

## Towards an Efficient Reprocessing of Endoscopes: on the Lack of Means and Machines

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Digestive endoscopy has matured gradually over the last two decades in Romania. Procedures now consume at least half the work week for the average practicing gastroenterologist, and generate most of their income. The demand for diagnostic and therapeutic procedures continues to grow, whereas at the same time, reimbursement is decreasing (1,2).

Together, these pressures are driving an increasing need and interest in making the endoscopic process more efficient and keeping a high quality. Patient management, developments in instrumentation (such as single-use instruments) and information management like electronic endoscopic information systems are critical issues to be addressed in further development of Romanian endoscopy. Endoscope reprocessing is a critical step in the interprocedural efficiency, guaranteeing unidirectional flow in order to keep a procedure room operational. This can be accomplished by sufficient amounts of trained staff and, often underestimated, efficient layout of endoscopy units. The ratio of automatic endoscope reprocessors to procedure rooms (ideally 2:1) varies widely, as is the planning of a centralized clean hold, dirty hold, reprocessing area and storage areas.

Transmission of infection between patients is perhaps the most controversial aspect of infection in the setting of reprocessing. From the rudimentary origins of the "flexible" gastroscope in 1932 until now, reprocessing has changed from washing the surface of the endoscope with tap water and detergent to the use of automatic disinfectors and implementation of guidelines for cleaning and disinfection.

Exogenous infections transmitted during endoscopy generally result from failure to follow these guidelines, underscoring the importance of meticulous attention to endoscope reprocessing.

In this month's issue of the *Journal of Gastrointestinal and Liver Diseases*, Frăjilă *et al* (3) address the current state of endoscope reprocessing in Romania. Generally accepted guidelines for high quality infection-control have been implemented in all centres. Nevertheless, automatic disinfectors are only available in a minority of centres, hampering efficiency. Equally concerning is the lack of purpose-designed rooms and adequate facilities for handling of, often toxic, detergents, thus endangering the health of the (nursing) staff. As emphasized by the authors, continuing efforts should be made to invest in means to uphold guidelines for reprocessing. This will further benefit efficiency and accomplish the purpose intended i.e. a high standard of endoscopic (and gastrointestinal) care in Romania.

### References

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