



Gastrointestinal Endoscopy Lab: Whiff Of Air Changing Biomes Within: Maybe, Must Be: Time To Explore Endoscopy Workers' Biomes

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My opinion

Since the pandemic started, I as anesthesiologist have been missing whiffs of air when almost always wearing mask especially at workplace. Then one day, I inadvertently sniffed that whiff of air which opened my eyes to the fact that mask can't prevent every whiff of air from reaching me. That whiff of air contained gases and aerosols [1-2] exiting from colon during colonoscopy when I went inside endoscopy lab to medically direct [3] non-physician anesthesia provider providing anesthesia for the said colonoscopy. It dawned to me that when my mask didn't prevent exiting colonic gases and aerosols from reaching me while medically directing anesthesia delivery in endoscopy lab, non-physician anesthesia providers, circulating nurses, colonoscopists and endoscopy technicians must be unavoidably sniffing them all the time by being inside endoscopy lab for the entire duration of colonoscopy-like procedures especially when endoscopy labs may be neither negative pressure rooms nor positive pressure rooms. Moreover, endoscopy technicians and circulating nurses who are only working in gastrointestinal endoscopy labs throughout their workweeks may be cumulatively sniffing more colonic gases and aerosols than non-physician anesthesia providers and colonoscopists who sometimes may be having other rotations, outpatient clinics and inpatient rounds during their workweeks. Historically, these whiffs of air might have been way larger quantitatively and cumulatively when non-physician anesthesia providers, circulating nurses, colonoscopists and endoscopy technicians were not required to wear masks in gastrointestinal endoscopy labs before the advent of pandemic [4-6]. Thus, the interesting question arises whether those cumulative whiffs of air induce any changes due to unavoidably sniffing newer nasal biomes and thereafter inadvertently ingesting newer gastrointestinal biomes among non-physician anesthesia providers, circulating nurses, colonoscopists and endoscopy technicians who are working non-stop in gastrointestinal endoscopy labs. Once such changes can be quantified among those working non-stop in gastrointestinal endoscopy labs,

it may be interesting to explore whether these changes if any in nasal and gastrointestinal biomes of non-physician anesthesia providers, circulating nurses, colonoscopists and endoscopy technicians have affected their morbidity and mortality induced by SARS-CoV-2 [7-9] during the ongoing pandemic unless patients utilizing bowel preparation solutions prior to their colonoscopies have been already changing their biomes [10] thus their colonic gases and aerosols wherein protective effect if any due to induced changes in nasal and gastrointestinal biomes of non-physician anesthesia providers, circulating nurses, colonoscopists and endoscopy technicians would have been lost already. Once healthcare providers quantify their own biomes [11-13], in due course of time, they may be able to convince their own patients to get tested for biomes for which third-party payers may have been already convinced to provide coverage in due course of time because knowing our everchanging biomes™ genomes may be more important for our existential healthcare than just knowing our own human genomes and/or ancestral human genomes. This may finally open our eyes by refocusing our attention from the old narrative [14-16] whether or not screening colonoscopy every decade prevents human colon cancer to the new narrative [17-21] that it may be biome enriching inhalation and ingestion by humans from their prebiotic and probiotic thus synbiotic environments day in day out which may affect the incidence of not only colon cancer among them but also many other diseases among them secondary to multi-millennium-old collaboration between human genomes and their constantly evolving symbiotic metagenomes and metabolomes. Å Å

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