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LETTER TO THE EDITOR

IFSO Endoscopy Committee Position Statement on the Practice of Bariatric Endoscopy During the COVID-19 Pandemic

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We read with great interest the "IFSO Endoscopy Committee Position Statement on the Practice of Bariatric Endoscopy during the COVID-19 Pandemic," and we would like to report our experience in a European endoscopy private tertiary center performing advanced therapeutic and bariatric interventional endoscopy.

As a private center, we received a "call to arms," asking us to contribute to the management of the pandemic. Following the recommendation of the French Society of Digestive Endoscopy (SFED) (http://www.sfed.org/professionels/covid19-et-endoscopie), we interrupted all elective endoscopic activities from 11 March 2020 onwards. Moreover, we dedicated 80 beds to COVID-19 patients. Furthermore, we upgraded 10 beds for post-surgical critical care to fully equipped intensive care unit beds. Nonetheless, our Unit continued to perform semi-urgent and urgent interventional procedures such as follows: EUS and ERCP for biliary acute pancreatitis and cholangitis and management of the few surgical adverse events.

We fully agree with the authors, when they affirm the importance of withholding elective procedures, but we would like to share our experience in two clinical cases, which we find to offer perspicuous insights, on the one hand, on how to rethink the new standard of care for patients "in the world after COVID-19" and, on the other, on how to adjust current recommendations in case of a new pandemic outbreak.

A 59-year-old woman with a BMI of 40.2 kg/m underwent sleeve gastrectomy (SG) at the beginning of pandemic outbreak, when we still performed elective procedures. At post-operative day 2, she presented an intra-abdominal collection that required urgent surgical drainage. During her stay in the intensive care unit, she tested positive for COVID-19 and developed a mild ground-glass pneumonia. In addition to morbid obesity, the patient suffered from type II diabetes and hypertension. At post-operative day 7, she underwent endoscopic drainage, coupled with enteral feeding in order to remove external surgical drain and avoid chronic fistula [1]. Ultimately, she recovered from COVID-19 despite multiple comorbidities, and at the 1-month endoscopic follow-up, she showed no medium extravasation from previous leak. Therefore, we recommended that she re-started normal diet. She did well and after 3 months (mid-June), we definitively removed the pigtail stent. At the last follow-up, she was asymptomatic and had a BMI of 30.86 kg/m, while eating a normal diet.

A 32-year-old male patient (BMI 47.62 kg/m) developed an upper staple line leak after a SG, which we performed in December 2019. We treated him with endoscopic internal drainage and nasojejunal feeding tube. At the 1-month follow-up, the stents were correctly in place with good granulation tissue. He started a normal diet and we scheduled the removal of the pigtail after 3 months (end of March). However, stent removal is not considered an urgent procedure; therefore, we postponed it after the end of the lockdown period (May). We performed telemedical consultation, and the patient declared no symptoms. At first endoscopy after the restart of elective procedures, the pigtail stents were correctly in place but during contrast medium opacification, a gastro-bronchial fistula was detected. Three days before endoscopic examination and after a face-to-face medical interview, the patient reported the onset of a productive cough. COVID test was negative. Currently, the patient receives antibiotics and he is still under treatment.

The aforementioned chronic bronchial fistula was a direct consequence of the excessive indwelling time of the stent. It got occluded, and thus, the ineffective drainage induced a collection that caused the chronic fistula.

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We discussed these two cases to represent two sides of the same coin. One patient underwent successful endoscopic internal drainage (EID) treatment nonetheless COVID-19 infection, whereas the other patient did not test positive for COVID, but suffered a major adverse event due to the pandemic. What did we do wrong? Nothing, we only applied national recommendations. The procedure in the second case is considered an elective one. Since the patient was completely asymptomatic, we decided to postpone it. In retrospect, we were wrong: contrary to what the statement says, we now believe that it is better to not always postpone "Elective removal or change of double pigtail plastic stents that were previously placed for management of a chronic post-bariatric surgery leak and are in a suitable position without associated symptoms" [2].

Stent removal and exchange should not be considered a "pure" elective procedure since, as we discussed, a retained stent can rapidly induce a secondary collection due to stent occlusion and ultimately, cause a chronic fistula, which is a life-threatening condition. During the pandemic, several patients with "common" diseases could not, or preferred not to, access the health system. As a matter of fact, hospitals are facing a second wave of patients with "old-fashioned" pathologies that did not receive an adequate medical assistance in the last 4 months, because of the pandemic. So the pandemic simultaneously struck two blows: the first blow was COVID-19 itself, whereas the second one precluded proper access to the health system to many of the remaining no COVID patients [3].

Moreover, as the article correctly reported, we have to keep in mind that using the proper personal protective equipment (PPE), it is possible to safely perform most endoscopic procedures, for both the patients and the physicians [4].

What we have learned on the management of our patients during this pandemic is that if on one hand, we have to follow national and international guidelines and recommendations, on the other, we need a tailored case-by-case approach as well. Ultimately, a thoughtful patient selection might very well be necessary. The pandemic has slowed down in Europe, but the virus is still present and new people are testing positive. Its biological behavior is still not fully understood. Maybe it will come back stronger during winter time or maybe it will keep on infecting a small number of people for a long time. Therefore, we agree that recommendations which prioritize certain classes of treatments are fundamental to reduce the pace of the pandemic. Nonetheless, we do believe that physicians should remain flexible, in order to guarantee proper treatment to "all other" pathologies, while maintaining quality standards as high as those we achieved prior to the pandemic itself.

Compliance with Ethical Standards

All procedures performed in the study, which involved human participants, complied with the ethical standards of the institutional and/or national research committees, as well as with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. We obtained informed consent from all individual participants, which we included in the study.

Conflict of Interest The authors declare that they have no conflict of interest.

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