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Speciality guides for patient management during the coronavirus pandemic

Clinical guide for the management of patients requiring endoscopy during the coronavirus pandemic

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We are publishing this advice to help endoscopy units and their teams prioritise activity during the COVID-19 outbreak. We know it is very difficult in these challenging and uncertain times to decide what is best for patients, the population at large and healthcare staff. There is a complex balance of risks to consider. We understand that service provision may need to flex as part of infection control to ensure we do not put staff and patients at undue risk. Staff providing or supporting any endoscopy procedures will need to be provided with appropriate personal protective equipment.

This guidance has been developed through conversations with multiple stakeholder groups, including radiology, and recognises that the limited availability of endoscopy and/or CT/CTC will require trusts to adopt a flexible approach to service provision and workforce. It will be kept under review and updated as and when new information becomes available.

Service provision during the COVID-19 outbreak

2 week wait referrals

- ***Primary care:*** despite the COVID-19 outbreak, some patients will present with symptoms which might be due to a digestive tract cancer.
- ***Appropriate clinical priority*** must be given to the diagnosis and treatment of people with the highest risk
- ***Avoid*** these patients presenting at A&E.
- ***Identify*** those (few) patients requiring further investigation

- ***Telephone access*** must be provided by hospital specialists to support primary care referrers
- ***Tele-consultations*** with patients should be considered to discuss risk-benefits of immediate or deferred endoscopy.

Suspected bowel cancer referrals:

- ***GPs*** can continue to refer in line with the current NG12 guidelines.
- ***Providers*** can also use a FIT test to help further prioritise referrals requiring urgent colonoscopy or CT colonography. This will help ensure that in the first instance care is made available for those most in need.
- ***CT abdomen and pelvis*** will remain an option for the frail and significantly comorbid when clinically indicated.

Patients on a 2WW referral:

- ***Should not be discharged from the pathway*** on the basis of a FIT test *alone*,
- ***Patients that do not require immediate follow up*** care should be held on a list for further investigation at a later date.
- ***Appropriate safety netting*** should be put in place for these patients to allow for a further clinical assessment should their symptoms worsen.

Emergency Inpatient endoscopy

Trusts should make provision for the following services to remain available to ensure patients can access urgent and emergency care:

- Acute upper GI bleeding
- Acute oesophageal obstruction
- 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

Bowel cancer screening

- ***FIT tests*** recently returned to hubs will be analysed
- ***Appointments with specialist screening practitioners (SSP)*** will be rescheduled.

- ***Bowel cancer screening service*** staff may have been redeployed to assist with coronavirus
- ***Plans*** should be developed to reschedule appointments when it is safe to do so.

- ***6000+ patients have already been told of their positive FIT test***, and are awaiting colonoscopy following their appointment with the SSP.

- ***Prioritization of these*** patients will be based on risk and we will share further guidance once available.

- ***A failsafe process*** must be in place where it is not possible for FIT positive participants to continue along the pathway (or if participants choose to defer colonic imaging); they should be held in until they can be seen.