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Letter: Covid-19—re-initiating clinical services for chronic gastrointestinal diseases. How and when? Authors' reply

We thank Britton et al for their considered letter[1] to our recently published review of prevention and management of Covid-19 in inflammatory bowel disease (IBD) patients.[2] We commend their survey evaluating adherence with social distancing and shielding recommendations in addition to patient preferences for method of out-patient review among 195 patients with high-risk chronic gastroenterological conditions, including 33 with IBD.[1] Self-reported efficacy of preventative measures was high, as assessed by the presence of symptoms potentially suggestive of Covid-19 or confirmed infection, while a preference for virtual consultation was definitively demonstrated.[1]

In the re-initiation phase of the pandemic, we aim to re-commence services in a tailored manner taking into consideration the current evidence for the role of telemedicine in IBD care. The management of IBD patients from remote locations is clearly established as being safe, acceptable to patients, cost-effective and convenient.[3,4] Additionally, electronic home monitoring tools for patients with IBD are feasible and highly accepted.[5] Overall, the use of electronic health (eHealth) technologies in IBD is associated with improved medication adherence, quality of life, and IBD-related knowledge, with reduced duration of disease relapse and activity.[6] The Covid-19 pandemic has effectively forced healthcare systems, practitioners and patients to adopt these tools as a means of minimising healthcare-related patient exposures,[7,8] with a high degree of acceptability as demonstrated by Britton et al.[1] However, unreliable access to necessary electronic resources, and variable computer competency and language barriers may limit vulnerable patients' engagement with telehealth technologies, and thus exacerbate existing healthcare access and outcome disparities.[9]

Despite its clear advantages during the Covid-19 pandemic, telemedicine is not universally preferred by IBD patients. A recently conducted survey by Grunert et al[10] of 415 patients and 116 non-IBD controls showed a median response of 'disagree' from IBD patients when asked whether they would prefer a video consultation to an in-person appointment. This was less pronounced in those with a higher degree of fear of contracting Covid-19 and in those under 40 years of age.[10]

Ultimately, the need to tailor patient care according to resource availability and computer literacy is essential, as has been anecdotally noted in our service. Inclusion of primary care physicians in telehealth consultations, ready availability of interpreter services and telephone (as opposed to videoconferencing) consultation options are all possible means for improving engagement with, and acceptance of, remote healthcare options.[9] Education and training for patients in the use of eHealth tools must be considered. Additionally, facilitating safe face-to-face consultations for point-of-care ultrasound assessment, endoscopic examination or perianal disease review may be necessary for particular patients. Such reviews should not be deferred when likely to significantly change management or allow avoidance of later complications or hospitalisation.[7] Therefore, going forward, these individual patient factors need to be taken into account before re-initiating services in the road to recovery from the Covid-19 pandemic.

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LINKED CONTENT

This article is linked to Al-Ani et al and Britton et al papers. To view these articles, visit https://doi.org/10.1111/apt.15779 and https://doi.org/10.1111/apt.16061

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