COVID-VU - a national survey of the use of flexible endoscopy for the upper aerodigestive tract in clinical practice amidst the COVID-19 pandemic

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Abstract

Keywords Flexible nasendoscopy, COVID-19, upper aerodigestive tract, aerosol generating procedure Objectives Flexible nasendoscopy (FNE) is an invaluable multi-disciplinary tool for upper aerodigestive tract (UADT) examination. During the COVID-19 pandemic concerns were raised that FNE had the potential of generating aerosols resulting in human cross-contamination when performed on SARS-COV2 carriers. ENT UK issued guidelines restricting FNE to essential cases, specifying that FNE should be performed in a well-ventilated room, preferably with a monitor screen and wearing enhanced PPE. We surveyed ENT UK members and Royal College of Speech and Language Therapists (RCSLT) members to determine the impact of the COVID-19 pandemic on FNE practice of the UADT. Design An observational internet-based survey Setting FNE practice in community clinics, outpatient departments, inpatient wards, ICUs, emergency departments and operating theatres. Participants UK-based ENT surgeons and speech and language therapists using FNE in clinical practice. Main outcome measures Frequency, indication and local guidelines of FNE of the UADT before, during and emerging from the COVID-19 first peak. Results 314 responses: 82% from ENT clinicians, 17% from SLTs and 1% from nurse practitioners (NP) and physician associates (PA). Overall, there has been a large reduction in the volume and indications for FNE during the first peak of the COVID-19 pandemic with limited recovery by mid-August. Cancer and airway assessments were impacted less. A wide range of FNE protocols are reported varying in choice of endoscope, extent of PPE and sterilization methods. Recommended practice appears influenced predominantly by local factors. The majority of services used reusable endoscopes manually cleaned with Tristel wipes or sent for central sterilization at non-uniform intervals, while a minority of services exclusively used single-use video-endoscopes. When there was no dedicated AGP rooms, centers managed with simple window opening and a widely variable room "down-time" between patients. Endoscope preference reflected user familiarity. ENT trainees expressed a preference for single-use video capturing endoscopes for continuing service models. Conclusion Despite guidance, local practice of FNE remains interrupted and highly variable nationally. A collaborative approach is required to re-introduce FNE safely across UK healthcare setting to ensure timely diagnosis and optimal patient care.

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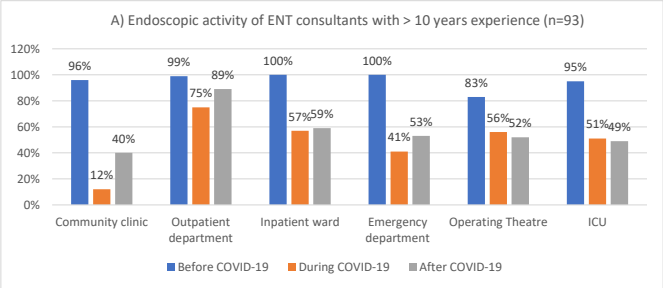

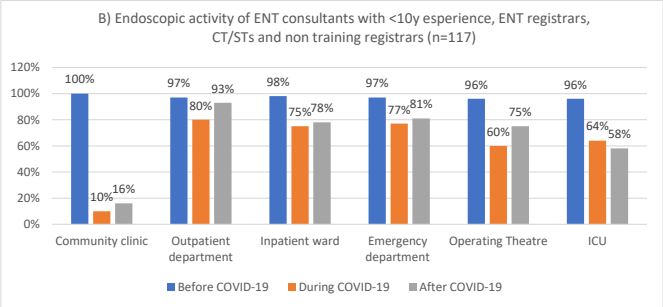

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