Point-by-point responses to reviewers

Dear reviewers,

Thanks for your hard work in reviewing our manuscript. We read with great caution to all your kinds comments. Our point-by-point responses to all comments are as following:

Reviewer #1:

The study is aimed to report the authors' experience for management of an endoscopy center during the outbreak of COVID-19. The title is "Management of an endoscopy center during the outbreak of COVID-19: experience from West China hospital".

1. **This is a review article.**

Response: Thank you for your friendly reminder. After consideration, we think it would be more appropriate to classify this article as an opinion review, and we have altered the manuscript accordingly.

2. **Several factors influence the outcome of this management. Please discuss these factors.**

Response: We have added a short description about the factors influencing the outcome of our management in the discussion and conclusion of the revised manuscript.

3. **What is the difference between management of COVID-19 and the other infectious diseases? Please discuss this.**

Response: COVID-19 has its own special characters. We have

discussed it in the article, please see the revised version for details.

4. Finally, please recommend the readers "How to apply this knowledge for routine clinical practice in the community hospitals?".

Response: Community hospitals generally provide no endoscopic procedures for patients, and thus the risk of virus exposure should be lower. We provided a detailed strategy for the management of patients during the whole process of endoscopic examination, and some parts of this strategy (like three-level screening strategy) can also be applied in community hospitals. We have discussed this in the discussion and conclusion of the revised manuscript.

Reviewer #2:

The article is strategic on concerns of presenting management experience on COVID-19. however the related surge in increase rate of the pandemic calls for global shared knowledge among professionals and non-professional health workers and so the article is commendable, the article further confirmed the roles of physician policy implementers on the three-level screening strategy by Gao et al., and an innovative self-made gastroscope isolation mask., however only minor corrections were effected and highlighted by Dr. Julius W. Atogebania, therefore can be considered for publications.

Response: Thanks for your friendly comments. We have revised the manuscript as other reviewers' comments. Hope you enjoy it.

Reviewer #3:

Specific Comments to Authors: Nicely written.

Response: Thanks for your friendly comments. We have revised the manuscript as other reviewers' comments. Hope you enjoy it.

Reviewer #4:

The article is completely badly formatted, out of order, and, to make matters worse, the submitted file is in reviewer mode, probably the article that was returned by the company that translated it. The authors haven't even reviewed this. The article was also sent as a "review" and this is not a review. It is an original study where the authors are exposing their experiences (of their service) in the face of the pandemic. This should also be reviewed.

Response: Sincere apologies for the mistakes we made. We have revised the format of this opinion review according to the requirements of the journal.

1) item 2.1.1 seems to be described as a protocol to be followed by the service and not that it was done as follows: "Mild illness (e.g., small colorectal polyps) should be delayed" "The schedule should be arranged according to the potential severity of illness. Priority is given to patients who are old, frail, children, have a history of taking immunosuppressants, diabetes, and other immunocompromised patients. In our center, all patients were informed about the risk of virus infection, if they would like to receive endoscopy during the outbreak. "

Response: Our endoscopy center provided all services for patients, including appointment, examination, treatment, to follow-up. Thus, the measurements presented in item 2.1.1 were done in our daily work (by shift medical staff), not just a protocol followed by the service.

2) In item 2.1.2: Have all your patients undergone tomography? Tomography of what? You must make this clear.

Response: Many patients may have radiographic abnormalities before symptoms occurring. A study included the first 51 patients in Wuhan with confirmed diagnosis of COVID-19 infection found that the initial CT images showed fibrosis and striplike lesions with deformation of the bronchus in 10 (19.6%) patients, which indicated that COVID-19 lesions may be present before symptoms develop and became obvious to patients and that CT should have been performed earlier in these cases[1]. CT has a high accuracy and may be useful as a standard method for the diagnosis of COVID-19. During the outbreak of COVID-19, the risk of virus exposure was relatively high, thus all patients should undergo chest computed tomography (CT) before undergoing endoscopy in our endoscopy center. We understand your concerns about radiation exposure and medical cost, but these problems can be compromised in the outbreak of the highly contagious disease. We have discussed it in the article, please see the revised version for details.

3) Did you get to carry out emergency examinations of unstable patients, for example, due to cholangitis? Did even these patients have to undergo a CT scan? Did even these critically ill

patients have to be moved to your sector? Were there no exams in the ICU or operating room?

Response: Yes, we have begun to perform emergency examinations for unstable patients. For some of these patients, imaging study was needed for disease diagnosis, and chest computed tomography can be performed at the same time. Of cause, these critically ill patients did not have to undergo chest CT scan separately. Bed examinations were preserved for critically ill patients in the ICU and operating room, and those patients would not be moved to endoscopy center. We have revised our manuscript in item 3.

4) In item 2.3: "If a patient was diagnosed with COVID-19 during follow-up, all the related medical staff had to stop working, and were quarantined at their home for at least 2 weeks. Related patients were contacted and quarantined as well. " How many patients had this diagnosis? How many of the staff had to be removed and how many were diagnosed with the disease?

Response: In our follow-up, no patients was diagnosed with COVID-19 after endoscopic examinations, and thus no staff were quarantined because of this reason. Four medical staff of our endoscopy center were under home quarantine for 14 days due to confirmed cases in their community. We have declared it in the first version of this manuscript.

5) Item 3: "Green channel was preserved for acute" Green channel? What is it? Use academic and unpopular terms.

Response: Thanks for your suggestion. We have changed the term

“green channel” to “special channel”, which refers to a simple, safe, and fast channel for patients with emergency in our endoscopy center.

6) ”All endoscopists, nurses, and healthcare personnel were trained in infection control and used personal protective equipment during endoscopy properly. ” What protective materials were used? Did everyone use the same? After finishing each procedure, was the material discarded?

Response: Protective materials include but not limited to disposable surgical gown, with a mask, hat, goggles, gloves, and protective shoe covers. We have added a table to elaborate personal protective equipments for different posts. Due to the consideration of material saving, it is impossible to change completely after each operation. We guarantee to disinfect hands and change gloves after each operation. Other protective equipment will not be replaced if there is no secretion splashing pollution. We have revised our manuscript in item 4.

7) The items below, again, seem to be a protocol to be followed by the (future) team and not what was followed: “4.2 During daily working The symptoms and epidemiological history of patients were re-checked before further intervention. Keep a distance from each patient in the explanation step before the start of endoscopic intervention. Wash hands before and after contact with a patient, after contact with a potential source of infection, and before and after wearing and removing personal protective equipment, including gloves [9]. Three levels of protection are required in case of exposure to respiratory

secretions, such as tracheal intubation, airway care, and sputum aspiration for general patients, as well as during performing any endoscopic procedure on confirmed or suspected COVID-19 infected patients [10]. The tissue samples obtained during endoscopy should be stored in a fixed area and the report of endoscopy should be provided to avoid cross infection. 4.3 After daily working Medical staff need to take off their disposable items in the exit channel, and put them in the medical waste bin. Seven-step hand-washing method should be applied. Take temperature before leaving endoscopy center. Change gown to personal clothes, and put the gown into a specific tub. When off duty, stay indoors and cooperate with the epidemic prevention management of the community. The manager of the endoscopy center should communicate with the hospital management team closely and regularly, monitor the outbreak closely, and change the plan quickly to maintain a sustainable and effective endoscopy service. ”

Response: As we responded before, our endoscopy center provided all services for patients, including appointment, examination, treatment, to follow-up. Thus, the measurements presented in item 4.2 and 4.3 were done in our daily work (by shift medical staff), not just a protocol followed by the service. This happens every day in our endoscopy center during the outbreak of COVID-19, and this is why medical staff in China is regarded as the busiest medical staff.

8) “No hospital infection happened in our endoscopy center as described above.“ However, you mention that you had a remote team. Can you make that clear?

Response: We don't have remote team. We set several nurses as dedicated staff contacted with patients via telephone for appointment and follow up.

9) As for the mask made in your service: Has it been tested by any regulatory body? What evidence is it working?

Response: The staff from Department of Infection Control of West China Hospital tested the mask before application in clinical practice. We also get ethical approval before applying this mask. We conducted a prospective randomized controlled study to determine the role of this mask during the outbreak of COVID-19, and the results suggested its safety and effectiveness. We will demonstrate those findings in future manuscript.

10) "We hope that our experience can provide values for China and other countries, suffering from the pandemic of COVID-19." This is not part of the conclusion of a scientific article.

Response: Thank you for your criticism. We have changed our expression in the revised manuscript.

11) Although the authors sent an English proofreading certificate, there are several spelling errors. I do not know if this article was reviewed before it was sent since they sent the article in review mode.

Response: There might be some errors in the submission. We have corrected these errors.

12) There is a boom in endoscopy articles versus COVID-19, their references must be expanded and formatted according to the journal's rules.

Response: Thank you for your friendly comment. We have reformatted the references according to the journal's rules.

Reference:

1. **Li Y**, Xia L. Coronavirus Disease 2019 (COVID-19): Role of Chest CT in Diagnosis and Management. AJR Am J Roentgenol, 2020. **214**(6): p. 1280-1286

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