

Supporting MMUH Endoscopy services during Covid-19

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Introduction During COVID-19, guidelines for performance of endoscopy meant procedure numbers were significantly curtailed. From April-June 2020, the Health Authorities in Ireland procured private hospitals to help meet the need for urgent endoscopy procedures from our public institution (MMUH) ¹.

Aims

1. to determine if additional private hospital capacity was utilised effectively for endoscopy, as this model is often employed to deal with long waiting lists in Ireland.
2. to compare pathology and follow up rates between the two institutions.

Methods We analysed all documentation relating to 242 endoscopy procedures outsourced to the private institution (MPH).

For the period of June 2020 we compared indications, follow up rates and pathology for outpatient endoscopy procedures performed in our public institution, MMUH (n=111) and MPH (n=104).

Results During the first wave of covid-19, 242 urgent procedures (205 patients) were outsourced to a private institution, comprising OGD=89, FC=65, LC=14, OGD+FC=37. 197 procedures (81.4%) were completed. 38 were not completed due to patient factors – refusal/DNA (45) and illness precluding attendance (6).

102 patients (61%) were subsequently discharged to the GP and 65 patients (39%) required hospital follow up. There was no significant difference between indications in both institutions (p=0.84).

Figure 1. Indication for Endoscopy MPH vs MMUH June 2020

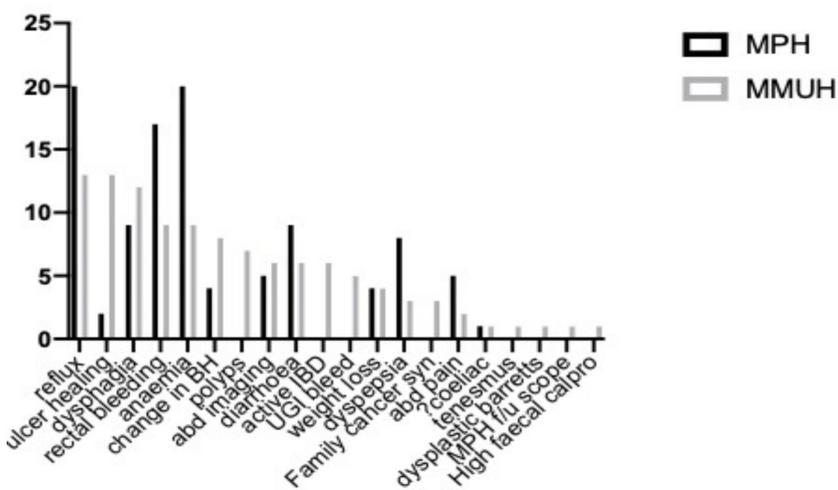


Figure 2 Pathology MPH cohort June 2020 n= 104

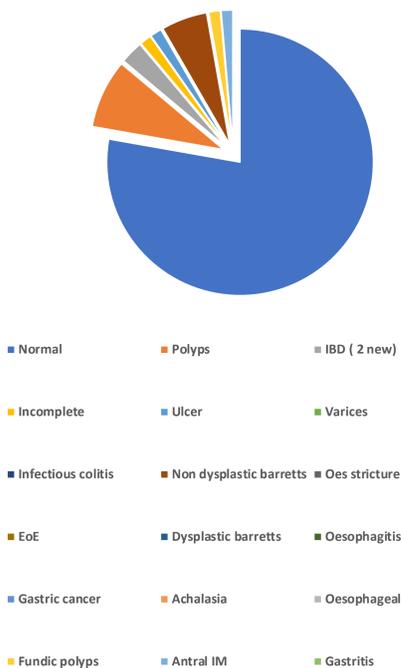
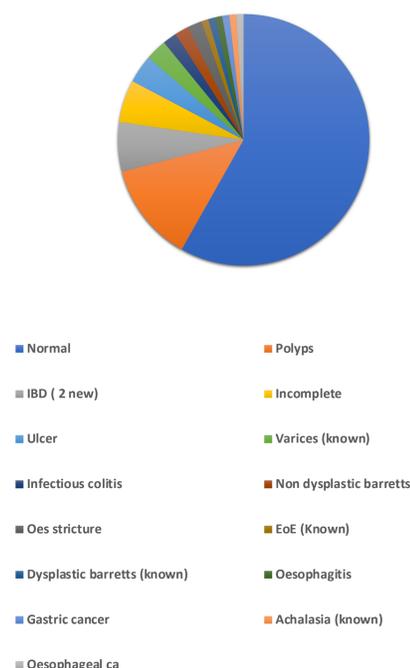
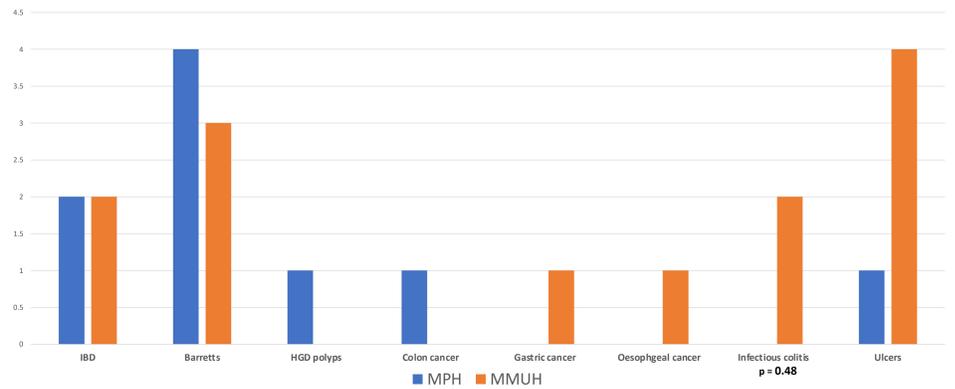


Figure 3 Pathology MMUH cohort June 2020 n=110



Rates of significant pathology in MPH vs MMUH were not statistically significant, p=0.48. Although the endoscopy procedures in both institutions were considered to meet urgent criteria, the majority of patients did not have significant pathology. This did not differ between the 2 institutions, p=0.09

Figure 4 Significant pathology identified MPH and MMUH June 2020 n=22



Only 22 patients were noted to have serious pathology and malignancy rates were low, with no difference noted between both institutions (Figure 5) p=0.48

Figure 5

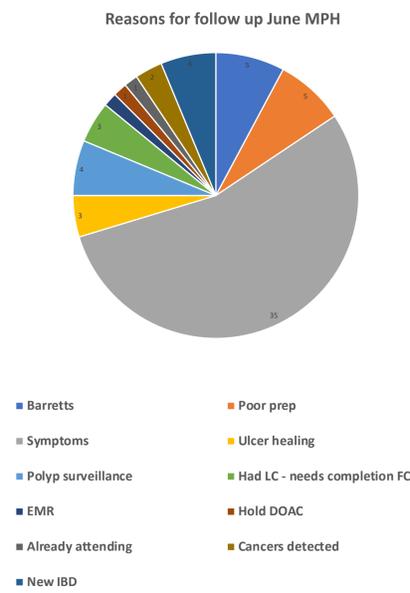
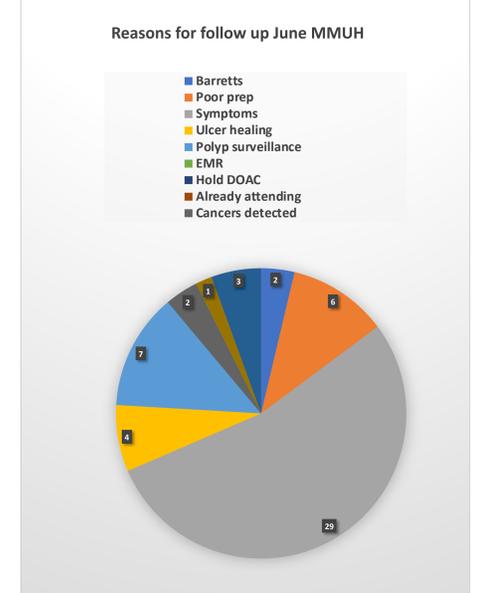


Figure 6



Follow up was required for 65 patients (39%) who had procedures outsourced to MPH (Fig 5)

- 35 for symptoms
- 5 for Barretts
- 5 due to poor prep
- 4 for new IBD
- 4 for polyp surveillance
- 3 for ulcer healing
- 2 for repeat procedure for EM
- 2 were already attending
- 1 to stop anticoagulation
- 3 needed a FC after a LC

Only 2 cancers were detected in MPH

Reasons for follow up in our public institution (MMUH) were similar (Fig 6). Only 2 cancers were detected in MMUH. There was no significant difference in reasons for follow up between our public and private institutions, P =0.85

Conclusion

- During the first wave of COVID 19 in Ireland, similar numbers of urgent outpatient endoscopy procedures were performed in our public and private institution. The use of private capacity in MPH during the first wave of COVID19 significantly reduced the burden on the public system for GI procedures.
- Although the endoscopy procedures performed in both institutions were deemed ‘urgent’, significant pathology was rare, between 4-7%, suggesting more stringent criteria for patient selection for endoscopy should be applied in the future.
- Despite the reduction in the burden of procedures on the public sector during the first wave, the arrangement of necessary follow up for the 39% of patients from the private hospital generated a substantial clinical and administrative workload on the already overstretched public system.
- We suggest a better model going forward is completion of the entirety of the episode of patient care in the private sector, rather than procedure only as with the current system.

References

1. Health Service Executive. Guidance for safe endoscopy unit operations in pandemic conditions. HSE Acute Operations Endoscopy Programme. HSE; March 2020 Available from: <https://hse.drsteevenslibrary.ie/Covid19V2>