Ten key guidance points: Aerosol Generating Procedures (AGPs) within the ENT clinic

The following factors, when applied together, will all contribute to reducing the potential risk of healthcare professionals and patients being infected by the SAR-CoV-2 virus during diagnostic endoscopic procedures. This document has been written with the aim of clarifying key points within the main ENT UK advisory document ‘Aerosol Generating Procedures (AGPs) within the ENT Clinic’.

1. Screening of patients by questioning for COVID-19 symptoms prior to consultation will greatly reduce the chance of seeing a patient within the pre-symptomatic phase of the illness, particularly as the infection rate within the community falls, and there is no need for COVID testing.

2. A designated AGP procedure room should be available within the outpatient clinic. The room must be well ventilated. Ideally, it should have mechanical ventilation with a known rate of Air Changes per Hour (ACH).

3. Advice on the ventilation of the designated room should be sought from a Consultant Microbiologist, ideally with Infection Control responsibility, and the Hospital Estates Director. While negative ventilation by an extraction unit is preferable, it is not mandatory.

4. The clinician should don appropriate PPE that includes a face mask (FFP3/2 disposable mask or reusable respirator) and eye protection during endoscopy. The mask may be stored and reused during the same clinic session as long as the clinician is satisfied that an aerosol has not been generated.

5. Upper airway endoscopy is only a potential Aerosol Generating Procedure (AGP). This is an important principle to understand.

6. The majority of endoscopies will not generate an aerosol or droplets. An aerosol is only likely to be generated with sneezing or coughing and will be clearly recognized by the clinician. Even then, the evidence suggests that coughing generates very little aerosol, but is included here for completeness.

7. For the less common occasion where an aerosol may have been generated, aerosol droplets will be contained by the patient wearing a surgical facemask. Patients should be advised to wear a surgical facemask for the endoscopy and asked avoid sneezing or coughing if possible.
8. For endoscopy without generation of an aerosol, **there is no logical need for a ‘rest period’ after the procedure.** A rest period should only be recommended for the less common occasion where an aerosol may have been generated by the patient. The time required for a rest period should be determined by microbiological advice according to the room ventilation characteristics.

9. Following endoscopy, only **the surfaces need to be cleaned** by disinfectant. At the end of the clinic session, the whole room should be thoroughly cleaned according to local Trust IPC guidance.

10. The endoscope should be decontaminated after use: the chlorine dioxide wipe system is eminently suitable for this. The potential risk of SARS-CoV-2 transmission associated with endoscope decontamination should be minimal if recommended guidelines are followed (please refer to ENT UK guidance document: [PPE for nasal endoscope decontamination during the COVID-19 pandemic](#)).

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