Impact of COVID-19 on UK stress echocardiography practice: insights from the EVAREST sites

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Abstract

Introduction: Healthcare delivery is being transformed by COVID-19 to reduce transmission risk but continued delivery of routine clinical tests is essential. Stress echocardiography is one of the most widely used cardiac tests in the NHS. We assessed the impact of the first (W1) and second (W2) waves of the pandemic on the ability to deliver stress echocardiography.

Methods: Clinical echocardiography teams in 31 NHS hospitals participating in the EVAREST study were asked to complete a survey on the structure and delivery of stress echocardiography as well as its impact on patients and staff in July and November 2020. Results were compared to stress echocardiography activity in the same centre during January 2020.

Results: 24 completed the survey in July, and 19 NHS hospitals completed the survey in November. A 55% reduction in the number of studies performed was reported in W1, recovering to exceed pre-COVID rates in W2. The major change was in the mode of stress delivery. 70% of sites stopped their exercise stress service in W1, compared to 19% in W2. In those still using exercise during W1, 50% were wearing FFP3/N95 masks, falling to 38% in W2. There was also significant variability in patient screening practices with 7 different pre-screening questionnaires used in W1 and 6 in W2.

Conclusion: Stress echocardiography delivery restarted effectively after COVID-19 with adaptations to reduce transmission that means activity has been able to continue, and exceed, pre-COVID-19 levels during the second wave. Further standardization of protocols for patient screening and PPE may help further improve consistency of practice within the United Kingdom.

Key Words

- stress echocardiography
- COVID-19
- coronary artery disease
- ischaemic heart disease
- survey
- national health services
Introduction

The coronavirus (COVID-19) pandemic is placing unprecedented strain on healthcare services across the world (1), with the UK’s National Health Service (NHS) experiencing greatest challenge in 70 years of its existence (2). The disease has spread rapidly across the United Kingdom (3) with now over 125,000 COVID-19-related deaths recorded in the country (3). The NHS activity restarted (4) following the first wave of COVID-19 infections but with new regulations to minimize patient’s contact with the healthcare professionals and to reduce risk of transmission via aerosol generating procedures (5, 6, 7, 8). Stress echocardiography is one of the most widely used tests to assess cardiac function and to determine whether a patient has evidence of coronary ischaemia (9, 10, 11). Therefore, continued delivery of stress echocardiography is essential to provide effective healthcare within the NHS. We studied whether COVID-19 and its associated healthcare regulations had impacted the ability to deliver stress echocardiography in the NHS.

Methods

The ‘Impact of COVID-19 on UK Stress Echocardiography Services’ survey was sent to the research teams from the 31 NHS hospitals participating in the EVAREST study (ClinicalTrials.gov ID: NCT03674255) in both July and November 2020. The EVAREST study is a UK-wide prospective stress echocardiography study that aims to evaluate real world performance, accuracy and cost of stress echocardiography and has been running since 2011. The existing network of the UK hospitals, set up as a part of the EVAREST study, provided the infrastructure to distribute the survey and collect results from hospitals across the UK. Survey results could be compared to historical data from the same centres based on the data collected by the EVAREST study as well as comparing the results between the two waves of COVID-19. The survey was developed as a consensus document in collaboration with the British Society of Echocardiography (BSE) and contained questions focussing on the impact of COVID-19 on stress echocardiography practice, patients and the NHS staff (Supplementary data, see section on supplementary materials given at the end of this article). The survey was deployed electronically to 31 NHS sites via Google Forms (Google LLC., Mountain View, California, United States). Responses from the sites were collated after 10 days.

Statistical analysis

Hospital characteristics and reported data from the NHS sites were reported using standard approaches.
To calculate the significance level of the difference in estimated numbers of stress echocardiography studies performed before and during the two waves of the pandemic, a paired two-tailed distribution t-test was used with a significance level of $P < 0.05$ (Microsoft Excel Version 16.39, Microsoft Corporation).

**Results**

**Participating sites**

A total of 24 NHS hospitals (77%) responded to the survey in July, immediately after the peak of the first wave ($W_1$) and 19 hospitals (61%) in November in the middle of the second wave ($W_2$). Seventeen hospitals responded to both the surveys. Data on the geographical spread, index of multiple deprivation, the number of hospital beds, the number of cardiology attendances and self-reported numbers of stress echocardiograms performed per annum at each site are presented in Fig. 1.

**Stress echo practice**

Figure 2A illustrates that stress echocardiography was being performed at 21 sites (87.5%) with three having stopped their service entirely in $W_1$. During $W_2$, stress echocardiography was being performed at all 19 sites (100%), with eight sites (42%) reporting that their stress echocardiography service was now unaffected by COVID-19. The number of sessions being performed at sites was reduced during $W_1$ (range 1–11 sessions per week) compared to pre-COVID-19 (range 1–20), recovering back to a range of 1–20 sessions per week reported by sites during $W_2$. Figure 2D shows a reduction in the number of patients seen in each stress echocardiography session,

![Graphs showing stress echo practice](image)
from 4 ± 0 pre-COVID to 2.7 ± 0.4 during W₁ and 2.9 ± 0.3 during W₂.

Using data from sites that indicated their numbers of stress echo sessions during both W₁ and W₂, Fig. 3 shows an overall 55% reduction in the estimated number of studies performed per month compared to pre-COVID-19 rates (78 ± 65 per month pre-COVID-19 vs 35 ± 32 per month during W₁, P < 0.05). The estimated number of studies performed during W₂ increased to more than that reported during W₁ (71 ± 79 per month during W₂ vs 35 ± 32 per month during W₁, P < 0.05). The estimated number of studies performed during W₂ was not significantly different to pre-COVID-19 rates (71 ± 79 per month during W₂ vs 78 ± 65 per month pre-COVID-19, P > 0.05).

Figure 3B shows that in higher volume sites, the estimated number of studies per week fell from 116 studies per week pre-COVID to 58 per week in W₁ (50% fall, P < 0.05). This recovered to 125 per week in W₂ (108% of pre-COVID levels). In smaller sites (Fig. 3B), studies per week fell from 40 studies per week pre-COVID to 17 per week in W₁ (42% of pre-COVID levels, P < 0.05). This recovered to 47 per week in W₂ (118% of pre-COVID levels).

Figure 2B shows that of the 20 sites that reported use of exercise stressor pre-COVID-19, 14 sites (70%) had stopped their exercise stress echocardiography (ESE) service either due to cessation of all stress echocardiography (four sites – 20%) or had replaced it with a dobutamine stress only service (ten sites – 50%) during W₁. The six sites (30%)
continuing their exercise stress service during W1 reported reduced the number of patients and a requirement to wear Level 2 PPE (fluid repellent disposable gown, respirator mask, gloves, eye protection).

Of the 16 sites who responded during W2 and performed exercise stress pre-COVID-19, three sites (19%) had stopped their ESE service during W2. Of the 13 sites still performing ESE during W2, six sites (46%) reported that their ESE service was operating at a normal pre-COVID-19 rate.

**Impact on patients and personal protective equipment**

Figure 4A illustrates the screening procedures used at the sites across the two waves. Sixty per cent of sites performed temperature checks during W1 and 63% did so during W2. During W1, two sites performed COVID-19 swab tests between 2 and 3 days prior to the appointment, with one site performing swab test after the stress echo.

The two sites performing swabs in W2 did so 72 h and 4–7 days pre-appointment, respectively. Twenty per cent of sites asked patients to self-isolate during W1, with two sites requiring 7 days and two 14 days. During W2, two sites (11%) required patients to self-isolate for 3 days (at one site) or 4 days (at the other) after their swab test, prior to their appointment.

**Figures 4B, C and D** provide more detail on the use of screening questionnaires at sites. Eighteen sites (90%) asked patients to complete a health questionnaire during W1, while 13 (68%) sites used questionnaires during W2. Seven different questionnaires were used by sites during W1, with most sites using either trust-derived (six sites – 33%) and BSE (six sites – 33%) questionnaires. Six different questionnaires were used during W2, with the majority of sites using trust-derived questionnaires (eight sites – 62%). The questionnaires were administered pre-appointment (41% in W1, 23% in W2), at the appointment (47% in W1, 54% in W2) and both pre-appointment and on the day (12% in W1, 23% in W2). Twenty-five per cent
of patients had not proceeded to stress echo based on the questionnaire at one site during the first wave. No sites reported this incidence rate during the second wave. Ten per cent of patients did not proceed at 22% of sites in W1 and 31% of sites during W 2. The remainder reported the questionnaire had not identified any patients. No cases of patients passing the questionnaire with a positive swab test were reported across both waves at all sites.

All sites, with the exception of one site during W2, performing stress echocardiography reported that every patient is required to wear a face mask/covering for the procedure (Fig. 5A). For dobutamine stress echocardiography, surgical masks were worn by staff in 90% of sites during W1 and 84% during W2. Fifty per cent and 62% of sites reported use of surgical masks for exercise echocardiography during W1 and W2, respectively. The other sites required FFP3/N95 masks.

**Staff and ongoing impact**

During W1, 42% of sites were reviewing their stress echo practice weekly, falling to 5% of sites reviewing practice weekly during W2 (Fig. 6A). During W1, the majority of sites (54.2%) reported that none of their staff were unable to perform stress echocardiography due to COVID-19. This number fell to 37% during W2, with 11% of sites reporting 25–50% of their staff were affected (compared to 0% during W1) (Fig. 7A). The effects of COVID-19 on resting echocardiography are also reported in Fig. 7B.

**Discussion**

This study shows stress echocardiography practice had restarted within a few months of the peak infection rate in
the majority of hospitals during the first wave of COVID-19 hospital admissions, albeit at a reduced rate. During the second wave of COVID-19, stress echocardiography practice has been able to operate at a level not significantly different from pre-COVID-19 rates. The impact of the first wave and subsequent recovery in W2 was not different between high and low volume centres.

The reduction in capacity during W1 is likely to have generated a significant backlog of patients and although our findings suggest a return to similar levels of activity in W2, this will not have been sufficient to clear this backlog. The reduction in capacity during W1 may have been mitigated by use of clinical triage to identify potentially inappropriate requests or suggest transfer to alternative imaging tests. However, the return to normal activity in W2 would suggest that any rationing or redistribution of care was only required for a short period. This is supported by our observation using data from the EVAREST study that rates of positive stress studies were very similar during November 2020 to January 2021 (14%) as before the onset of the COVID pandemic (18%).

The major variation between sites was the selection of screening tests for risk of COVID-19 in individual patients. Current BSE guidance recommends varying degrees of screening, from a COVID symptom questionnaire for DSE and TOE patients up to asking patients to self-isolate for 2 weeks followed by a negative swab test 72/48 h before their exercise stress echo. The guidance suggests that the intensity of screening should be adjusted according to the current local prevalence of COVID positive cases (12).

Variation also exists in the use of PPE with only 38% of sites still performing exercise stress during W2 using Level 2 personal protective equipment. Departmental policies on use of PPE did not appear to have any significant association with staff absence rate. There is a paucity of data with regard to the aerosol generating potential of exercise stress echocardiography. British Society of Echocardiography guidance states that the consensus opinion amongst stress echo experts in the United Kingdom is that exercise stress echocardiography may be considered an aerosol generating procedure (12). There is, therefore, a need for more investigation into whether exercise stress echocardiography has an increased risk of infection and, until evidence to the contrary, current BSE guidance has remained unchanged. It is possible that the wider use of faster testing and even vaccination passports,
as the vaccination programme continues to expand, could be integrated into stress echocardiography practice to reduce transmission.

It is important to note that the results for W1 presented in this paper were collected in July, several weeks after the first peak of the COVID-19 pandemic in the United Kingdom, when stress echocardiography practice may have been more adversely affected by staff redeployment and infection rates. Additionally, the numbers of studies performed per month during the two waves are estimated, based on the reported number of sessions per week. Hard data on the number of studies would provide a more robust evaluation of the effect of the pandemic on the number of studies performed.

In summary, while the number of studies performed did fall during the first wave of infections, there has been no long lasting impact on ability to deliver stress echocardiography within the NHS during the COVID-19 pandemic. During the second wave, most services were operating at normal rates and services had fully adapted to take account of requirements to reduce the risk of exposure through use of alternative stressors and PPE. Significant heterogeneity in screening tests and personal protective equipment used may require standardized national guidance to ensure consistency but local flexibility of service design may explain the apparent resilience of the cardiology centres to deliver stress echocardiography during a pandemic.

Supplementary materials
This is linked to the online version of the paper at https://doi.org/10.1530/ERP-20-0043.

Declaration of interest
P L is a shareholder and non-executive director of Ultromics, which develops AI echocardiography software, has previously consulted for Intelligent Ultrasound and has held research grants from the ultrasound contrast company Lantheus Medical Imaging. P L is an inventor on patents in the field of echocardiography.

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Author contribution statement
All authors were responsible for the design of the EVAREST COVID-19 impact survey. A M, C D and W W disseminated the survey and collated results. C D performed data analysis. C D, D A and P L drafted the manuscript. The final version was reviewed by all authors and investigators.

References

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