

## CT Colonography activity and Covid-19: British Society of Gastrointestinal and Abdominal Radiology guidance

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### UPDATE

The British Society of Gastroenterology (BSG) and Joint Advisory Group on GI endoscopy (JAG) originally published guidance on the use of endoscopy during the current Covid-19 pandemic on March 17<sup>th</sup> and March 20<sup>th</sup> (<https://www.bsg.org.uk/covid-19-advice/endoscopy-activity-and-covid-19-bsg-and-jag-guidance/>). The guidance is being kept under review, and has been updated on March 23<sup>rd</sup>.

In summary, BSG-JAG is **currently recommending that ALL non-emergency endoscopy stops immediately.**

In line with BSG-JAG, we recommend that **CT colonography should also stop unless there is explicit local agreement amongst all relevant stakeholders that capacity exists to continue a reduced service.**

This local decision must consider the safety of patients and wider public, as well as healthcare staff, while maintaining capacity and resource. The potential risk of transmission of Covid-19 in faeces, and the risk of the disease particularly in older patients is described in our statement 1.0 dated 21/03/20. However, now that endoscopy is likely to cease, not all patients requiring investigation will be the frail elderly group typically referred for CTC.

Our expectation is that CTC should **cease** in most hospitals, but acknowledge capacity may currently still exist in certain centres.

Patients requiring investigation for possible colorectal cancer under a 2 week wait referral pathway should be risk-stratified using symptoms and FIT testing (assuming such testing is available). One possible option would be:

- FIT <10 → discharge
- FIT 10-150 → Reassess post-COVID (or, if service capacity allows, prompt CT abdo/pelvis and if negative reassess post-COVID with repeat FIT or a luminal test)
- FIT >150 → Prompt CT abdo/pelvis, and if negative reassess post-COVID with repeat FIT or a luminal test

Precise investigation pathways will depend on local availability of FIT testing, demand, capacity and staffing, and should be discussed with appropriate medical professionals including primary care providers, radiologists, gastroenterologists, endoscopists and lower GI surgeons. Infectious diseases specialists will be able to provide crucial information regarding risks of transmission to staff and patients.

The risk to patients of contracting Covid-19 while attending for investigation must be considered; given the high mortality in patients >70 years, it may be appropriate to defer investigation in patients older than this, even if a FIT is >150.

Those services who maintain some capacity to perform CTC should decide how best to implement the test within any local pathway. Ultimately, each service (or region) must define their own pathways depending on their current situation, capacity and levels of service provision (particularly ongoing provision of cancer surgery). Pathways must be reviewed on a regular basis.

### Supporting information

- CT colonography is used as an alternative to endoscopy, in older and/or frail patients, and those with co-morbidities such as cardiovascular and respiratory disease. The incidence of a colorectal cancer diagnosis in this population is low for those referred via a 2 week wait pathway (3-7%) and the incidence on CTC is in the lower part of this range. This compares to a current Covid-19 mortality rate of around 5% in those aged 70-79 and over 9% in those aged 80+. The risks of transmission of Covid-19 must therefore be considered in all clinical decision-making regarding CTC.

- Since JAG-BSG have advised non-emergency colonoscopy should stop, there is now a large cohort of otherwise healthy patients with colorectal symptoms who ordinarily would have had colonoscopy. This is a very different patient population to those typically referred for CTC.

- Covid-19 RNA is excreted in faeces at the time of infection and may persist for at least 2 weeks after respiratory samples become negative. Faeces should be considered as infectious for transmission of Covid-19. Currently lower GI endoscopy is not considered an aerosol prone procedure (AGP), although this remains under review. CTC should be considered in the same risk category as lower GI endoscopy, and equivalent levels of PPE should be implemented. This should include appropriate hand washing procedures, gloves, apron and surgical mask. Strong consideration should be made to the use of a protective visor/goggles, accepting the risk of splash events will likely be less than lower GI endoscopy. Although it may not be practicable, consideration should be given to designating a "clean scanner" for patients without known or suspected Covid-19.

- CTC needs to be performed by highly trained radiographers and reported by dedicated trained radiologists and radiographers; at this time of unprecedented demand on services this cannot be guaranteed. The time taken to scan the patient and report the subsequent images is also significantly more than that of a standard CT abdomen and pelvis adding further pressures.

- Standard CT abdominal and pelvis (with or without prolonged oral contrast) is an accepted alternative to CT colonography for detecting established colonic cancer, particularly in patients with suggestive symptoms or signs. The diagnostic accuracy of standard CT for tumours falls significantly below that of CT colonography.

- The risk of leaving an undiagnosed cancer in situ for an as yet undefined period (assumed to be between 3 and 6 months) is unknown. The short-term risk is largely mitigated by the use of prompt CT abdo/pelvis. The longer term risk (e.g. an early stage cancer becoming node-positive, or interim development of metastases) is presently unknown.

**BSGAR Committee – 24<sup>th</sup> March 2020**

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