VICTOR PEREZ-CHIRINOS: So first of all, thanks everyone for connecting today to this webcast. Let me introduce myself. My name is Victor Peréz-Chirinos, I'm the business unit manager for the Iberian business for Boston Scientific.

Just want to give you some housekeeping rules for today, which are just, make sure that you use the Q&A box that you have at the bottom of your screen to send your questions that we'll be reviewing after the presentation. Also, remember to stay muted. I think that's a common rule, normally, in these conference calls.

And also, just to keep you informed, we are going to launch three polls, three questions through the webcast, that we ask you to answer in real time. Let's see how this works, it's the first time that we do it. But I think it's interesting, because we want to keep it as interactive as possible.

So with that, let me introduce our guest speaker today, which is Dr. Maite Herráiz, she is from Spain. She works at the University of Navarra Clinic where she's in charge of the prevention and consultation unit for high risk of digestive tumors.

The University of Navarra Clinic is one of the most recognized private institutions in Spain, with two hospitals, one in Pamplona, and the other one in Madrid just recently opened. Since last year, Dr. Herráiz is also part of the medical committee of the hospital, of the clinic.

She is a member of the Spanish Society of Endoscopy since 1998, so just a couple of years ago. And she has been on the board of directors of the Society for the past 12 years. And most recently, since last year, since 2019, she holds the position of president.

So let me thank her for her time during these difficult times. And as we know, Spain is one of the most impacted countries in the world by COVID-19, so I highly appreciate her time, and spending time to dedicate with us. So thank you very much for that.

And with that, I want to give you the control of this, and you can start whenever you want. So, thank you again.

MAITE HERRAIZ: OK. Thank you. Hi, everyone. Thank you for coming to this webcast. I want to thank also to Boston Scientific for making this possible. As Victor said, we are in a difficult time. I think it's very important for us just to share and listen to other colleagues, and to learn about all our experience.

So with this, I just want to start with my presentation. The title today is Planning For Sustainability, and how the manage the endoscopy department post COVID-19. So first of all, I just want to share with you this cartoon about the WHO classification of the phases of a pandemic.

Because I do want to remember that here in Europe, we are still in the phases five and six of the pandemic. So we are in this difficult moment with many countries locked down. But we have to start thinking about our future, and how we will resume the endoscopy unit activities.

So for today, I just want to share with you these three topics. Well, I just want to make the point that I would like to share with you this, they just are suggestions. We have some experience in Spain, because we have this many patients. But we're still learning how to manage of all these big problems.

So first of all, I will make some considerations for how to resume the endoscopic activity. I will also talk about what we know about SARS-CoV-2 transmission, which is very important for us. And finally, I will talk about how we should be scheduling patients for GI endoscopy, what I called the 3P rule.

So we have to-- the framework in we are working is this, that I make in this slide. So we have to keep in mind that we are in the COVID-19 caused by SARS-CoV-2, it has become a global pandemic, and the incidence of mortality is different among countries.

This is not just a matter of luck, it's because some countries are making good decisions. So we have to listen to those who know. Also, we can't forget that the overall mortality is 1.4%, and for those with severe disease, the mortality is 22%.

We don't have, still, effective drugs, and a vaccine will also be a long time coming. So maybe for a year, or maybe even more. Meanwhile, other diseases stay out there and hospitals have to resume the activity. We all know that the endoscopy units provide essential services to patients. And if we left them alone, maybe another peak of mortality can come from these diseases.

OK. So next point is the transmission of this Coronavirus. And this is very important, because we all know that there is a human to human spread through respiratory secretions, aerosol, feces, and also contaminated environmental surfaces. And what is very important, is the transmission can occur in both symptomatic, but also in asymptomatic individuals.

On the right hand, you can see a very nice picture from the New England Journal of Medicine a couple of weeks ago. And they show this fluorescent dye experiment from a simulated patient cough that ended up on the laryngoscopist's face.

And I think of us have to keep in mind this image, because we all know that during the endoscopic procedure, this could happen. Endoscopic procedures could pose a risk of generating aerosol and increase the risk of SARS-CoV-2 transmission. So we are facing this higher risk of a spread of this pandemic, and this is because of the short physical distance between patients and the personnel of the endoscopy.

So how we have to resume, then, the endoscopic activity. Well, we are still in this pandemic phase, but we have to think about the future. So all the different societies recommend to do this in a stepwise manner according to health care priorities, but also in available resources of individual centers.

I mentioned before, the 3P rule that I just called in this manner. And I think this could be a guidance for resume the endoscopy activity. So first of all, it will be P for prioritization, second, prevention, and third, and last, P for protection. So in the next minutes, we'll see one of these situations.

So as you can imagine, all the topics that I am talking about this afternoon are based on some scientific papers that I will resume in the last slide. And here, it comes from the ESGE, which is for a position they made two days ago.

So for prioritization, we have this decision pathway for doing endoscopic procedures. And I just want you to see, first of all, we have to see for this, the main reason of the patient's need for GI endoscopy. And if this is an urgent or an emergency procedure we have to proceed, as you know, we were making this during the pandemic.

But for the next phase, we have to think about these elective procedures. And the key question is to evaluate the morbidity and mortality risk of GI diseases versus risk of COVID-19 disease. And if the risk of morbidity and mortality for GI disease is higher, then we have to go through this patient risk stratification.

But if there is, the risk is not higher for GI disease, than we should postpone this procedure. I think it's very important that every single endoscopy unit go through this pathway, and make their own decision. Because they are seeing, the situation is very different among countries, but also in the same country.

So here in this slide, I just want to say that different scientific societies, like ESGE or ISGE, even the Spanish Society, but maybe in other countries, are making this position statement.

And again, I said that all of us have to go through these papers, read it, and think about our situation, about our country, and our place, our city, and decide how it's going to be, this prioritization, at least in our case.

So at the end of the day, we'll end up with these three different situations. The urgent endoscopy, the other ones that we can discuss on a case by case basis, and elective endoscopy that we can defer until the end of this situation, maybe. This table came from the Asia-Pacific Society.

So I would like to know at this point if you have in your endoscopy unit already, some policy to prioritize the indications for the endoscopy. So Elisa, if you can-- none today. Question. Please, give your answers so all of us get a sense about what's going on in the different countries and the different units. We can hear you. OK.

Well, many of you, a lot of-- almost 80% has already a policy just to prioritize the indication. Well, I think it's interesting, this 10% that don't know. So one, I think it's a very good recommendation, just to go through this work.

OK, so go to the next P. The second P is prevention. So, this means that we have to keep saying, as I already mentioned, we are in a higher risk than other health care professionals. So if we want to prevent any nosocomial infection from COVID, we should try to prevent.

So for that, we have to make a risk stratification for potential COVID-19 infection in patients who require gastrointestinal endoscopy. This is, well, I would say very simple. Maybe if not, it's not. But we have just made a try with asking the patient for a brief questionnaire about cough, fever, shortness of breath, or diarrhea.

Also, we have to ask about a history of contact with a COVID positive individual. We have to make the point that here in Europe, we are in a situation of community transmission. So maybe we have to think everyone has a potential positive individual nearby.

And here is a very interesting point. This table came from the last ESGE recommendation, that they talk about testing for COVID-19. And we have a lot of discussion in Spain about this point, and I think that the question raised from the accuracy of the test. If you are in a hospital with a very low accuracy of this test, maybe it's not a very good option to go through this point.

The high risk patients are these other ones on the right side. They already have symptoms, who looks like COVID-19. Or they have been tested positive for the Coronavirus. So this is a very important point that you have to decide, also, in your hospital, in your endoscopy unit.

And I would like to ask you if, in your opinion, testing for COVID-19 is a good option for risk stratification before a gastrointestinal endoscopy in your institution? So Elisa, please, can you send it? We have the question here.

I want to know if-- what's your sense about the accuracy of this test in your institution, or the availability of the test in your institution. Maybe it's not possible to generalize to everyone. OK. So we'll see the results. OK. 68% agree with this position to make the test. And well, I was thinking the positive results will be less. So I think it's-- maybe we are in a better position than I thought before.

OK. So we'll talk about the last 3P, which is protection. So after prioritized the indication, and making a very good stratification with the patient, then we have to think about the protection.

And we have to-- I mean, all of us also have read a lot of paper from the different colleagues, the Chinese colleagues, or the other Asian colleagues. The Italian colleagues, their paper from Professor Repici and also from the American ones. And we know about the PPE, the personal protective equipment.

So these are the two different PPE for a low risk patient, but also for high risk or positive patient. The main difference is the surgical mask, or they need upper respiratory PPE, either FFP2 or FFP3 mask. We have also discussed about the use of two pairs of gloves.

This is very important with positive or high risk patients, because it's useful when we are taking off the PPE to avoid to get contaminated. And the other part of the PPE are very similar between the two different situations.

So here, I would like to share with you this recommendations from the Asian-Pacific colleagues. They recommend how to have-- to be the provision of endoscopy service during the COVID-19 pandemic. I think it's a very nice recommendation, because they show us how-- and also here in Europe, and absolutely in Spain, that we haven't had enough PPE supplies.

So you can make some provision in the different phases of the situation, and it can be useful to think about how we have to resume the activity, and how we can go from the urgent endoscopy only, or go to the other different scenarios.

So I would like to ask you. In your opinion, is there enough personal protective equipment available for health care professionals in your institution? I know that sometimes, we have some PPE, but not for every day, or for every person. Maybe we can discuss this point.

You have to learn how we have to deal with the trainees, trying to have not much people in the room, just to avoid to use many PPEs. So can we have the answer? OK. Well, this is very interesting. 38% have answered yes to this question, but almost 60% have said no.

Well, I think this is very, very important, because this can be difficult-- I mean, a point that we can't do endoscopy if we don't have the sufficient, or the equipment to do the endoscopy prepared, or just to be in a safe position.

Well, I'm very surprised. Because I was thinking that maybe the answer with the PCR for COVID-19 was, it was no, and with the PPE, it can be yes, but it has been on the other side. So we have to think about this, because here, discussing with some colleagues who are thinking,

OK, if we don't have enough test-- but maybe this is a Spanish situation. But if we don't have enough tests, then we can go and treat every patient as a high risk patient. But for that, we need to have the PPE for that high risk situation. So I mean, I think this is a very interesting point.

Yeah, here you have the references. I ask you to go through these, I think they are very important papers. And just, I would like to summarize saying that thinking in this general framework, every endoscopy unit has to make their own policy. We will see that many of us has already, about 80% has already the pathway for prioritization of the procedures, but this is the first P.

The second P was prevention, and only 60% had PCR. But what makes me worry, is that only 50%, less than 50% has the PPE available for the endoscopy. So we have to think about this.

We have to talk to our authorities, and just to know that we are in a high risk situation. Just not only for us, we are in a high risk situation for our patients, and for the pandemic to keep going. So I mean, I think this is a very important summary of this seminar.

So thank you very much for your attending. And I will hear if you have any questions, and I can say anything about that. Thank you very much.

VICTOR PEREZ-CHIRINOS: Great. Hi. Thank you, thank you Dr. Herráiz, thank you for the presentation. Quite helpful to hear and listen for you, your point of view. Quite interesting, some of the answers. So I do have some questions for you coming from the audience. Let me start with this one. Let's see.

We have a question here, for example. So in your opinion, when should be the testing for COVID-19 be performed? I imagine this is for patients. When should this be happening?

MAITE HERRAIZ: OK. I think it has to be closer to the procedure that you can. So if you can have the answer in 24, or one or two days, then it should happen in that moment. So let's say three days early, for have time for the patient, for the results to come, the answer, and for the patient to prepare for the endoscopy. If you are in an urgent endoscopy, maybe the rapid test could be useful. Or if not, just use the high risk PPE.

VICTOR PEREZ-CHIRINOS: OK. Another question is, for example, when do you decide-- when do you feel is safe for a health care professional, in this case, for an endoscopist, to go back to work, to resume back to work when they have been infected by COVID-19? When, in your opinion, they should be able to go back to work?

MAITE HERRAIZ: OK. Well, this is a very tough question. In our hospital, we are using a two weeks after finishing all the symptoms. I guess every different hospital has a different policy. I don't know if there are some tests available in other hospitals. In our hospital, they are making some tests, but we have to keep in mind that we don't know what happened with immunity. So, well, I think you have to do it according to the hospital.

VICTOR PEREZ-CHIRINOS: OK. Thank you. Another one, here. So we-- there is an opinion here, obviously. They say, we test patients, we test basically everybody. So Europeans, should we test also endoscopists as well? And how this should be done, and obviously, when Is the best?

MAITE HERRAIZ: OK, this is a very good question. And I haven't talked about that, but of course, if we are doing trials every day for patients, we have to do a symptomatic trial every day for every single person in the endoscopy unit. And of course, if someone has a fever, or cough, or any other symptoms related with COVID-19, they don't have to show up to the endoscopy unit.

So this is first, a symptomatic trial. And then, I don't think it is useful to do PCR, because we don't know-- well, in an asymptomatic individual, endoscopist, and also with the immunity test, we have this problem. We don't know what it means.

It means that person has been in contact with the virus, but we don't know anything else. So it's true, in some cases. In Spain, in some hospitals, in my hospital, we have started testing personnel, but we don't really know what that means. So I mean, if it is available, maybe it's useful just to know. But I don't know, what are the conclusions, or the after that.

VICTOR PEREZ-CHIRINOS: Yeah. OK, thank you. Let me see, let me look for another question. For example, this one. So this is regarding the PPE, the gowns and everything related. In this case, it's the isolation gown. Could it be used-- he's asking here if it could be, if it should be changed after one case, or it can be used in the room for the whole day, or I imagine for some longer time, or it should be exchanged after every patient.

MAITE HERRAIZ: Yeah. This is also a very good question. And first of all, it depends on if you are treating a COVID-19 positive patient or not. If you are a dealing with a positive patient, it depends on the shortage of the material. I mean, if you have enough to change every patient, of course, it's better if you can change.

But in many hospitals, you don't have that opportunity. Maybe, I mean, so you have to deal with your situation if you are working with COVID-19. So for that reason, is the recommendation about the trainee, or other people that in other times, they are walking around the room, the endoscopy room. But now, it has been recommended that only those persons who are taking active part in the procedure has to be there, just to save some equipment.

VICTOR PEREZ-CHIRINOS: OK. Yeah. Thank you. One more here, this one is interesting. Should the endoscopy units create two different circuits for patients, one with COVID, and the other one with at least, not COVID positive test. So should there be two different ways for these patients?

MAITE HERRAIZ: If it's possible, I think it's a very good recommendation, because as I already mentioned, the virus can go through faces, but also from different stuff, some material. So if you can separate as much as you can, the two different circuits, the COVID positive patients and the other one, it's very interesting.

And also, it has been recommended to separate the recovery room. And if you don't have the possibility to do different recovery rooms, then the patient, it has to be awake. If you do the endoscopy with anaesthesia, with Propofol in the same room, and then go to the halls or to the street from the room, not to go to another place, making that place dirty. So this is very, very important, to keep the spaces safe.

VICTOR PEREZ-CHIRINOS: Mm-hmm. Great. Yeah, so one more if you're OK.

MAITE HERRAIZ: Yeah, I'm OK.

VICTOR PEREZ-CHIRINOS: OK. So currently, there are some ratios for the time of each procedure right now, so more or less. The question here is, either in your hospital or the Spanish Society thinking about how this can change as the rooms will have to be disinfected most likely after every case, so this is going to take longer. And this probably means less patients being treated daily in the endoscopy room. So what's your thought about that, and how do you think institutions can manage that?

MAITE HERRAIZ: Yes, this is also a very good question. And as you mentioned, in the Spanish Society of gastrointestinal endoscopy, we are making this recommendation, just to add 15 more minutes for every procedure. Or maybe even more, depending on the facility, of cleaning the rooms between one patient and another.

So at least for the very initial resume of activity, we have to think that the agendas have to be loose, and we have to make more time for every procedure. And I think we have to talk with our authorities and tell them that-- I mean, it's not just for us, but also it is.

But it's because we don't want to be in that chain of transmission of the virus, so maybe people outside the endoscopy, they don't know how are the risk. But we are facing different risk for the aerosol, for the feces, and also we have to keep in mind this can transmit to the person who are making the decisions.

VICTOR PEREZ-CHIRINOS: Thank you. That's good. That's really good, it was a good question. I guess it's a tough one, decision. For example, here's is a question, it's a bit different. So first, they're congratulating you on the presentation, just to say. And they're asking about bariatric endoscopy procedures. For example, intragastric balloon or endoscopic sleeve, gastroplasty what's your opinion on it, how this should be managed? I would say that's the question.

MAITE HERRAIZ: Well, I think this is a very tough question. And I think it's-- well, I will say, I have read many recommendations from different societies. And many of them put this indication in the very, very, very last group, and they don't recommend to do these procedures nowadays.

But I think it depends on the situation of the hospital, the place where you are working. I mean, I think it's different for a public or private hospital, many of these procedures are made in a private hospital.

But if you can assure every-- if you can test the patient, you will see that he is COVID-19 negative, if you want to be more sure, just to make an X-ray just to be sure there is none in the area. So I mean, I guess in that situation, I don't think there is any reason for avoiding these procedures.

VICTOR PEREZ-CHIRINOS: OK.

MAITE HERRAIZ: That is my opinion. Many societies say other recommendations.

VICTOR PEREZ-CHIRINOS: Yeah, OK. Well, thank you. I think this one is just probably-- it's interesting, because it's also, you are working in a private institution. How do you think it's going to change, or how is this going to affect the cost of the procedures and the payments from the health insurance in this case?

As you know, there's going to be an increase in the cost of some of the procedures because of the equipment needed. And also at the same time, it's linked to the other question, where there's going to be less time, so there's going to be less patients being treated. So how do you think is this going to be managed by private institutions?

MAITE HERRAIZ: Well, I can tell you that we are working with insurance right now, because I mean, we are facing this problem, and many other private hospitals are also facing with this problem. So I mean, it's a real problem. You'll have to-- I mean, anyone or someone has to pay for the PCR, for the PPE, and all this equipment, it has some cost.

So we are dealing with the different insurance companies. I mean, we are just in the middle of the negotiations, so I don't have any answer. But I guess it's going to be a tough situation. But I mean, we have to go through it.

VICTOR PEREZ-CHIRINOS: Yeah.

MAITE HERRAIZ: I think I would say, everyone has a responsibility in this situation. So maybe they have also to understand that everyone has to be safe, so I don't know. We will try to get them to this point.

VICTOR PEREZ-CHIRINOS: Yeah. Tough one. I think we're going to be all involved in this one, because we as a company, you as professionals, patients as well, institutions, I think we all have to manage this.

MAITE HERRAIZ: Yeah. So therefore, it has to be for everyone. Yeah.

VICTOR PEREZ-CHIRINOS: Maybe one last one, if you're OK. I think we've given good time to questions. This is mentioning being in an epidemic zone, maybe Navarra is not that affected as some areas. But in the first week when resuming to activity, the question here is, what do you think about dealing with all patients as if they were COVID-19, no matter what?

Probably, if you don't have the possibility to test everybody, because it might be the case, what do you think about this? Treating everybody as if they were COVID-19 patients, or potential.

MAITE HERRAIZ: I think, again, it has to be the case. We have started testing some patients, and I mean, it's incredible. There are many asymptomatic patients who are PCR positive. So here in Spain, for the last week, we have been at home.

But maybe in the next two or three weeks, we'll be out there. And if we have positive asymptomatic patients right now, I can't imagine what's going to happen in the next few weeks. So I mean, if you don't want to have nosocomial outbreak in your hospital, you have to be ready to have the PPE equipment and treat every patient as if they are positive.

VICTOR PEREZ-CHIRINOS: Yeah. Well, thank you. I think we've given enough time. There are some question that were left, there were plenty of questions. So I thank everybody, and sorry if your question was not answered. But we tried to resume and give answers to most of you. So I again want to thank you for your time, highly appreciate these difficult times. So I really, really want to thank you for your time and a fantastic presentation. Thank you.

MAITE HERRAIZ: Thank you very much, very interesting.

VICTOR PEREZ- Thanks everyone, thanks for attending. See you in the next one.

CHIRINOS: