

Changes in COPD Patient Care after the COVID Pandemic

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The Covid-19 pandemic has made it necessary to reorganise the healthcare activity of health centres in all countries in order to devote all the resources to caring for patients affected by this virus, and consequently to suspend the activity of scheduled consultations in the monitoring of patients with chronic diseases, such as patients with chronic obstructive pulmonary disease (COPD), for an indefinite period, on the one hand because of the lack of medical resources to care for them, but also to prevent contagion when they go to health centres [1].

It should not be forgotten that COPD is a disease with a high prevalence, 10% in the population between 40 and 80 years of age, which predominantly affects the population group most affected by Covid-19, the elderly, and which is often associated with high morbidity and mortality.

As these are chronic respiratory patients, there is a greater risk of Covid-19 infection, as confirmed by some of the first published analyses that indicate a greater severity in COPD patients [2]. But there are also studies that, surprisingly, suggest a lower rate of infection in COPD, without being able to clarify the cause, although perhaps the fact of knowing that he has a lung disease will make him more protective, avoiding contact from a period prior to government restrictions [3]. On the other hand, we still do not know what sequelae Covid-19 infection may entail in a patient with COPD, who already had a previous respiratory limitation, and especially in those who have suffered from pneumonia from the virus.

These patients suffer, with greater or lesser frequency, exacerbations, which have a significant impact on the evolution of the disease and its mortality. Sometimes patients needed to come to the hospital, not only for such exacerbations, but also for treatments administered in the hospital itself, in rooms equipped for this purpose that are usually organized in the day hospital. These may be biological treatments by subcutaneous injection or even drugs administered intravenously. In the case of biologics, they are fortunately being adapted to be self-administered by the patient at home (after the first doses are placed in the hospital with supervision and the patient is trained in their use). More complex is the change in intravenous drugs, which require a nursing trip to the patient's home and the availability of prepared products, and with simplicity to administer them at home.

During this pandemic period, COPD patient care has been modified to telephone follow-up, home monitoring and control from primary care, without the possibility of resorting to physical examination or the usual complementary tests.

As we control the pandemic we have to resume medical consultations for these chronic patients, who, moreover, in some cases may be waiting months to see their specialists, but adapted to the new circumstances. We must seek resources to facilitate accessibility to health care, increasingly applying virtual consultation, remote monitoring and home treatment.

It has become necessary to reorganize the clinical assistance that until now has been face-to-face, to a non face-to-face consultation. Telephone consultation is a good resource if it is carried out by trained personnel and, if possible, who know the patient and his/her peculiarities, through a structured interview [4]. Ideally, it should only be applied in situations where the health problem is well identified and only requires follow-up and adjustment of treatment, as may be the case with COPD. An important section will be to resolve the doubts raised by the patient, in the current situation, about the risks of contracting the Covid infection and what protective measures should be applied, but in general also about their COPD and its treatments.

The use of the video call allows the patient's image to be added to the simple voice of the traditional call, thus complementing the medical assessment with the skin colour, pattern and frequency of breathing, or supervising the inhalation technique, as well as providing a greater psychic reinforcement for the patient, being able to see and hear their doctor.

In spite of the great amount of resources offered by new technologies, their establishment in health is still poor and there is a long way to go. Medical applications in health have grown exponentially in recent years, as has, in parallel, access to electronic devices by the general population.

The average age of COPD patients can be a barrier to the use of these new technologies, as it mainly affects older people, who are unskilled in electronic devices and not in a position to learn new instruments. However, some studies that have been carried out with remote monitoring through electronic diaries or mobile phones indicate a high level of participation of this type of patient, although it is true that there may be a selection bias for a study, so we would have to see what would happen if we took it into regular clinical practice.

Our group carried out a follow-up study of patients with COPD using a mobile phone application, in which a high level of daily compliance with the application was observed, with a high level of user satisfaction. Two out of every three patients (66%) recorded their symptoms daily on their mobile phone, over a period of 6 months, with few dropouts from follow-up (about 20%) [5].

The communication tools and the development of technologies offer us an opportunity for a more efficient management in front of a progressive healthcare demand in chronic respiratory diseases related to the aging of the Spanish population. In the coming years, they will be valuable and complementary tools in medical care, and especially suitable for the prevention and management of chronic diseases. They will allow us to identify symptoms earlier, which could go unnoticed in a routine medical visit, and, furthermore, they will allow us to offer the patient information for the implementation of self-care plans in the early detection and treatment of COPD decompensations [6].

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