardized scores ≥ 80/100 from the first procedure. Intubation ease obtained standardized scores ≥ 80/100 in more than 80% of cases since the 3rd procedure, the ease of maneuver obtained standardized scores ≥ 80/100 in more than 80% of cases since the 4th procedure, the image quality obtained standardized scores ≥ 80/100 in more than 80% of cases since the 9th procedure.
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