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ABOUT COVER

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The primary aim of *World Journal of Gastrointestinal Endoscopy* (*WJGE*, *World J Gastrointest Endosc*) is to provide scholars and readers from various fields of gastrointestinal endoscopy with a platform to publish high-quality basic and clinical research articles and communicate their research findings online.

WJGE mainly publishes articles reporting research results and findings obtained in the field of gastrointestinal endoscopy and covering a wide range of topics including capsule endoscopy, colonoscopy, double-balloon enteroscopy, duodenoscopy, endoscopic retrograde cholangiopancreatography, endosonography, esophagoscopy, gastrointestinal endoscopy, gastroscopy, laparoscopy, natural orifice endoscopic surgery, proctoscopy, and sigmoidoscopy.

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Endotracheal intubation in patients with COVID-19 using an ultrathin flexible gastrointestinal endoscope

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Abstract

Pneumonia caused by severe acute respiratory syndrome coronavirus 2 occasionally becomes severe and requires endotracheal intubation. Endotracheal intubation is usually performed using a laryngoscope; however, the operator needs to be in close proximity to the patient's face during the procedure, which increases the risk of droplet exposure. Therefore, we simulated fiberoptic endotracheal intubation on a mannequin representing the patient, using an ultrathin flexible gastrointestinal endoscope as an alternative to the bronchoscope, in order to maintain distance from the patient during the procedure. We performed this procedure 10 times and measured the time required; the median procedure time was 6.4 s (interquartile range, 5.7-8.1 s). The advantage of this method is the short procedure time and distance maintained from the patients. The flexible tip-steerable control and length of the gastrointestinal endoscope contributed to shortening the procedure time and maintaining distance from the patients. In addition, this method can handle difficult airways without risk of misplacement of the endotracheal tube. However, it is necessary to consider the risk of aerosol generation associated with this procedure. In the pandemic setting of coronavirus disease 2019, this approach may be useful when a gastrointestinal endoscopist is in charge of endotracheal intubation of patients with coronavirus disease 2019.

Key Words: Endotracheal intubation; SARS-CoV-2; COVID-19; Laryngoscopes; Bronchoscopes; Gastrointestinal endoscopes

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Core Tip: Proximity of the operators to the patient is inevitable with conventional endotracheal intubation procedures. In this endotracheal intubation method, the gastrointestinal endoscope is used as an alternative to the bronchoscope. Thus, endotracheal intubation can be performed while keeping a relatively safe distance from the patient, as the gastrointestinal endoscope has a long effective length. Furthermore, the flexible tip-steerable control of the gastrointestinal endoscope enables quick and reliable endotracheal intubation.

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TO THE EDITOR

Endotracheal intubation is performed in patients with severe respiratory failure induced by severe acute respiratory syndrome coronavirus 2^[1]. These patients are usually intubated using a laryngoscope^[2]. Coronavirus disease 2019 (COVID-19) is highly contagious; thus, preventing the propagation of infection requires maintaining a safe distance and avoiding direct exposure to droplets from infected patients^[3]. However, it is difficult for healthcare professionals to maintain distance while intubating patients using a laryngoscope because operators need to stand in close proximity to patients' faces.

Here, we report the use of an ultrathin flexible gastrointestinal endoscope with a tip outer diameter of 5.0 mm (GIF-XP260N; Olympus, Tokyo, Japan) to perform endotracheal intubation on a mannequin representing the patient. The purpose of this simulation-based study was to evaluate the feasibility and usefulness of using a gastrointestinal endoscope as an alternative to the bronchoscope in endotracheal intubation. This procedure included four steps (Figures 1 and 2) as follows: First, the operator holding an endoscope over which a 7.0 mm endotracheal tube was mounted stood to the left of the supine patient; second, the endoscope was inserted into the trachea; third, we ensured instant insertion of the endotracheal tube into the trachea using the endoscope as a guide; and finally, the endoscope was withdrawn. We repeatedly performed the procedure 10 times and recorded the corresponding time taken for each procedure. The procedure time was defined as the total time elapsed between the insertion of the endoscope into the mouth and the final withdrawal of the endoscope. The median procedure time was 6.4 s (interquartile range, 5.7-8.1 s; Table 1).

Bronchoscope-guided endotracheal intubation in patients with COVID-19 has already been reported^[4,5]. In our method, an ultrathin gastrointestinal endoscope was used as an alternative to the bronchoscope. This method is advantageous owing to the short procedure time. This can be attributed to the flexible tip-steerable control of the gastrointestinal endoscope because the gastrointestinal endoscope has angulation control knobs for up, down, left, and right movements, whereas the bronchoscope has an angulation control knob only for up and down movements^[6]. Hence, the gastrointestinal endoscope may serve as a better alternative to the bronchoscope for endotracheal intubation. This technique will also be useful in patients with difficult airways in order to avoid the risk of misplacement of the endotracheal tube^[7]. Furthermore, the effective length of the gastrointestinal endoscope used was 1.1 meters allowing the operator to maintain a relatively safe distance by standing to the left of the patient, minimizing direct exposure to droplets from patients.

However, our method has a few limitations. Conventionally, endotracheal intubation is performed by anesthesiologists familiar with techniques used in intubation^[1]. Notably, gastrointestinal endoscopes are not usually available in the emergency room or intensive care unit where endotracheal intubation is often performed. Furthermore, owing to the potential for generating aerosols, it is unlikely that flexible bronchoscope-guided intubation will be the first choice in conscious patients with COVID-19^[1,2].

During this COVID-19 pandemic, there may be occasions when a gastrointestinal endoscopist is in charge of endotracheal intubation in patients with confirmed or

Table 1 The procedure time

	Time (s)
1 st	10.2
2 nd	7.9
3 rd	8.1
4 th	10.0
5 th	6.5
6 th	5.6
7 th	4.5
8 th	5.8
9 th	5.6
10 th	6.2
Median, 6.4 (interquartile range, 5.7–8.1)	



Figure 1 The ultrathin gastrointestinal endoscope mounted into an endotracheal tube.

suspected COVID-19. If the gastrointestinal endoscopist is not familiar with endotracheal intubation using a laryngoscope, the intubation procedure is expected to be time-consuming, thus increasing the risk of direct exposure to droplets from patients. Therefore, endotracheal intubation using this method may be useful in reducing the risk of exposure to severe acute respiratory syndrome coronavirus 2.

CONCLUSION

Endotracheal intubation using an ultrathin flexible gastrointestinal endoscope is a quick and reliable procedure that can be performed while maintaining distance from the patient. Therefore, this method may be useful in endotracheal intubation in patients with COVID-19.

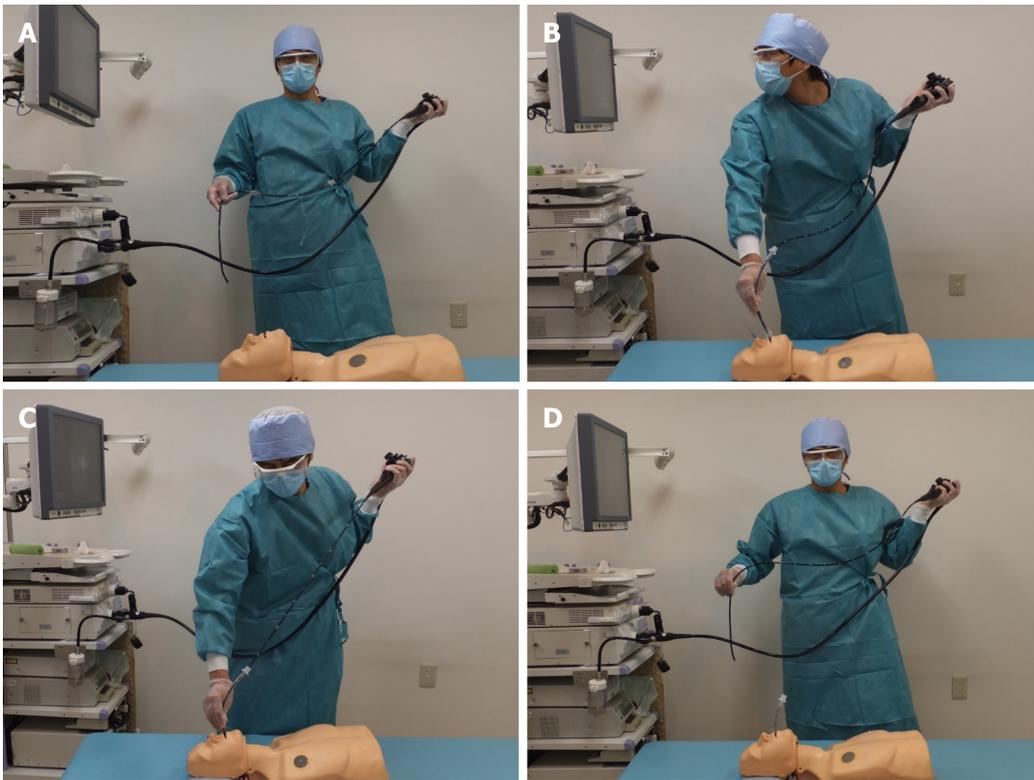


Figure 2 Gastrointestinal endoscope-guided endotracheal intubation. A: The operator standing to the left of the patient; B: Inserts the endoscope into the trachea; C: Endoscope-guided endotracheal intubation is performed; and D: The endoscope is withdrawn.

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