

Implementation of virtual rapid access outpatient clinics for suspected gastrointestinal malignancies during the COVID-19 pandemic: could they become the default in the future?

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The outbreak of the COVID-19 pandemic in January 2020 has had a major impact on the way elective and emergency medical care and services are delivered. Especially during the peak waves of the pandemic, there was a notable decline in the number of emergency surgical and medical acute admissions, due to the fear of hospital-acquired COVID-19 [1]. As a result, many patients presented to seek medical advice only upon inability to cope with their symptoms or gross systemic deterioration [2–4]. In addition, we observed that patients with more vague, quiescent symptoms were not presenting for assessment as previously in the outpatient clinics. Unfortunately, the same was true even for patients with symptoms described as “red flag” for suspected malignancies, such as involuntary weight loss, altered bowel habits, symptomatic anaemia, or bleeding per rectum. That led us, as a surgical service with dedicated fast-track pathways (known as “2-week wait clinics” – 2wwc) for investigation of patients with suspected gastrointestinal symptoms, to plea for continuation of the stream of these referrals from the general practitioners in our catchment area. However, due to reasonable concerns from the patients’ regarding the risk of acquiring COVID-19 during these outpatient visits, we had to substitute our traditional 2wwc with entirely virtual clinics.

Despite the initial scepticism, particularly taking into account the inability of the clinic running the 2wwc to perform a physical examination and assess in person the functional status of the patients, it seems that after a short period of adaptation, this “virtual switch”

turned out to be a very useful evolution. Using a structured approach to the patient’s symptoms and having a simple electronic record of their accompanying medical problems, as well as any previous imaging or endoscopic examinations, we were able to deliver the service without major problems. In most cases the clinician has already decided the type of investigations that would be required; e.g. for a middle-aged person with occasional bleeding per rectum and altered bowel habits realistically we would request a colonoscopy, along with a computed tomography (CT) scan of the abdomen and pelvis or a CT-colonography. Therefore, we realised that usually the telephone consultation would confirm to proceed along the lines of a more or less pre-thought investigation pathway. Of course, in marginal cases with patients at the extremes of age or with multiple co-morbidities, a face-to-face consultation would facilitate a risk/benefit adjustment of the standard investigation bundles, but this minority of patients were, as required, rescheduled with high priority to a subsequent 2wwc date, enabling well-rounded decision-making.

With respect to the follow-up 2wwc, after the performance of the required imaging/endoscopic assessments, patients with negative investigations were easily reassured over the phone or consulted regarding the need for any completion tests in a very cost-effective manner for the department and also for the patients because they would not need to arrange days off work or arrange transport for their hospital visit. Also, we found that the duration of the telephone consultations was shorter than the traditional face-to-face ones, en-

abling a more efficient way of running the 2wwc follow-up service. Finally, the overall reduction of physical rapid access appointments has allowed our outpatient department to function with a limited skeleton staff, re-distributing the nursing personnel and allied health professionals in more critical sectors of our hospital.

In summary, we believe that the outbreak of the COVID-19 pandemic has forced us to work in an environment of telemedicine, for which the infrastructure already existed. This crisis has inevitably changed the way of clinical practise, but it has also shown us that the sensible use of virtual medicine can be safe and cost-effective for healthcare systems as well as patients.

Conflict of interest

The authors declare no conflict of interest.

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