APSDE-COVID statements: recommendations should be modified according to the prevalence of COVID infection rates

We read the article from Chiu *et al*[1] and would like to congratulate the authors and Asian Pacific Society for producing APSDE (Asian-Pacific Society for Digestive Endoscopy)-COVID statements. The statements make perfect practical sense in the times where robust evidence is lacking. However, there are some conflicting messages coming out and I would like to draw attention toward it.

Figure 1 is suggesting a very extensive algorithm of clinical and laboratory testing to identify the infective potential of the patient and based on that to decide if urgent or semiurgent or elective endoscopy should be performed and the type of personal protective equipment (PPE) to be used. However, statement 2 clearly indicates and quiet rightly so that in the current pandemic we should only perform endoscopy for urgent indications. I feel that the algorithm in figure 1 is best suited for countries with low incidence or recovering from pandemic and statement 2 is best suited for countries with high incidence in the midst of pandemic (the USA, Europe). A clarification along those lines will reduce the confusion and save resources and time.

The logic behind the testing for COVID-19 in patients who fulfil the criterion for urgent endoscopy is questionable. Endoscopy in these individuals is likely to be life-saving so has to be performed urgently and not delayed till test results come back. It makes no sense to take prolonged histories at least now at this stage in Europe and the USA as plenty of patients have been detected with COVID-19 infection without any contact or travel history and asymptomatic patients are infective during

endoscopy and PPE decisions on laboratory testing makes no sense either in these individuals (urgent indications for endoscopy) as the sensitivity of test is not 100%. Recent study by Tao *et al*[2] reported a sensitivity rate of around 70% suggesting that a lot of these individuals with COVID-19 infection could test negative on reverse transcription PCR assays.

The best strategy for countries with high incidence rates like Europe and the USA would be to perform endoscopy for only urgent indications and all these patients should be considered as probable COVID-19 cases. When performing endoscopy for urgent indications, enhanced PPE should be the norm irrespective of clinical history and test results in high-incidence countries.

However, if we are going to perform endoscopy in known patients with COVID-19, then an additional measure of negative pressure room should be considered on top of the enhanced PPE.

The algorithm in figure 1 should be applicable when we are coming out of the pandemic or in very low incidence countries.

I would also like the authors to comment on the role of endotracheal intubation during endoscopy. I believe that the infective risks of colonoscopy is low and equally, very few colonoscopies will meet the urgent endoscopy criterion so endotracheal intubation cannot be justified. However, Endoscopic Retrograde Cholangio Pancretoscopy (ERCP) and gastroscopy carry a significant risk of aerosol generation and as we will only be performing these procedures for urgent indications (low numbers), so why not perform them under general anaesthesia with intubation as it will create a closed circuit with minimal risk of aerosol escaping.

Would the authors consider the above suggestions and issue an addendum in favour or against these suggestions so that the community especially in the west could be guided appropriately?

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