Impact of lockdown on rheumatology outpatient care in the age of COVID-19

We read with great interest the editorial written by McInnes1 who discussed regarding the role of the rheumatologist and the rapidly changing landscape in the practice of rheumatology brought about by the COVID-19 pandemic. European League Against Rheumatism (EULAR)2 had also recently published several recommendations for the management of rheumatic and musculoskeletal diseases when local measures of social distancing are in effect. We were interested in the impact caused by local public health measures to control the pandemic on rheumatology outpatient care at our centre.

Extraordinary measures have been advocated globally to control the spread of the COVID-19 pandemic. Malaysia’s first COVID-19 case was reported on the 25 January 20203 and cases spiked in March 2020 reaching the highest number in South-East Asia in early April. Malaysia instituted a lockdown from 18 March 2020 which was extended 9 June 2020 (a 12-week period) as a public health measure to curb the pandemic.4 5

During the pandemic, our hospital was designated as a COVID-19 hybrid hospital tasked with taking in both COVID-19 and regular patients. Several hospital-wide strategies were implemented to contain the pandemic and decongest the hospital including rescheduling of non-urgent patient appointments, reducing non-essential laboratory and radiological investigations, the implementation of teleconsultation and referral of stable patients to primary healthcare facilities for continuation of follow-up. We routinely run three general rheumatology and two dedicated systemic lupus erythematosus (SLE) clinics each week. To study the impact of lockdown on rheumatology outpatient care, we retrospectively analysed the number of patients attending our clinics 12 weeks prior to lockdown (25 December 2019 to 17 March 2020) comparing it to the lockdown period itself.

In the prelockdown period, the number of patients in both the general rheumatology and SLE clinics was 1126 and 704, respectively, as illustrated in table 1. During the lockdown, there was a reduction by 70.9% to 328 patients in the general rheumatology clinic and by 58.9% to 289 patients in the SLE clinics. In addition, the number of patients who were affected by compulsory rescheduling was 664 (66.9%) in the general rheumatology clinics and 341 (54.1%) in SLE clinics. The number of new cases seen in both clinics was reduced by 66% in rheumatology clinics and 77% in SLE clinics. Unsurprisingly, the rates of patients defaulting appointments increased in both clinics: 14.5% in the general rheumatology clinic and 13.6% in lupus clinic.

There are a few possible explanations for the above findings. First, fear and anxiety towards the possibility of contracting COVID-19 from healthcare facilities caused many patients to either reschedule or default their appointments. Second, the suspension of public transport rendered some patients unable to attend their appointments. Finally, patients who were either placed under quarantine or admitted to the hospital for investigation of COVID-19 were unable to attend their appointments.

This unprecedented situation adversely affected rheumatology outpatient care as demonstrated by the findings above. We anticipate that there will be a surge in patients experiencing flares of their underlying disease in the postlockdown period. This could be due to either inadequate supply of medications from defaulting follow-ups or poor compliance due to fear. Pineda-Sic et al6 reported that lack of availability of medications and fear of getting sick from COVID-19 were factors for changes or suspension in medications.

We implemented several strategies to help improve patient outcome and compliance during this period including triaging of patients prior to their clinic visit. Patients deemed stable over the past 6 months without changes in medications were rescheduled with a repeated prescription. This aims to reduce the number of patients defaulting their medications and prevent flares of diseases. A secondary effect allows us to decongest our clinic and reduce patients waiting time thus exposure to the hospital environment.

Additionally, stable patients who required a review were given the option of telephone consultation similar to other centres.7 8 In our centre, a teleconsultation protocol (online supplementary appendix 1) for patients who were stable and did not have significant cognitive impairments or language barrier was created. It was not used for newly referred patients to ensure the performance of an adequate initial assessment. Our approach was similar to the current recommendations by EULAR.2

In conclusion, the rapidly changing landscape of this pandemic has drastically altered the practice of rheumatology outpatient services worldwide. It has brought about a direct impact on outpatient care at our centre and compelled us to adapt quickly and adopt unique solutions such as telemedicine to ensure that we can provide the best care for our patients.

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Table 1 Number and percentage of patient attended, defaulted and new case in general rheumatology clinic and lupus clinic 12 weeks prelockdown period (25 December 2019 to 17 March 2020) and during the 12-week lockdown period (18 March 2020 to 9 June 2020)

<table>
<thead>
<tr>
<th>Clinic</th>
<th>General rheumatology clinic</th>
<th>Systemic lupus erythematosus clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prelockdown</td>
<td>During lockdown</td>
</tr>
<tr>
<td>Total scheduled patients (%)</td>
<td>1126 (100)</td>
<td>328 (100)</td>
</tr>
<tr>
<td>Total attended (%)</td>
<td>988 (87.7)</td>
<td>240 (73.2)</td>
</tr>
<tr>
<td>New cases</td>
<td>27 (2.4)</td>
<td>9 (2.8)</td>
</tr>
<tr>
<td>Repeated cases</td>
<td>961 (86.1)</td>
<td>231 (69.6)</td>
</tr>
<tr>
<td>Defaulted (%)</td>
<td>138 (12.3)</td>
<td>88 (26.8)</td>
</tr>
</tbody>
</table>
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