Gastrointestinal endoscope contamination rates – elevators are not only to blame: a systematic review and meta-analysis

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ABSTRACT
Background and study aims Duodenoscopes that are contaminated due to inadequate reprocessing are well-documented. However, studies have demonstrated poor reprocessing of other kinds of endoscopes as well, including echoendoscopes, gastroscopes, and colonoscopes. We estimated the contamination rate beyond the elevator of gastrointestinal endoscopes based on available data.

Methods We searched PubMed and Embase from January 1, 2010 to October 10, 2020, for studies investigating contamination rates of reprocessed gastrointestinal endoscopes. A random-effects model was used to calculate the contamination rate of patient-ready gastrointestinal endoscopes. Subgroup analyses were conducted to investigate differences among endoscope types, countries, and colony-forming unit (CFU) thresholds.

Results Twenty studies fulfilled the inclusion criteria, including 1,059 positive cultures from 7,903 samples. The total contamination rate was 19.98% ±0.024 (95% confidence interval [CI]: 15.29% – 24.68%; I² = 98.6%). The contamination rates of colonoscope and gastroscope channels were 31.95% ± 0.084 and 28.22% ±0.076, respectively. Duodenoscope channels showed a contamination rate of 14.41% ± 0.029. The contamination rates among studies conducted in North America and Europe were 6.01% ± 0.011 and 18.16% ± 0.053%, respectively. The contamination rate among studies using a CFU threshold >20 showed contamination of 30.36% ± 0.094, whereas studies using a CFU threshold <20 showed a contamination rate of 11% ± 0.026.

Conclusions On average, 19.98% of reprocessed gastrointestinal endoscopes may be contaminated when used in patients and varies between different geographies. These findings highlight that the elevator mechanism is not the only obstacle when reprocessing reusable endoscopes; therefore, guidelines should recommend more surveillance of the endoscope channels as well.

* These authors contributed equally.
Introduction

In recent years, reusable duodenoscopes have become an area of interest because of numerous reports of infection transmission by contaminated duodenoscopes following ERCP [1–4]. Duodenoscopes are prone to reprocessing errors because of their complex designs, especially around the elevator mechanism. Many studies found that microbes harbor in the instrument channel and other places in the endoscope as well. In addition, the channels of the endoscopes are prone to scratches when tools are inserted, which can create additional areas for the microbes to harbor [5,6]. Microbiological testing is standard at most endoscopy units; however, sampling methods and requirements vary across countries.

Adenosine triphosphate (ATP) testing is an established and inexpensive indicator for washing efficacy [7]. Nevertheless, this test should not replace routine microbiologic methods because of their low sensitivity and specificity [8]. ATP tests poorly correlate with microbiologic standards for assessing endoscope contamination [9]. Visual inspection using a borescope has been suggested as a quality assurance step in reprocessing to detect scratches and other irregularities within endoscope channels. Several studies identified internal defects of instrument channels to be more frequent than anticipated, increasing their microbiological contamination susceptibility [6,10,11]. Inconsistencies in recommended quality measures to detect microbiological debris in endoscope channels may also pose safety risks.

In July 2019, the United States Food and Drug Administration (FDA) was made aware of a hospital in Oklahoma that had used contaminated gastrosopes on almost 1,000 patients. However, no patient-related infections were allegedly reported or detected [12]. Several studies investigating duodenoscope contamination rates sampled both the elevator and the working channel and detected microbiological organisms in both parts [9,13–15]. Duodenoscopes with disposable endcaps have been introduced as an attempt to overcome the challenges of duodenoscopes being vectors for patient cross-infections [16]. However, studies showed that even single-use endcap duodenoscopes remain contaminated after reprocessing [17,18]. Bronchoscopes have been implicated in multiple outbreaks and associated with high contamination rates, even without the elevator [18–21]. The fact that positive microbiological samples have been identified in various non-elevator endoscopes may indicate that contamination issues due to inadequate reprocessing are not limited to duodenoscopes. Previous studies investigated contamination rates in endoscope channels and areas beyond the elevator mechanism; nevertheless, no studies estimated the overall contamination rate associated with patient-ready gastrointestinal endoscopes unrelated to the elevator mechanism. We aimed to assess the contamination rate beyond the elevator of patient-ready gastrointestinal endoscopes based on the data from 2010 to 2020.

Methods

Study selection

We conducted a systematic literature review to identify full-text studies published in English, investigating contamination rates associated with all types of gastrointestinal endoscopes. Studies concerning duodenoscopes and linear echoendoscopes, which are both endoscope types with an elevator, were included if data were available for any channels sampled. The comprehensive literature search is presented in Fig. 1. The analysis and inclusion criteria were based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Guideline [22].

Studies were identified through a systematic literature search from January 1, 2010 until October 10, 2020 in the electronic databases PubMed, Web of Science, and Embase. To identify relevant studies, we conducted the search using the following medical subject headings (MeSH) and keywords: (duodenoscope” [MeSH Terms]) OR (gastroscope” [MeSH Terms]) OR (bronchoscope” [MeSH Terms]) OR (gastrointestinal endoscope” [MeSH Terms]) OR (endoscope” [MeSH Terms]) OR (GI” [MeSH Terms]) OR (gastrointestinal” [MeSH Terms]) OR (gastrointestin” [MeSH Terms]) OR (gastrointestinal tract” [MeSH Terms]) OR (gastrointestinal tract” [MeSH Terms]) OR (gastrointestinal tract” [MeSH Terms]).
Inclusion and exclusion criteria

The search was conducted to identify relevant randomized controlled trials, surveillance studies, and prospective or retrospective cohort studies investigating contamination rates associated with reprocessed gastrointestinal endoscopes. The search was limited to studies published after 2010, as microbiological surveillance testing in endoscopy and was recommended in both European and US guidelines in this period followed by various updates in reprocessing guidelines [23–27] because a time horizon of 10 years was considered reasonable due to various updates in endoscope reprocessing guidelines in the last 10 years. For inclusion, the total number of microbiological samples (N) and the number of positive cultures (n) needed to be reported. It was imperative that all samples were acquired from a gastrointestinal endoscope excluding samples taken from the elevator mechanism and not from any patients or other medical equipment. Exclusion criteria included all types of studies performed on animals or in vitro models, as well as conference abstracts, editorials, letters, and gray literature that did not report any original findings. We assumed high heterogeneity between studies due to varying study design and definitions of positivity. To account for the heterogeneity, studies with sample size of less than 50 were excluded to avoid bias in the random-effects model [28].

Titles and abstracts of all identified studies were independently reviewed by two authors (SL and NBL). Studies that did not fulfill the inclusion criteria were excluded, and the full texts of the remaining publications were independently reviewed by three authors (SL, NBL, and SA). Any disagreements related to the inclusion or exclusion of studies were resolved by consensus.

Data extraction

All included studies were assessed for eligibility by three independent reviewers (SL, NBL, and SA). The authors were not blinded to any information within the studies. For each included study, we extracted the following baseline characteristics: first author, year, study design, country, hospital, endoscope type(s), sampled channels/areas, positive cultures, sample size, type of microorganism, reprocessing method, and CFU threshold.

Outcomes

The primary outcome of the meta-analysis was the total weighted contamination rate beyond the elevator, based on the number of positive microbiological sample cultures (n) relative to the number of samples in total (N). Three subgroup analyses were carried out to assess potential significant differences between countries and applied CFU thresholds. The first subgroup analysis was conducted for studies only including samples from gastroscope channels and colonoscope channels both individually and combined. The second subgroup analysis was conducted for studies only, including samples taken from duodenoscope channels and areas beyond the elevator. The third subgroup analysis was conducted for studies that originated in North America, Europe, and the rest of the world (RoW). The fourth subgroup analysis was conducted among studies with a CFU threshold >20 and those with a CFU threshold <20.

No patient-specific data were assessed because the analysis only focused on gastrointestinal endoscopes. There were no missing data for any of the data points used to calculate the weighted contamination rates.

Data analysis and statistical methods

A meta-analysis was conducted based on data from studies where contamination rates of gastrointestinal endoscope channels, insertion cord, and all other surface areas beyond the elevator mechanism were assessed. The primary objective of the meta-analysis was to calculate the total contamination rate beyond the elevator of reprocessed patient-ready gastrointestinal endoscopes. Four subgroup analyses were carried out to do the following: 1) investigate the contamination rate among samples from gastroscope and colonoscope channels both separately and combined; 2) investigate the contamination rate among samples from duodenoscope channels; 3) assess the contamination rate in various countries (North America, European countries, and RoW); and 4) assess the contamination rate among studies using a CFU threshold >20 and studies using a CFU threshold <20.

We used the meta-package (metafor) in RStudio version 3.6.2 to conduct the statistical analyses. All data were pooled using a random-effects model based on proportions (prop). The random-effects model was applied because we anticipated heterogeneity, predominantly arising from variations in both sample size (N) and outcome (positive samples, n). We used the inconsistency index ($I^2$) test to estimate the level of heterogeneity between the included studies. $I^2$ indicates the proportion (%) of variation between the studies linked to heterogeneity rather than a coincidence [29, 30]. Heterogeneity values below 50% indicated low to moderate heterogeneity levels [30]. Publication bias was assessed using funnel plots. To avoid drawing any subjective conclusions based solely on the funnel plot, we evaluated the asymmetry of the funnel using Egger’s regression. All study outcomes were presented in forest plots (Fig. 2).
Results
Characteristics of included studies
We identified a total of 1,914 peer-reviewed studies. After duplicates were removed, a total of 1,230 studies were screened based on title and abstract. After applying our inclusion and exclusion criteria, the number of studies was narrowed to 152 studies that were assessed in full text for eligibility. After the full-text assessment, 20 studies fulfilled all inclusion criteria and were included in the final meta-analysis.

▶ Fig. 1 shows the PRISMA flowchart illustrating the study selection process.

All 20 studies included in the final analysis were published between January 1, 2010, and October 10, 2020. The included studies yielded a sample size of 7,903 cultures sampled from various gastrointestinal endoscope channels and areas beyond the elevator. There were a total of 1,059 positive samples. One study (Becq et al., 2019 [31]) provided complete data for both echoendoscopes and duodenoscopes and, therefore, was included in the analysis twice (i.e., 21 data points were included in the random-effects model).

Baseline characteristics of all included studies (n = 20) in the primary analysis are provided in ▶ Table 1. Of the included studies, six studies (30%) were conducted in the United States, seven (35%) were conducted in Europe, including studies from the Netherlands (n = 2), Italy (n = 2), France (n = 1), and Austria (n = 2). Five studies (25%) were conducted in Asia, including studies from Taiwan (n = 3) and China (n = 2). Finally, one study (5%) was conducted in Canada, and one study (5%) was conducted in Brazil. ▶ Table 2 shows the total sample size and number of positive samples taken from gastrosopes and colonoscopes separately and combined.

The majority of the studies (17 of 20, 85%) reported using high-level disinfection (HLD) as the reprocessing method used to clean the gastrointestinal endoscopes. Two studies (10%) tested a combination of both HLD, double HLD (dHLD), and ethylene oxide (EtO) sterilization, and one study compared dHLD and HLD (5%). Thirteen of 20 studies (65%) reported a CFU threshold, six studies (30%) reported a CFU threshold >20, and seven studies (35%) reported a CFU threshold <20.

Analysis of primary outcomes
Meta-analysis of the included studies demonstrated a pooled contamination rate beyond the elevator of 19.98% ± 0.024% (95% confidence interval [CI]: 15.29%–24.68%; I^2 = 98.6%; ▶ Fig. 2). Heterogeneity between the included data points (n = 21) was considered to be high. Funnel plot analysis and Egger’s regression test indicated no significant publication bias (P = 0.0531).

Subgroup analyses
Meta-analysis of studies only including samples from colonoscopes (n = 7) showed a contamination rate of 31.95% ± 0.084 (95% CI: 15.55%–48.36%; I^2 = 95.2%; ▶ Fig. 3). Egger’s regression test indicated significant publication bias (P = 0.0531).
<table>
<thead>
<tr>
<th>First author, year</th>
<th>Study design</th>
<th>Country</th>
<th>Hospital</th>
<th>Endoscopes type(s)</th>
<th>Sampled channels/areas</th>
<th>Positive cultures, n</th>
<th>Sample size, N</th>
<th>Type of microorganism</th>
<th>Reprocessing method</th>
<th>CFU threshold</th>
</tr>
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<tbody>
<tr>
<td>Snyder, 2017 [33]</td>
<td>Parallel group randomized study</td>
<td>United States</td>
<td>Beth Israel Deaconess Medical Center</td>
<td>Duodenscopes</td>
<td>Working channel</td>
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<td>United States</td>
<td>Beth Israel Deaconess Medical Center</td>
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<td>Study design</td>
<td>Country</td>
<td>Hospital</td>
<td>Endoscopes type(s)</td>
<td>Sampled channels/areas</td>
<td>Positive cultures, n</td>
<td>Sample size, N</td>
<td>Type of microorganism</td>
<td>Reprocessing method</td>
<td>CFU threshold</td>
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<td>Paula, 2015 [35]</td>
<td>Descriptive study</td>
<td>Austria</td>
<td>Vienna University Hospital</td>
<td>Duodeno-scopes</td>
<td>Air, water, suction, and biopsy channel</td>
<td>47</td>
<td>412</td>
<td>Unspecified skin bacteria and aerobe spore-forming bacilli</td>
<td>HLD</td>
<td>&gt; 100 CFU</td>
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<td>Alfa, 2012 [36]</td>
<td>Descriptive study</td>
<td>Canada</td>
<td>St Boniface General Hospital</td>
<td>Colonoscopes, gastroscopes, duodeno-scopes</td>
<td>All channels</td>
<td>21</td>
<td>141</td>
<td>gram-positive Bacilli, gram-positive Cocci</td>
<td>HLD</td>
<td>N/A</td>
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<tr>
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<td>Descriptive study</td>
<td>China</td>
<td>Unspecified, all endoscopy units in Tianjin, China</td>
<td>Colonoscopes, gastroscopes</td>
<td>Biopsy channel</td>
<td>104</td>
<td>184</td>
<td><em>Pseudomonas aeruginosa</em>, <em>Escherichia coli</em>, Acinetobacter kwofii, Stenotrophomonas maltophilia, Malodorous mononeurosis, <em>Enterococcus faecalis</em>, Testicular pseudomonas, Burkholderia cepacia</td>
<td>HLD</td>
<td>&gt; 20 CFU</td>
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<td>Chang, 2019 [38]</td>
<td>Descriptive study</td>
<td>Taiwan</td>
<td>Unspecified, 14 major tertiary care teaching hospitals</td>
<td>Duodeno-scopes</td>
<td>Distal end outer surface, distal attachment cap, elevator wire channel, suction biopsy channel</td>
<td>43</td>
<td>135</td>
<td>N/A</td>
<td>HLD, dHLD, EtO</td>
<td>N/A</td>
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<td>First author, year</td>
<td>Study design</td>
<td>Country</td>
<td>Hospital</td>
<td>Endoscopes type(s)</td>
<td>Sampled channels/areas</td>
<td>Positive cultures, n</td>
<td>Sample size, N</td>
<td>Type of microorganism</td>
<td>Reprocessing method</td>
<td>CFU threshold</td>
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<tr>
<td>Chiu, 2012 [40]</td>
<td>Prospective surveillance study</td>
<td>Taiwan</td>
<td>Chang Gung Memorial Hospital, Kaohsiung Medical Center</td>
<td>Colonoscopes, gastroscopes</td>
<td>Biopsy channel</td>
<td>57</td>
<td>420</td>
<td>GNGN bacteria, Klebsiella pneumoniae, Acinetobacter baumannii, Enterococcus spp., Comamonas testosteroni, Chryseobacterium indologenes, Sphingomonas paucimobilis, Pseudomonas putida, Viridans Streptococcus, Stomatococcus spp., Prevotella bivia, Escherichia coli, Pseudomonas aeruginosa, Enterococcus faecium, Bacteroides fragilis, Bacteroides vulgatus, Bacteroides distasonis, Clostridium perfringens, Proteus mirabilis, Moraxella osloensis, Candida glabrata</td>
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<td>Valeriani, 2018 [41]</td>
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<td>Unspecified, 10 Italian hospitals</td>
<td>Colonoscopes</td>
<td>Unspecified, inner channels</td>
<td>5</td>
<td>52</td>
<td>B. vulgatus 16S amplicon, B. vulgatus OmpA, Enterococcus faecalis, Escherichia coli, B. fragilis, S. aureus</td>
<td>HLD</td>
<td>N/A</td>
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<td>Becq, 2019 [31]</td>
<td>Prospective single-center study</td>
<td>United States</td>
<td>N/A</td>
<td>Echoendoscopes</td>
<td>Working channel</td>
<td>5</td>
<td>110</td>
<td>N/A</td>
<td>HLD</td>
<td>&gt;0 CFU</td>
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<td>Chiu, 2012 [42]</td>
<td>Descriptive study</td>
<td>Taiwan</td>
<td>N/A</td>
<td>Enteroscopes (DBE)</td>
<td>Suction channel</td>
<td>9</td>
<td>57</td>
<td>Klebsiella pneumoniae, Escherichia coli, Pseudomonas aeruginosa, E. aerogenes, A. baumannii, Enterococcus sp., Gm (+) bacilli glucose-nonfermenting gp., Proteus vulgaris, Staphylococcus epidermidis, Bacteroides caccae, Prevotella melaninogenic</td>
<td>HLD</td>
<td>N/A</td>
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<tr>
<td>Decristoforo, 2018 [43]</td>
<td>Descriptive study</td>
<td>Austria</td>
<td>Unspecified, 29 endoscopy centers</td>
<td>Colonoscopes, gastroscopes, duodeneroscopes</td>
<td>Biopsy/suction channel</td>
<td>10</td>
<td>218</td>
<td>Sphingomonas paasasanguinis, Streptococcus viridans, Moraxella osloensis, Pseudomonas pseudocaligenes, Pseudomonas oleovorans, Pseudomonas luteola, Streptococcus mitis, Moraxella osloensis, Staphylococcus aureus</td>
<td>HLD</td>
<td>≤10 CFU</td>
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<td>Ribeiro, 2012 [44]</td>
<td>Descriptive study</td>
<td>Brazil</td>
<td>Unspecified, gastrointestinal endoscopy units in Belo Horizonte</td>
<td>Colonoscopes, gastroscopes</td>
<td>Air/water channel</td>
<td>70</td>
<td>99</td>
<td>Pseudomonas aeruginosa, Escherichia coli, Acinetobacter baumannii, Klebsiella pneumoniae</td>
<td>HLD</td>
<td>N/A</td>
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<tr>
<td>First author, year</td>
<td>Study design</td>
<td>Country</td>
<td>Hospital</td>
<td>Endoscopes type(s)</td>
<td>Sampled channels/areas</td>
<td>Positive cultures, n</td>
<td>Sample size, N</td>
<td>Type of microorganism</td>
<td>Reprocessing method</td>
<td>CFU threshold</td>
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<tr>
<td>Rauwers, 2020 [45]</td>
<td>Prospective nationwide cross-sectional study</td>
<td>Netherlands</td>
<td>61 Dutch ERCP centers</td>
<td>Duodendoscopes, echoendoscopes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Balloon channel, biopsy channel, suction channel</td>
<td>13</td>
<td>133</td>
<td>N/A</td>
<td>HLD</td>
<td>≥ 20 CFU</td>
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<td>Ji, 2020 [46]</td>
<td>Descriptive study</td>
<td>China</td>
<td>Unspecified, 59 Endoscopy units in Tianjin</td>
<td>Colonoscopes, gastroscopes</td>
<td>Biopsy channel</td>
<td>180</td>
<td>280</td>
<td>N/A</td>
<td>HLD</td>
<td>&gt; 20 CFU</td>
</tr>
<tr>
<td>Bartles, 2018 [47]</td>
<td>Controlled randomized study</td>
<td>United States</td>
<td>Unspecified, four facilities with endoscopy labs</td>
<td>Echoendoscopes and duodendoscopes</td>
<td>Suction and working channel</td>
<td>84</td>
<td>2,925</td>
<td>Enterococcus spp, Enterobacter cloacae, Aeromonas spp, E. coli (ESBL +), E. coli (ESBL -), Enterococcus faecium&lt;sup&gt;2&lt;/sup&gt;</td>
<td>dHLD, HLD</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The study was conducted in the main hospitals of different Italian regions (Campania, Emilia Romagna, Lazio, Liguria, Marche, Molise, Tuscany, Veneto, Sardinia, and Sicily) involving ten endoscopy units that reprocess approximately 50–100 endoscopes per business day.

<sup>1</sup> Samples from the original biopsy channels for both duodenoscopes and echoendoscopes.

<sup>2</sup> Only high-concern pathogens were specified in study.
Meta-analysis of studies with gastroscope-specific samples (n = 6) showed a contamination rate of 28.22% ± 0.076 (95% CI: 13.35%–43.10%; I² = 96.4%) (Fig. 4). Egger’s regression test indicated no significant publication bias (P = 0.1293). Meta-analysis of studies including samples from both gastroscopes and colonoscopes (n = 8) showed a contamination rate of 33.20% ± 0.084 (95% CI: 16.80%–49.60%; I² = 98.9%) (Fig. 5). Egger’s regression test indicated significant publication bias (P = 0.0434). Meta-analysis of studies with duodeno-scopes channel-specific samples (n = 8) showed a contamination rate of 14.41% ± 0.029% (95% CI: 8.70%–20.13%; I² = 96.4%) (Fig. 6). Egger’s regression test indicated no significant publication bias (P = 0.9919).

Meta-analysis of studies conducted in North America (USA and Canada) (n = 7) showed a pooled contamination rate of 6.01% ± 0.011% (95% CI: 3.88%–8.15%; I² = 89.3%; Supplementary Fig. 1). The pooled contamination rate among studies conducted in European countries (n = 7) was 18.16% ± 0.053% (95% CI: 7.75%–28.57%; I² = 98.1%; Supplementary Fig. 2). Studies defined as RoW (n = 6) demonstrated a contamination rate of 42.10% ± 0.011% (95% CI: 19.78%–64.41%; I² = 98.7%; Supplementary Fig. 3). Egger’s regression test indicated significant publication bias (P = 0.0025) for studies conducted in Europe. Egger’s regression test did not indicate significant publication bias for studies conducted in North America and RoW (P = 0.0655 and P = 0.2231). Finally, meta-analysis of studies using a CFU threshold > 20 (n = 6) showed a pooled contamination rate above the elevator of 30.36% ± 0.094% (95% CI: 19.16%–41.56%; I² = 99.3%), whereas studies using a CFU threshold < 20 (n = 8) showed a contamination rate of 11% ± 0.0469).
Discussion

We performed a meta-analysis to estimate contamination rates unrelated to the elevator mechanism among patient-ready gastrointestinal endoscopes. Our findings suggest that the overall contamination rate among patient-ready gas-trointestinal endoscopes is 0.28% (95% CI: 0.13%, 0.43%).
reported contamination rate beyond the elevator of patient-ready gastrointestinal endoscopes is 19.98%. Subgroup analyses found different contamination rates depending on the type of endoscope. Studies only including samples from colonoscopes showed a contamination rate of 31.95% ±0.084% compared to studies only including samples from gastroscope where the contamination rate was 28.22% ±0.076%. The endoscope type with the lowest contamination rate was duodenoscopes (14.41% ±0.01%). Additionally, subgroup analyses found different contamination rates across countries, with the highest contamination rate among studies conducted in what was defined as “RoW,” including studies from China, Taiwan, and Brazil (42.10% ±0.011%). The contamination rates in studies originating from Europe and North America were 18.16% ±0.053% and 6.01% ±0.011%, respectively. Finally, studies using a CFU threshold >20 showed a significantly lower contamination rate of 0.094%. In contrast to these findings, studies using a CFU threshold <20 showed a significantly lower contamination rate of 11% ±0.026%. However, we should also note that these conclusions could also be impacted by differences in study design, definitions of positivity, and apparent neglect to categorize any sample with a pathogen as a positive, high-risk finding.

Our subgroup analysis indicated the lowest contamination rate among studies carried out in North America. These findings may reflect the increasing awareness of the risk of contaminated endoscopes and development of FDA guidelines leading to stricter adherence to reprocessing guidelines. However, most of the communications related to endoscope reprocessing has concerned duodenoscopes with a special focus on the elevator, which does not explain why the contamination rate beyond the elevator channel was lower than that of other countries as well. We found the contamination rate beyond the elevator was 18.16% in Europe, significantly higher than the contamination rate in North America. Despite very limited communications regarding contaminated endoscopes and reprocessing in European countries, these findings may indicate that contamination issues are not limited to the United States. Our previous study on duodenoScope contamination rates found an overall contamination rate of 15.25%, whereas only four studies were conducted in European countries [32]. Rauwers et al. invited 74 Dutch endoscopy centers to sample duodenoScopes and linear echoendoscopes and found that ~15% of the endoscopes were contaminated [33]. Our findings suggest a higher contamination rate for colonoscopes and gastroscope compared to duodenoScopes. This might be due to the fact that most of the samples included in these analyses originated from “RoW” where an overall higher contamination rate was found compared to North America and Europe. These studies may have skewed the data toward higher contamination rates for both colonoscopes and gastroscope. We also would like to stress on the impact of various culture methods on microbial growth. It is important to note that most studies conducted prior to 2018 did not utilize a neutralizer to counteract the effect of residual reprocessing chemicals on microbial growth, and most of the earlier studies incubated samples for only 48 hours. However, the study by Saliou et al. notes the importance of longer incubation times to grow viable slow-growing microbes. Therefore, the positivity rate in their study was far higher than almost any of the other included studies (35%). Later in 2018, the US FDA/CDC released new guidance recommending that flush-brush-flush sampling methods be used to harvest samples; neutralizers be used to counteract reprocessing chemicals; and samples be incubated for at least 72 hours.

Very limited evidence exists on the attributable infection risk associated with contaminated gastroscope and colonoscopes. Wang et al. estimated the post-endoscopic infection per 1,000 procedures within seven days for colonoscopy (screening and non-screening) and gastroscope. The infection risk for screening colonoscopy was 1.1/1,000, and for non-screening colonoscopy, it was 1.6/1,000. The infection risk for gastroscope was 3/1,000, which was almost twice as high as that of colonoscopy [34]. Lin et al. compared the incidence of infection within 30 days after colonoscopy and sigmoidoscopy. Following colonoscopy, the overall infection risk was 0.37%, which was significantly higher than that of the control group (0.04%; P<0.001) [35]. Few cases of gastroscope-associated cross-infections have been published [36–39]. Naas et al. reported an outbreak where two patients developed carbapenem- and colistin-resistant Klebsiella pneumoniae due to a contaminated gastroscope [37]. The bacteria mutated to 17 different isolates over 4.5 years in one of the infected patients, and the patient died due to sepsis with intestinal bacteria, including the original carbapenem- and colistin-resistant Klebsiella pneumoniae [39]. However, the lack of evidence linking contaminated gastrointestinal endoscopes other than duodenoScopes to infections could indicate a smaller risk associated with non-endoscopic retrograde cholangiopancreatography procedures. Nevertheless, the discrepancy could be due to lesser degrees of awareness about infection risk from the endoscope parts beyond the elevator mechanism.

In recent years, contaminated duodenoScopes have gained much attention due to their complex design [2,16]. However, duodenoScopes are not the only types of endoscope with complex designs; linear echoendoscopes also have similar designs. Sun et al. stated that there is a significant overlap between the indications for endoscopic ultrasound (EUS) and ERCP, and recommended that similar reprocessing FDA recommendations should be applied for all endoscopes with elevator mechanisms. [40] Despite similarities between duodenoScopes and echoendoScopes, few studies report contamination data or infection related to EUS. Chapman et al. found that 21 of 521 cultures (4.1%) obtained from echoendoscopes were positive following HLD. [41] Rauwers et al. investigated contamination rates of both duodenoScopes and echoendoscopes and found that 13 of 133 samples (9.8%) taken from the balloon, biopsy, and suction channels were positive for microbiological growth [33]. This suggests that the elevator may not be the only obstacle when reprocessing elevator-containing endoscopes. Additionally, Olympus recently issued an “urgent field safety notice” concerning the use of EUS endoscopes. Olympus has revised instructions for use for various EUS endoscopes after an investigation indicated a potential risk of infection due to residue in the air/water channel. To further mitigate this risk, Olympus has updated the instructions for use for 23 affected EUS endo-
scope models by adding an inspection step before reprocessing [42].

Gastrointestinal endoscope channels are prone to scratches and their long, narrow channels make them difficult to properly investigate for microbiological debris [5, 41, 43]. Our analysis casts doubt on the suggestion that disposable endcaps are the answer to contamination issues; several studies reported high contamination rates in the channels and areas beyond the elevator. Ridtitid et al. compared bacterial contamination and organic residue using rapid ATP testing and cultures from duodenoscopes with detachable versus fixed distal caps after HLD. The authors found that, after HLD, the proportion of bacterial contamination and the organic residue was significantly lower in the group with detachable end caps than in the group of duodenoscopes with fixed end caps (37.0% vs. 75.9%; P<0.001; relative risk 0.49, 95% CI 0.33–0.71). However, even with a significant reduction in the contamination levels, the duodenoscopes were still not completely free of bacterial residues. Our subgroup analysis demonstrated a 14.41% contamination rate among studies only including samples from duodenoscope channels.

Contaminated endoscopes remain a challenge, and until the potential harmful effects of this are fully investigated, these issues should be taken seriously. The US Centers for Disease Control and Prevention recommends surveillance culture for bacterial contamination from both the elevator and the working channel. Nevertheless, one should keep in mind that stricter recommendations related to meticulous surveillance sampling and microbiological culturing have both practical and financial impacts [17]. However, contamination rates have been shown to drop following the implementation of microbiological surveillance [15]. Microbiologic testing of endoscopes is costly and requires 72 hours for culture; it may be difficult for some endoscopy facilities to achieve this if their budgets are limited [17, 44]. On the other hand, endoscope-related infections caused by contaminated endoscopes are also costly to treat, especially as most endoscope-related infections are caused by multidrug-resistant organisms [45–47]. Regardless, we should strive for best patient care while keeping the rate of infection transmission as low as possible.

We believe that the findings of this study are informative and relevant for decision-making in infection control and future clinical guidelines. Nevertheless, when concluding on these results important limitations must be considered. One of the main limitations is the high heterogeneity among included studies. The high heterogeneity could indicate that there is no “real” true effect behind the data included in the analysis because there is no consensus regarding the outcomes from the included studies [48]. On the other hand, despite being widely used, I² is not always an adequate measure for heterogeneity because it is exquisitely dependent on precision of the included studies and because I² tends to be 100% if the single studies have substantial sample sizes [29, 48]. Another limitation is the inconsistency regarding how each study tested the level of contamination and the choice of CFU threshold. Some studies did not state which CFU threshold they applied to determine whether the endoscopes were considered contaminated. A third limitation is the indication of publication bias that may be resulted from the lack of published negative results. Finally, limitations exist with respect to the channels and areas sampled beyond the elevator mechanism and samples pooled from different institutions. Data were derived from studies not directly investigating the contamination rate of a specific area in the endoscope and potentially with varying methodology between institutes, which would increase the risk of confounding factors affecting the findings.

Conclusions

Despite the abovementioned limitations, we believe that the findings of this study are highly important and may help overcome issues related to contaminated endoscopes, not only related to the elevator mechanism and duodenoscopes.

Our findings support the notion that contamination issues due to inadequate reprocessing are not only limited to duodenoscopes and the elevator mechanism. We found a 19.98% contamination rate unrelated to the elevator in several gastrointestinal endoscopes. Meta-analyses found variations in contamination rates among countries, with the highest pooled contamination rate among studies conducted in Asia and Brazil (42.10%) and in Europe (18.16%). The lowest pooled contamination rate was found among studies conducted in North America (6.01%).

Competing interests

Hemant Goyal serves as a consultant for Aimloxy LLC. Sara Larsen, Lotte Klinten Ockert, and Dr. Sven Adamsen are employed by Ambu A/S. Dr. Tharian is a consultant and speaker for Boston Scientific and Medtronic. Dr. Thosani is a consultant for Boston Scientific, a consultant for and receives research support from Pentax America, a speaker for Abbvie, an advisory board member at Colubris Rx, and receives royalties from UpToDate.

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