Identifying COVID-19 related Harms in Uveitis

Dr SC Mansfield Smith MBChB MRCP(UK), Dr NJ Ghadiri MClined FRCP FHEA , Dr SM Sharma MBChB MRCP MRCOphth PhD, Mr TR Burke MD FRCOphth MRCPI.

UVEITIS NATIONAL CLINICAL STUDY GROUP

Background

This study was **conducted during the COVID-19 pandemic** to identify cases of harm in uveitis patients and their root causes

Core objectives :

- Identify patients with uveitis across the UK and Ireland who **came to harm during the pandemic**
- Identify the **cause of harm** e.g. patient factors, social factors, service delivery factors.
- Categorise the **severity** of systemic and ocular harm using RCOphth guidance (Table 1)

Methods:

Data was collected over a **7-month period from January 2021-July 2021 in 5 UK uveitis centres** using the Redcap Survey Database

Case exclusions: Expected complications of planned treatment. Natural progression of disease despite adequate care. Development of another disease

Table 1 RCOphth Categories of Ocular Harm

Category of Harm	Example of patient outcomes
Minor	• A loss of >0.1 in LogMAR VA score in one eye
	• Longer healing time than expected from treatment
	• Pain from treatment for a continuous period <28 days
Moderate	• A loss of >0.2 LogMAR VA score
	• VA less than 6/18 (approx. 0.5) in one eye and/or significant field loss in one eye.
	• Requirement for additional unplanned treatment.
	• Pain from treatment for a continuous period of 28 days
Major	• Loss of vision in one eye with VA less than 6/60(1.0)
	• Removal of one eye
	• Registered sight impaired
	• VA less than 6/18 (approx. 0.5) in both eyes and/or significant loss of visual field in both eyes.

Results

14 anonymised cases of harm

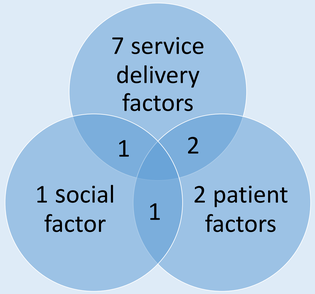
Certainty of harm related to COVID: 10 definite, 4 possible.

Table 2 Events leading to harm

Category of Ocular Harm	Description of Harm
Minor	Very delayed cataract surgery post Iluvein implant.
	Patient believed no clinic available due to pandemic, waited with symptoms, contacted optometrist then forwarded to telephone appointment. This resulted in delayed treatment, higher and longer course of systemic steroids.
	Repeat ozurdex delayed as lockdown occurred while in another city and unable to return for treatment. Outcome: limited improvement in VA due to chronic CMO.
	Delay in diagnosis of bilateral panuveitis flare, unable to attend as having to home-school due to pandemic.
Moderate	Due to delay in F2F review required repeat orbital floor triamcinolone.
	1st ozurdex given but cataract surgery cancelled so required a further ozurdex.
	Incorrectly reviewed in telephone clinic. Patient had a steroid response and developed optic neuropathy IOP 43 + VF defect due to delay in F2F.
	Patient symptomatic in one eye but frightened to attend due to C19 , only presented when both eyes inflamed.
	Patient was unable to obtain adalimumab during a lockdown which occurred while away from home. The patient went without treatment for 3/12, vision dropped to 6/60 and developed hypotony. Required extra systemic steroids.
	During telephone clinic incorrect advice given about lowering treatment, patient then experienced flare of inflammation.
Major	IVDU with endogenous endophthalmitis wrongly triaged to telephone appointment
	Patient with scleritis developed secondary glaucoma during lockdown as he/she did not have clinic review. Outcome: vision worsening in both eyes, secondary angle closure, optic neuropathy, IOP 50,48, awaiting tube
	Did not receive systemic immunosuppression for weeks as lost to follow up. Missed infliximab infusions, required rescue doses with IVMP+Infliximab.
	Patient self stopped systemic immunosuppression due to fear of COVID. Patient had active uveitis for months.

Free text comments from survey

"Telephone consultations not safe for uveitis patients."
"Unable to contact patient over the phone."
"Low mood precipitated by events."
"Patient's anxiety made worse by COVID."



Root cause of harm categorised by clinician

Length of delay of treatment/review
2 weeks- 12 months (average 4 months)
3 of the 4 major cases of harm delay: at least 4/12 (range: 2 weeks - 7 months)

Conclusions:

Factors identified indicating patients likely needed a face-to-face review:

- **IOP checks for steroid responders**
- **Complex and socially vulnerable patients.**
- **Intended change in treatment plan.**
- **When a delay of 4 months or more to review a patients with a complex management plan has already occurred.**

Robust fail-safe mechanisms to identify these groups of patients are required.

Survey responses revealed assessing patients' anxieties and mental health is particularly important during major events. The clinician can address their concerns about treatment and in turn may aid compliance.

This study provides an insight into the causes of harm to uveitis patients during the COVID-19 pandemic and can be used as a point of reference in case of future lockdowns.

Visit: https://www.uveitisstudygroup.org/ for more information