

Table 2. Summary of consensus statements.

Statement	Classification of recommendation	Quality of evidence	Level of agreement
Pre-requisite			
1. Only an endoscopist with appropriate training and the relevant competency should independently perform OGD.	A	III	100%
Pre-procedure			
2. All upper gastrointestinal endoscopies performed should have an appropriate indication that should be documented.	A	II	100%
3. Informed consent should be ideally obtained and fully documented by the procedurist or a medical professional who is deemed by the procedurist to have adequate knowledge to fully explain the procedure.	A	III	100%
4. Patients should be assessed for fitness to undergo a diagnostic OGD.	B	III	93.3%
5. Team pause or time out is to be conducted and documented. A safety checklist should be completed before starting an OGD.	A	III	100%
6. An appropriate time slot should be allocated depending on procedure indications and patient characteristics.	B	II	93.3%
Intra-procedure			
7. Normal endoscopic examination should include a minimal of 10 photos consisting of the following anatomical landmarks: upper oesophagus and lower oesophagus, GE junction, fundus, corpus/body, incisura, antrum, pylorus, D1 and D2.	C	III	93.3%
8. Standardised terminology is encouraged for relevant findings and documentation (e.g. Los Angeles classification for erosive esophagitis, Prague classification for Barrett's oesophagus, Forrest classification for bleeding ulcers).	A	III	96.7%
9. In patients who have not undergone evaluation of <i>Helicobacter pylori</i> status before, this should be screened during gastroscopy by performing rapid urease test or histology.	A	III	93.3%
10. In patients who have clinically relevant gastric cancer risks, at least 2 biopsies from the antrum and 2 biopsies from the corpus should be taken for histology to exclude intestinal metaplasia.	C	III	80%
11. Patients should be monitored during sedation at an appropriate time interval, with the relevant information documented.	A	III	100%
12. The doses and routes of administration of all medications used, including reversal agents, during the procedure are to be documented.	A	III	100%
13. All endoscopies should be performed with high-definition video endoscopy systems, with the ability to capture images and take biopsies.	A	II-3	96.6%
14. All endoscopy units should have an internationally accepted guideline and policy on sedation.	B	III	96.7%
15. Adequate mucosal visualisation should be achieved by a combination of adequate air insufflation, flushing and aspiration and the use of mucosal cleansing techniques.	A	III	100%
16. A malignant-looking lesion should be described and photo documented, with biopsies taken for histology.	A	II-2	86.7%
Post-procedure			
17. All endoscopy units should have pre-determined discharge criteria and should provide patients with post-discharge instructions.	A	III	100%
18. Follow-up management plan should be specified.	A	III	96.7%
19. All adverse events related to the procedure should be documented.	A	III	100%
20. All endoscopy units should have a system to monitor for post-procedure and late adverse events occurrence.	C	III	90%

GE: gastroesophageal; OGD: oesophago-gastro-duodenoscopy