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imperative and cannot be overemphasized. We designed an algorithm for restarting semiurgent and elective procedures once there is de-escalation of isolation measures (Fig. 1).

Our reliance on PCR makes it difficult to test all individuals, considering the logistic and financial difficulties. Serologic tests with antibody testing may be the solution, where tests can be offered for all individuals. However, current first-generation enzyme-linked immunoassays for COVID-19 IgM and IgG are still in the stages of evolution and require validation in our setting.⁴ The caveat is also that early stages of the disease may not be detected, leading to increased infections in the hospital. The American Enterprise Institute has provided a roadmap to reopening after the coronavirus pandemic.⁵ India is likely to go from phase 1 to phase 2 after lockdown measures are relaxed. Despite our slogan being “Go Corona Go,” I guess that the virus is here to stay. What remains crucial is to build our disease surveillance, testing, and treatment capacity to smooth the transition. To conclude, we may still not be ready for prime time with PCR testing for all patients, largely because we may not need it in the first place at the moment.

DISCLOSURE

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Response:



We thank Dr Sundaram and colleagues¹ for their interest in our article.² Comparing the implementation of a COVID-19 testing campaign before endoscopy between 2 countries (India and the United States) illustrates the

complexity of this pandemic. Differences in disease prevalence, cost of endoscopy, access to polymerase chain reaction (PCR) testing, and characteristics of local healthcare systems determine the feasibility and benefit of PCR screening at a grassroots level.

Before a PCR program is considered in other healthcare systems, it is important to answer 2 key questions. First, is PCR testing cost effective? As shown by Sundaram et al,¹ when the cost of the test is higher than the primary procedure, the “test all endoscopy candidates” strategy is prohibitive. The effectiveness of COVID-19 screening is difficult to assess. Do we measure clinical benefit for the patient, do we include the benefit to the healthcare providers and system, or do we consider the benefits to family members as well? These 2 parameters have to be contrasted with the willingness to pay for each community. Overall, the benefits of testing run parallel with disease prevalence. In low-prevalence areas with limited resources, clinical screening (symptoms, fever, and exposure) is necessary to increase pretest probability and justify the costs of testing. Despite limited data measuring how COVID-19 testing has affected healthcare budgets, PCR testing comes with opportunity costs. Assigning funds to testing can divert resources from other critical healthcare needs. Will it limit HIV and tuberculosis treatments, or neglect vaccination and reproductive health campaigns? These strategies may still be a priority in low-income and middle-income countries. Performing urgent endoscopies without testing (in low-risk settings, in patients with negative history and symptoms), following adequate requirements for personal protective equipment would be an acceptable alternative.

Second, do the benefits of testing reach beyond the health system? In our study,² we measured only the direct impact of COVID-19 testing on the patient and the healthcare providers. However, if the test result is positive, this affects the community (requiring home isolation and other preventive interventions). Four months after the first cases were reported in India and the United States, identifying asymptomatic carriers remains one of our biggest challenges.³ While researchers find efficient ways to monitor exposed individuals and identify asymptomatic carriers, the question of who deserves testing will be revisited frequently. Do we test before all procedures? Should we test for lower endoscopies if risk can be reduced by the use of physical barriers? Should we test healthcare workers regularly? Triage algorithms like the one presented by Sundaram et al¹ may be particularly beneficial until we answer these and other questions.

We encourage teams across the globe to measure how clinical algorithms allow resumption of endoscopy workflow and to continue epidemiologic surveillance to monitor infections associated with endoscopy. Hopefully, countries with low disease prevalence, like India, can transition safely to the next COVID-19 phases without implementing expensive screening programs.

DISCLOSURE

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Complete distal migration of fully covered self-expanding metal stents: fruits may fall off when ripe



To the Editor:

We read with great interest the study by Lee et al,¹ in which the endoscopic placement of modified nonflared fully covered self-expanding metal stents (FCSEMSs) resulted in 100% stricture and pain resolution and reduced the rate of stent-related adverse events.¹

It is noteworthy that 1 case of asymptomatic complete distal migration was documented.¹ This spontaneous migration was probably the consequence of main pancreatic duct (MPD) stricture resolution. Therefore, in the strict sense, whether this case should be regarded as an adverse event is questionable.

It may be suboptimal to generalize all distal migrations as adverse events, because stents may fall off when dominant strictures are resolved. Park et al² reported that of 13 patients receiving pancreatic FCSEMS placement, 4 (30.8%) patients experienced complete stent distal migration, all of whom were asymptomatic with stricture resolution confirmed by pancreatography. Tringali et al³ reported 7 (46.7%) complete distal migrations in a

cohort of 15 patients, with 5 being asymptomatic. In a recent study evaluating FCSEMS placement for benign biliary strictures, spontaneous stent passage without the need for immediate intervention was defined as successful stent removal.⁴ On the other hand, early distal migration, leaving an MPD stricture unresolved, could indeed be an adverse event. Korpela et al⁵ reported a significantly decreased percentage of stricture resolution in patients with stent distal migration compared with those without migration (14.3% vs 84.6%, $P = .004$).

Compared with scheduled removal, asymptomatic spontaneous complete distal migration still decreases the time of stent placement. It is unclear whether such a decrease influences the potential risk of stricture recurrence.

In a word, whether distal migrations are regarded as adverse events should be judged in combination with the symptoms and condition of MPD strictures. We suggest that future studies distinguish between symptomatic and asymptomatic distal migrations, identify potential predictors, and clarify the long-term outcomes in patients with asymptomatic migration.

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