GASTROENTEROLOGY PROFESSIONAL SOCIETY
GUIDANCE ON ENDOSCOPIC PROCEDURES
DURING THE COVID-19 PANDEMIC

Below is guidance regarding how to manage the clinical procedural needs of patients during the COVID-19 pandemic. Any decisions should be informed by the local situation and available resources. There may be state, local and institutional rules in place that must be considered as well. This guidance is offered until more definitive data-driven information becomes available.

For those patients for whom a procedure or appointment is not deemed immediately necessary, each practice should implement mechanisms to assure appropriate follow-up once the immediate impact of the COVID-19 pandemic has eased or passed.

All <u>Elective</u> Procedures <u>Should Be Delayed</u>

1. Screening and surveillance colonoscopy in asymptomatic patients
2. Screening and surveillance for upper GI diseases in asymptomatic patients, including surveillance for esophageal varices in patients with cirrhosis
3. For patients needing interval endoscopy for obliteration of esophageal varices post-acute bleeding, the individual circumstances of the patient need to be taken into account to determine safety of delay (i.e., size of varices, red wale markings, CTP status of the patient, acute bleed characteristics).
4. Evaluation of non-urgent symptoms or disease states where procedure results will not imminently (within 4-6 weeks) change clinical management (e.g., EGD for non-alarm symptoms, EUS for intermediate risk pancreatic cysts)
5. Motility procedures - esophageal manometry, ambulatory pH testing, wireless motility capsule testing and anorectal manometry

<u>Urgent/Emergent</u> Procedures <u>Should Not Be Delayed</u>

1. Upper and lower GI bleeding or suspected bleeding leading to symptoms
2. Dysphagia significantly impacting oral intake (including EGD for intolerance of secretions due to foreign body impaction or malignancy (stent placement))
3. Cholangitis or impeding cholangitis (perform ERCP)
4. Symptomatic pancreaticobiliary disease (perform EUS drainage procedure if necessary for necrotizing pancreatitis and non-surgical cholecystitis, if patient fails antibiotics)
5. Palliation of GI obstruction [UGI, LGI (including stent placement for large bowel obstruction) and pancreaticobiliary]
6. Patients with a time-sensitive diagnosis (evaluation/surveillance/treatment of premalignant or malignant conditions, staging malignancy prior to chemotherapy or surgery)
7. Cases where endoscopic procedure will urgently change management (e.g., IBD)
8. Exceptional cases will require evaluation and approval by local leadership on a case by case basis