A Guide for Urogynecologic Patient Care Utilizing Telemedicine During the COVID-19 Pandemic: Review of Existing Evidence

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ABSTRACT

The novel coronavirus (COVID-19) pandemic has had a major impact on how patients are evaluated and treated for diseases and conditions in normal patient care. Due to lack of effective treatments for this virus or vaccines to prevent infection, focus is placed on infection prevention through use of social distancing, quarantine, and face masks. To prevent COVID-19 infections in healthcare settings, the Centers for Disease Control and Prevention has recommended decreasing or eliminating nonurgent office visits. Telehealth has emerged as an alternative way to deliver effective patient care, while reducing patient and physician exposure to the virus. Telehealth is any remote healthcare process, including provider training or team meetings, whereas telemedicine refers to use of specific technology to connect a patient to a provider. High quality of care can and must be provided by Female Pelvic Medicine and Reconstructive Surgeons (FPMRS) as well as other specialists and health professionals using telemedicine.

Because of the health care emergency during the pandemic, the Centers for Medicare and Medicaid Services have broadened access to and reimbursement for telemedicine services. Rapid advances in communications technology and widespread wireless access in many modern households have allowed the adoption and integration of telemedicine into urogynecology and other health practices. There are no clear guidelines for the use of telemedicine in FPMRS.

The aim of this study was to conduct an expedited review of the evidence and to provide guidance for managing common outpatient FPMRS conditions during the COVID pandemic using telemedicine. FPMRS conditions were grouped into those that likely to require different treatment with virtual management compared with in-person visits, and those that could use accepted behavioral counseling and not deviate from current management paradigms. Rapid systematic review methodology was used to screen for articles related to 4 topics: (1) telemedicine in FPMRS, (2) pessary management, (3) urinary tract infections, and (4) urinary retention. In addition, 4 other topics were addressed (based on past systematic reviews and national or international society guidelines): (1) urinary incontinence, (2) vaginal prolapse, (3) fecal incontinence, and (4) defecatory dysfunction. Finally, clinical experience and expertise were pooled to reach consensus on 4 remaining areas: (1) FPMRS conditions amenable to virtual management, (2) urgent care scenarios requiring in-person visits, (3) symptoms that should alert providers to a possible COVID infection, and (4) special consideration for managing patients with known or suspected COVID-19.

Overall, behavioral, medical, and conservative management provided in a virtual setting (via phone or Internet communication) will be valuable as first-line treatments. Certain situations were identified that require different treatments in the virtual
setting than in person, whereas others were shown to require an in-person visit despite risks of COVID-19 exposure and spread of infection.

This study presents guidance for treating FPMRS conditions via telemedicine in a format that can be actively referenced. The strengths of the study include use of an expedited review method, extensive experience of the authors in conducting systematic reviews, as well as being seasoned FPMRS practitioners. Main limitations include the rapid methodology, lack of data regarding many of the pertinent questions, and missed salient studies, because of the expedited evidence methods.

EDITORIAL COMMENT

(FPMRS practice can often be amenable to a telemedicine approach for care owing to the fact that symptom assessment and treatment decisions frequently depend upon patient report and interview. This review provides a very practical working document that can serve to guide urogynecologic groups seeking to implement safe practices as they rapidly expand their telehealth offerings due to the COVID pandemic. The motivation to do so is obvious; not only have many centers been forced to temporarily close or significantly attenuate ambulatory care offerings, but the urogynecologic patient population is skewed toward older age, which, along with diabetes, immunosuppression, and other chronic conditions, increase the risk of COVID-19 morbidity and mortality.

A few conditions remain very appropriate for in-person urgent visits despite the pandemic. Women with severe or worsening pelvic floor myalgia or interstitial cystitis can benefit best from in-person assessment and treatment. Although acute urinary tract infection symptoms can, in many cases, be treated empirically without bacterial confirmation, patients with diabetes or fever or failure to get relief of symptoms after initial therapy course probably warrant the patient presenting in order to provide a laboratory specimen. Postoperative patients with complications or postpartum patients with acute perineal concerns need in-person assessment, as do new symptoms of fistula, persistent vaginal bleeding, or pain in the presence of a pessary, new mass, or acute or worsening voiding dysfunction or urinary retention.

The authors make particular alert of new pelvic complaints that may be related to COVID-19 symptoms: worse stress incontinence in the presence of new respiratory cough and worse fecal incontinence due to new-onset diarrhea should trigger concern for COVID-19 infection.

This article will also likely provide a reference document to support more permanent care plans. These new algorithms of triage of care decisions will become our new normal in many cases, if we observe few ill effects of managing chronic pelvic floor conditions with fewer in-person visits or greater duration of time between visits.—ACW)