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Young GI angle: first wave of the pandemic through the view of gastroenterologists

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The World Health Organization (WHO) announced an outbreak of pneumonia with unknown aetiology in Wuhan City, China, on 31 December 2019. In early January, the pathogen was identified and named as the novel coronavirus 2019 (COVID-19).[1] The Turkish Ministry of Health set up the National Coronavirus Scientific Advisory Board and announced a number of actions such as using thermal cameras at the airports and stopping flights from China subsequently.

During February, our gastroenterology department was providing a full capacity healthcare service in outpatient clinics, endoscopic procedures and hospitalised patients.

At the beginning of March, first Italy, then countries in the rest of Europe were rapidly affected by the disease. Eventually in the early hours of 11 March 2020, the Minister of Health confirmed the first novel coronavirus case in Turkey. Also, on the same day, WHO announced the COVID-19 outbreak as a global pandemic.[2]

The daily routine was changed thereafter. Outpatient clinics became silent, endoscopy appointments began to decline and patients started to refuse hospitalization. Our hospital administration set up extraordinary meetings and then announced that all elective surgeries were cancelled and specific wards for COVID-19 were planned.

Our gastroenterology department decided to postpone all elective outpatient clinic appointments. Improvised telemedicine visits via personal phone calls were planned to manage immunocompromised patients (such as patients with inflammatory bowel disease (IBD), liver transplantation and hepatocellular carcinoma) whose appointments should not be cancelled. On-call visits evolved as the main patient monitoring method for the management of chronic gastrointestinal disease upon requests from our patients. We started to accept only high-risk patients, patients in a severe disease course or patients who were under intravenous infusion therapies. During this experience, we began to think about the need for regular hospital visits with a scale of risks and benefits.

A state of emergency was announced at our hospital at the beginning of April 2020. As a Division of Internal Medicine department, all gastroenterology fellows equated to an internal medicine specialist and were directly involved in the medical management of patients with COVID-19. One gastroenterology fellow in four (IE) was appointed as a full-time COVID-19 frontline healthcare worker. He provided care only to COVID-19 patients in the newly opened pandemic hospital for 3 months. During this period, his only gastroenterology practice was the management of hepatic involvement of COVID-19 or hepatotoxicity related to COVID-19 treatment. Other fellows started to apply to COVID-19 night shifts in addition to the diminished daytime gastroenterology routines such as the outpatient clinic and endoscopic procedures. The pandemic had a significant effect on almost all aspects of gastroenterology fellowship training, but at that time this was not our priority. In addition, all academic staff in the Department of Internal Medicine were appointed as supervisors for COVID wards. In these extraordinary times, we were all serving in the frontline to cope with the pandemic, put ting in a huge effort and trying to perform at our best.

Most of our clinical studies were also disrupted as we postponed visits of the patients. All new research projects besides COVID-19 were postponed. Multidisciplinary research projects or meetings were suspended. Physical meetings of more than three participants were cancelled. Clinical or research visiting fellowship programmes were also postponed or cancelled. Weekly meetings such as, journal clubs, multi-disciplinary case discussions and grand visits (visits that are performed by all academic staff, fellows, residents and interns) were also cancelled. However, we set up an online educational meeting via videoconference for an hour in the week, and that was mostly focused on COVID-19 implications on gastroenterology. Even the pandemic affected our academic schedule, we did our best to overcome with this and continued with our personal learning schedules. Unfortunately, there was at least a three-month gap in our fellowship programme which has a bad, although not the worst, impact.

There is no doubt, the most challenging situation was the risk of transfer of the virus from hospital to our own homes, family members and loved ones. This

is the most difficult part of being a frontline healthcare worker. Some colleagues isolated themselves from family members and even from their own homes by living in separate apartments. The Department of Psychiatry organised an online mental health support programme for healthcare workers. Hopefully, up to now, we have found a way to cope with this burden and have not been hurt physically or mentally enough to require professional support.

The decrease in the number of daily cases in the last week of April was like a harbinger of spring after a long winter season. Normalization projections started to be announced in the first week of May. But this brought bigger concerns, such as when would everything return to normal? What was the new normal? At the end of the June, elective outpatient visits and endoscopic procedures were reinstated with a a reduction of 25–50% in daily case numbers.

Normalisation period

Controlled normalisation strategies were discussed in the subsequent three months. The optimal normalization strategy for the endoscopy unit and outpatient clinic was accepted as maintaining social distancing for patients, visitors and healthcare professionals. It was inevitable that we had to decrease the daily number of outpatient and inpatient visits and endoscopic procedures but it was also a big challenge to deal with the current patient volume with postponed appointments, since the number of appointments was decreased by half. We tried to cancel non-essential visits by discussing the definition of non-essential.

The contagion risk of patients and healthcare workers during endoscopic procedures was also another concern. Initially, we are performing only urgent cases and selected semi-urgent cases based on the personal protective equipment (PPE) supply of our hospital, considering priority of the procedures that were described by a previous position statement of the European Society of Gastrointestinal Endoscopy (ESGE).

National and international symposiums and congress which were postponed or cancelled were held as virtual events. This enabled a new kind of platform with superiorities such as lower or no attendance fee, easy to arrange timing and a reach to more participants. On the other hand, lack of physical networking and social activities were inferior aspects of these meetings.

Acceptance of new normal/future concerns

An online video visit may become a permanent complementary option for the routine out-patient appointment. It would be safer, easier and more time-consuming when compared with a physical appointment. Virtual video visits are personal video chat communications between a health professional and a patient using a computer or tablet over a secure connection. This has been tested by a research team at Massachusetts General Hospital, USA, where they reported a promising initial experience for patients and clinicians.[3] We tried to investigate how to tailor these visits based on the needs of patients in daily gastroenterology practice. Currently, we use short phone call visits to manage appointments according to the patient's clinical status. Recently, the national telehealth system was announced that is integrated with the hospitals' digital system that will enable remote visual inspection and clinical data on hospital record simultaneously. Thus, we will be even better prepared for the second wave as winter is coming.

Decreasing the number of appointments is a rational option for both outpatient clinics and endoscopy units, but it could adversely impact on-the-job training. Especially, developing procedural skills may take a longer time. If the neo-normal clinical regulations continue for a long time, the fellowship rotation programme or even total training time may have to be revised.

It is uncertain whether national and international scientific conferences, symposiums, congresses and interactive courses will be physically organised. There is a big question mark in our minds: whether it will be possible again for visiting clinical or research fellowship programmes to take place or when they will start.

Extraordinary times demand extraordinary measures. We had the best luck with the collective work capability of our professors and colleagues to fight this unprecedented pandemic. Certainly, we have to adapt to this new era and we can make it with team spirit and the support of our mentors.

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