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Letters to the editor

OVERVIEW

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Urgent upper gastrointestinal endoscopy referrals cancelled due to the COVID-19 pandemic

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Editor – The British Society of Gastroenterology have done a superb job in providing timely and well thought-out guidance for endoscopy services following the COVID-19 pandemic.[1] One of the points highlighted is the critical role of senior clinical decision-making for triaging and prioritisation of referrals for endoscopy while capacity is restricted. The curtailment of elective outpatient endoscopy services at the peak of the COVID-19 pandemic resulted in the cancellation of endoscopy appointments. At our institution, virtual clinic review was undertaken by a consultant gastroenterologist for all patients who had their appointment for urgent upper gastrointestinal (GI) endoscopy cancelled. A total of 117 patients were reviewed (mean age 57.5 years; range 19–89 years; 62.4% female), of whom 75 (64.1%) had been originally vetted as direct-to-test referrals from primary care; 34 (29.1%) patients had been previously seen in clinic, and the remaining eight (6.8%) had the endoscopy requested following hospital admission. The indications for endoscopy were suspected upper GI cancer alarm features in 109 (93.2%) cases. Following clinic review, four (3.4%) patients underwent immediate endoscopy due to severe high-risk symptoms. It was possible to remove 35 (29.9%) patients from the waiting list as they did not require an endoscopy any longer. Thirty-two (91.4%) of these patients had either been originally vetted as direct-to-test or had been referred following an inpatient episode. These results demonstrate that clinic review of patients listed for urgent endoscopy can reduce the demand by around one-third. While direct-to-test diagnostics have been advocated for patients with suspected upper GI cancer in order to provide a timely diagnosis, only about 4% of such patients will have a cancer confirmed.[2] When endoscopy capacity is restricted, as during the COVID-19 pandemic, a strategy of clinic review first would help to target those patients most likely to benefit from endoscopy. ■

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Qualitative fit testing

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Editor – We recently spent 7 weeks coordinating qualitative fit testing (QFT) of FFP3 masks at a major London hospital site. Upon reflection, we believe that fit testing within the NHS should be routine.

Although adequate respiratory protective equipment (RPE) is required for protection from COVID-19 transmission, QFT should already be the norm for NHS workers.[1,2] RPE is worn in intensive care, theatres, respiratory wards or side rooms to prevent transmission of various airborne diseases. Although RPE has been proven effective, adequate protection requires prior fit testing and depends upon a 'good fit'.[3–5] Many staff who have worn RPE regularly are only now undergoing QFT for the first time, which highlights a systematic failure of the NHS to protect its workers.

Some research has also suggested that certain facemask models are more suited to male and Caucasian face shapes.[6–8] This is important, given the higher rates of COVID-19 cases among black and minority ethnic staff.[9] Of the eight different models of mask that we tested, none had a perfect fit rate and only one had a fit rate above 60%: variety is key. Costs and strain on suppliers have limited the variety of masks in hospital sites; however, the range of masks available must reflect the varied demographics across the NHS workforce. Regular QFT before the pandemic would have allowed fit rate comparison between models, and stock could have been prioritised accordingly.

We urge the NHS to review its fit testing policy. Trusts could routinely perform QFT on new staff members, using multiple facemask models to account for changes in availability. Individuals could keep a record of their QFT results so that if they move between sites, they have evidence stating which mask(s) fit and, thus, should be provided by the new site. Finally, NHS trusts could perform regular analysis of anonymised fit testing data and assessment of stock to ensure that all staff, regardless of gender or ethnicity, are adequately protected.

We make these proposals on the grounds of improved public health measures for this country and acceptable working conditions for NHS staff. ■

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Von Willebrand factor

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Editor – Ladikou *et al* have elegantly shown in their series that levels of factor VIII and von Willebrand factor (VWF) are markedly raised in patients with COVID-19 and that there is a reduced level of ADAMTS13 which may be secondary to depletion of the enzyme through consumption.[1] Similar results have been reported by others and there is a growing recognition that COVID-19 may trigger a 'thrombo-inflammatory' cascade that should be targeted.[2–5] Endothelialitis, whether caused by COVID-19 or another septic process, triggers the release of VWF, including the highly biologically active and more adhesive ultra-long VWF that can bind platelets spontaneously via glycoprotein Ib receptors. The ultra-long VWF multimers released from the Weibel–Palade bodies have a lower shear stress for unfolding and therefore may represent the initiating molecules for this self-assembly process which leads to hyper-adhesive strings capturing platelets and the microthrombosis that is now well established as part of the disease.[6–10] This represents the first step in platelet activation and thrombus growth. Under normal conditions ADAMTS13 cleaves VWF and regulates the VWF/platelet interaction, however, this regulatory mechanism may be overwhelmed by the degree of microthrombosis seen in COVID-19 as is suggested by the results presented by Ladikou *et al*. We believe that targeting the initial VWF/platelet interaction with caplacizumab presents an attractive target that may prevent widespread microthrombosis and its clinical sequelae and that this drug may prove be particularly effective for patients that present with abnormally raised VWF, and abnormal VWF / factor VIII ratio or reduced ADAMTS13. We believe that investigation of caplacizumab in these patients warrants urgent investigation. Anfibatide represents an alternative drug with a similar mode of action to caplacizumab and should also be considered high on the list of drugs to be investigated. ■

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