In the setting of a pandemic, there are following three main
drivers for provision of health care services: (1) the limited
availability of resources (masks, personal protective equip-
ment [PPE], face protectors, etc.), (2) the risk of potential
exposure and spread of infection to patients, and (3) the
availability of appropriate health care workers (HCWs). A
gastroenterologist’s role in the pandemic balances between
two big challenges: on the one hand to reduce/prevent
transmission from asymptomatic or symptomatic novel
coronavirus disease 2019 (COVID-19) patients and to pro-
tect members of the endoscopy team, and on the other
hand, an equally big challenge of meeting the requirements
of the non–COVID-19 population with gastrointestinal (GI)
problems by virtue of a careful process of selection. This is,
indeed, a delicate exercise in decision making and therein
lies the importance of “Triaging in the Endoscopy Service.”
Add to this, the complexities of preprocedure testing and
resource allocation, the enormity of this challenge increases
several folds.

A very pertinent question that keeps coming up for discus-
sion is “why is the spread of the disease via HCWs such a con-
cern?” The answers, to my mind, are fairly straightforward.
If inappropriate utilization of PPE, is one major concern, the
shortage of HCWs due to infection and/or quarantine, is an
equally big concern. The infected “asymptomatic” HCW as
a vector for transmission to patients and to others should
probably be the biggest concern, especially in the wake of a
community spread.

Gastroenterologist, therefore, is a very crucial link in this
chain (as also the pulmonologist), and this is because every
endoscopic procedure is potentially aerosol generating, and
this includes colonoscopic procedures as well. All patients
undergoing endoscopy should be considered potentially
infective, unless previously tested.

Lakhtakia and Ramchandani have been very clear and
lucid about the science and art of triaging. Their message
is very effectively summed up in the final algorithm, which
revolves around four questions as follows:

1. Does the patient have FTOCC (fever, travel history, occu-
pation, contact, and cluster)?
2. Does the patient have respiratory symptoms?
3. The COVID-19 test: not done/positive/negative
4. The type of procedure: emergency/urgent or time sensi-
tive/elective or time insensitive

There are great recommendations to be followed, judi-
ciously and strictly, but some questions still do remain. If
the routine procedures are being put off, then for how long?
4 weeks? 8 weeks? 6 months? We don’t have the answers yet.
What are the parameters, that if fulfilled, will deem it safe for
us to come back to normal functioning? Or has COVID-19 the
potential to change our practice of endoscopy forever? Only
time will tell.

Conflict of Interest
None declared

References
1 Lakhtakia S, Ramchandani M. Triaging patient undergoing