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Safe endoscopy during the COVID-19 pandemic

To the Editor:

We read with great interest the article by Repici et al[1] regarding the recommendations for the department of endoscopy during the COVID-19 outbreak. Here, we report our experience with >18,000 procedures per year in a tertiary care referral center in Brescia, in northern Italy, which has been at the epicenter of the COVID-19 outbreak in Europe, and a COVID-19 hospital since the beginning of March. During the COVID-19 outbreak, especially during the lockdown, endoscopy unit activities were limited to emergency and oncologic procedures to preserve the health of both patients and operators.

Seven physicians and 19 nurses were dispatched to the COVID-19 department. The remaining 4 physicians and 7 nurses were dedicated to the endoscopy unit. All procedures performed between March 1 and May 1, 2020, were considered high-risk procedures because of the dramatic incidence of infection in that period and in that specific geographic area (Fig. 1). Because of this and according to the recommendations by Repici et al, all operators wore high-risk personal protective equipment (including hairnet, 2 pairs of gloves, water-resistant gown, FFP2/3 respirator, face shield) and observed proper hand hygiene during donning and doffing.

During that time, 375 procedures were performed (166 EGDs, 144 colonoscopies, 21 ERCPs, 23 EUSs, 16 PEGs, 5 video capsule endoscopies) in non–negative-pressure rooms. All patients wore surgical masks (except during upper endoscopy) and gloves. Of those patients, 23 had established COVID-19 positive test results and underwent endoscopic procedures in a dedicated room. All rooms were disinfected and/or decontaminated at the end of each procedure.

No case of transmission of infection in the endoscopy unit was recorded during the observation period and for 15 days after May 1 between operators and patients. After May 15, the hospital organized extensive serologic screening among the staff involved in the endoscopy unit confirming, the absence of infection (IgM and IgG anti–COVID-19: negative). In conclusion, the recommendations Repici et al[1] seem to provide a safe and effective method to prevent SARS-CoV-2 diffusion in the department of endoscopy.

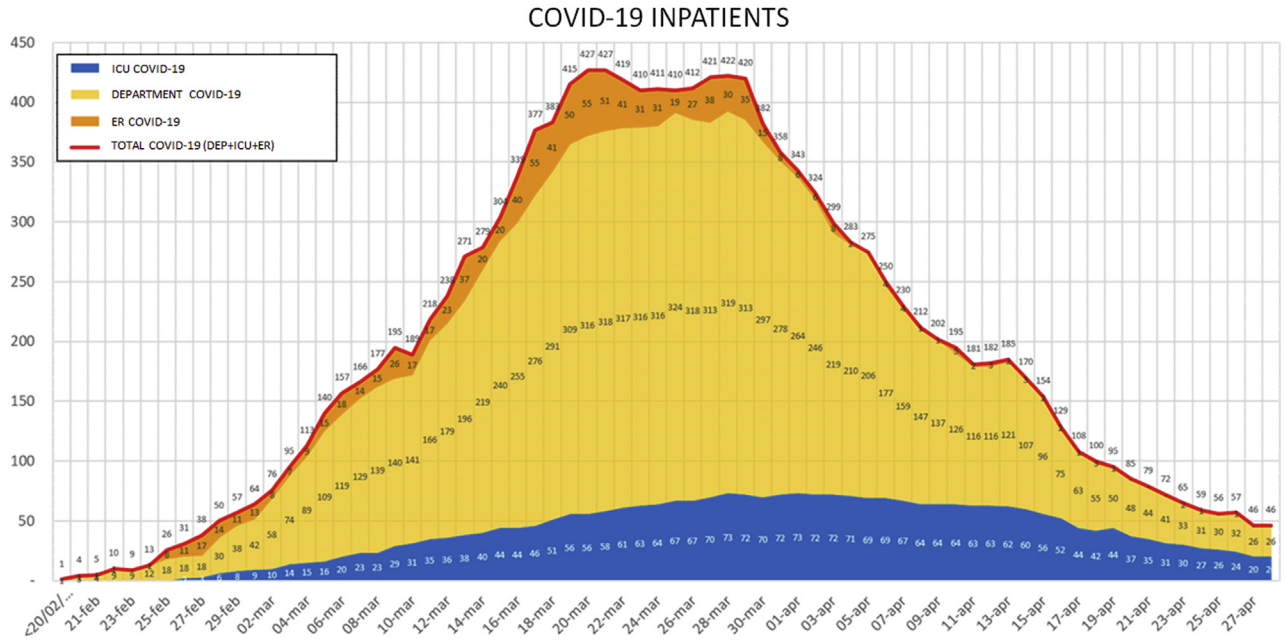

Figure 1. COVID-19 inpatients during SARS-CoV-2 outbreak in Brescia, Italy.

DISCLOSURE

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Leonardo Minelli Grazioli, MD
Sebastian Manuel Milluzzo, MD
Cristiano Spada, MD PhD
Endoscopy Unit
Division of Medicine, Gastroenterology, and Endoscopy
Fondazione Poliambulanza Istituto Ospedaliero
Brescia, Italy

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Optimal stent placement for malignant hilar biliary obstruction

To the Editor:

We read with great interest the article by Xia et al,[1] a retrospective study addressing optimal stenting for malignant hilar biliary obstruction. Their analysis suggests that bilateral stent placement and the use of metal stents are superior to unilateral and plastic stents. They acknowledged that missing "size/shape of the stents" is a limitation, but we want to raise an additional concern.

Adequate biliary stent placement in hilar strictures is dependent on the volume of functional liver drained. This was demonstrated in a study published in *Gastrointestinal Endoscopy* by Vienne et al,[2] showing that the main factor associated with effective drainage was draining >50% of the viable liver volume. They also demonstrated that intubating an atrophic sector increased the risk of cholangitis. Subsequently, our group demonstrated that imaging targeted stenting to achieve >50% drainage of viable (not atrophic, and not replaced by tumor) liver volume with metal stents or multifenestrated plastic stents was both safe and effective.[3] Although patency was shorter with multifenestrated stents, there was no difference in survival or adverse events. As shown in Supplementary Table 2 of the study by Xia et al,[1] >50% drainage was achieved in every patient who underwent bilateral stent placement compared with 21% and 8% in the unilateral groups. On the basis of these data, bilateral stent placement will be effective if it achieves >50% drainage of viable liver, but it is unclear whether it will be effective when <50% of the liver is drained.

Approaching the problem of hilar tumor stent placement as bilateral versus unilateral may actually harm the patient if it is not integrated with the anatomic concerns noted above. Although ducts may be dilated, drainage of a nonfunctional liver will be ineffective. Endoscopists need to approach this problem with an understanding of segments, sectors, and tumor burden by reviewing imaging and oncologic intent before undertaking the procedure.

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Sasan Mosadeghi, MD, MS
Martin L. Freeman, MD, MASGE, MACG
Division of Gastroenterology, Hepatology, and Nutrition
University of Minnesota
Minneapolis, Minnesota, USA

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Endoscopic submucosal dissection for esophageal neoplasia in the West: Are we there yet?

To the Editor:

Evidence continues to accumulate supporting the role for endoscopic submucosal dissection (ESD) in the resection of large esophageal neoplasia.[1] Genere et al[2] recently reported their single-center experience on ESD with a scissor-type knife in comparison with widespread EMR.

In that study, a greater proportion of upgraded histologic diagnoses were encountered in the ESD versus EMR group (27.5% vs 12%; $P = .05$), which is consistent with the 25% rate of histologic upstaging we previously reported with ESD on Barrett's esophagus (BE) neoplasia.[3] The potential advantage of ESD as an accurate diagnostic tool should not be understated. A recent study has further called into question the diagnostic accuracy of EMR in BE neoplasia, inasmuch as nearly one third of EMR specimens resulted in equivocal pathologic results with the dreaded diagnosis of "at least intramucosal adenocarcinoma" compared with none with ESD.[4] These findings have profound clinical implications because diagnostic uncertainty can potentially lead to unnecessary