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Authors' reply

We appreciate the careful comments from Gaurav Syal and colleagues on our recent consensus guideline.[1] The article mentioned by Syal and colleagues[2] is indeed a retrospective study for asymptomatic patients with pouches. However, recommendation 4.12 is about endoscopic assessment of treatment response in pouchitis along with Crohn's disease and cuffitis. All randomised controlled trials in the treatment of acute or chronic pouchitis in the current literature listed endoscopic scores as a key part of the measurement of treatment response.[3-5] Our panel felt that findings in pouchitis can be extrapolated to other inflammatory disorders of the pouch. In addition, previous prospective studies have documented that the assessment of symptomatology alone is not reliable for the diagnosis of pouchitis.[6] However, in a strict sense, recommendation 4.12 could have been further divided into three sub-recommendations for pouchitis (level 1, grade A), Crohn's disease of the pouch (level 3a, grade B), and cuffitis (level 4, grade D), respectively.

The rationale for recommendations 4.8 and 4.17 was based on published data or evidence as well as standard clinical practice. Prospective cohort studies (level 2 evidence) showed that endoscopy plays a key role in the diagnosis and differential diagnosis of inflammatory and functional disorders of the pouch. Our recommended approach for the evaluation of segments of the pouch body and peripouch areas was verified by a recent historical cohort study.[7] Tissue biopsy is valuable for diagnosis and surveillance. Analogous to diagnostic and surveillance colonoscopy in general IBD patients, taking biopsies from the pouch and peripouch areas (two to four pieces each) to document the degree, type, and distribution of inflammation, and to rule out the presence of granulomas, viral inclusion bodies, or dysplasia, should be part of routine clinical practice. Nonetheless, we acknowledge that separate recommendations on the specification of a biopsy protocol—eg, anatomical location and number of biopsies, type of forceps, and diagnostic criteria for backwash ileitis—might be helpful.

Recommendations 4.18 and 4.19 describe surveillance protocols for pouch neoplasia, which were largely based on a large prospectively maintained historical cohort.[8] The natural history of colitis-associated neoplasia has not been fully defined, even less so in pouch neoplasia. We agreed that surveillance pouchoscopy is indicated, particularly in patients with risk factors. The recommendations were based on the poorly defined natural history and frequency of pouch neoplasia, the risk factors for this condition, power calculations for risk stratification, the protective value of mucosectomy, the efficiency of endoscopic detection and biopsy, and most importantly the poor prognosis of pouch cancer.[9] Our recommendations are in line with the current evidence in principle, leading to a subsequent question on a detailed surveillance protocol, including interval, tools, endoscopic imaging techniques, and location and number of biopsies.

We appreciate Syal and colleagues' feedback which helps to clarify the process and rationale of some items in our consensus guideline.

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Gastrointestinal services in India during COVID-19: does governance matter?

During the first wave of COVID-19 in India, when the majority of hospitals were converted into exclusive COVID centres, it was astonishing to see the performance of the Department of Gastroenterology, Kovai Medical Center and Hospital, Tamil Nadu, India.[1] This hospital is part of the private sector, with an autonomous governing body responsible for making policy decisions. Although there were directives from the central government regarding functioning of hospitals during the pandemic, private hospitals could make their own decisions about priorities.

A recent multicentre study on the impact of the first wave of the COVID-19 pandemic on cancer care in India demonstrated a highly compromised service.[2] In this study, public hospitals had larger reductions in patient numbers and their related services than private hospitals between March and May, 2020, compared with the same period in 2019. For instance, more patients received external beam radiotherapy at private hospitals in 2020 compared with 2019 (4%), whereas there were large reductions over the same time period in public (33%) and charitable (43%) hospitals. This demonstrates the different results between private and public sector hospitals in India, which needs urgent further exploration. Although the functioning and structure of private and public hospitals are somewhat similar, there is a difference in the governance and leadership at a high level. The governing bodies of public hospitals often comprise mostly ministers and leaders from the central or state government political parties and generally have limited medical background and experience. By contrast, the governance bodies at private hospitals comprise medical professionals—as reported by Ramakrishnan and colleagues,[1] where the chairman is a renowned health professional. Hence, governance is perhaps a major reason for such divergent results and needs immediate attention.

We would also like to bring attention to the importance of differentiating between patients who had been referred and those who presented directly to the hospital in Ramakrishnan and colleagues' report. Gastroenterology services are super-specialty facilities in India and many patients using these services are referred from private clinics. Thus, differentiation of patients into those referred and those who present directly is of vital importance. This information will indirectly reveal the active/inactive status of the surrounding small clinics, which cater to a large number of patients on a day-to-day basis.

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Authors' reply

We thank Gargi Sarode and Sachin Sarode for their interest in our recent Correspondence.[1] As a designated COVID-19 hospital (and the largest non-governmental COVID-19 hospital in our city[2]), neither non-enforcement of government directives nor referral pattern (both before the pandemic and during it, we received less than 10% of referrals