

Table 1. Warfarin and DOAC treated groups

	Warfarin, n=95			DOACs, n=204			p
	Median	Range	IQR	Median	Range	IQR	
Time from referral to DCCV, months	5	2–24	3–6	4	1–12	3–6	0.002
GP visits, n	6	3–20	4–9	1	1	1–1	<0.001
UHS visits, n	4	2–6	4–5	4	2–6	3–4	0.003
Total distance travelled, km	51.86	10.65–343.80	34.63–99.7	38.80	5.95–316.75	21.96–83	<0.001
Coagulation studies, n	6	4–26	5–11	1	1–1	1–1	<0.001
Travel-related CF, kgCO ₂ e	12.58	2.58–83.37	8.38–24.18	9.41	1.44–76.8	5.32–20.13	<0.001
Total CF, kgCO ₂ e	85.49	52.07–185.55	67.39–97.29	58.16	38.26–120.98	64.17–47.81	<0.0001
CO ₂ e expressed as equivalent car travel for the whole care pathway ^a	534	325–1160		363	239–756		

^aEquivalent car distance travelled assumes 160 gCO₂/km. CF = carbon footprint; DOAC = direct acting oral anticoagulant; DCCV = direct current cardioversion; GP = general practitioner; IQR = interquartile range; kgCO₂e = kg carbon dioxide equivalence; UHS = University Hospital Southampton NHS Foundation Trust.

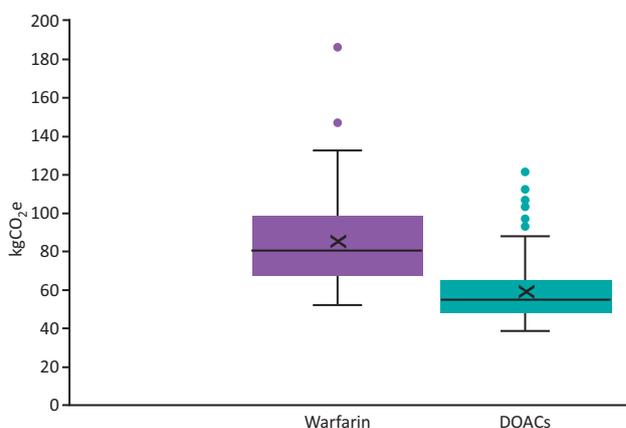


Fig 1. Total kgCO₂e of the care pathways for warfarin vs DOAC treated patients. DOACs = direct acting oral anticoagulants (and includes the pooled results from the patients receiving rivaroxaban, apixaban and dabigatran).

What this study adds

SCPG avoids time-consuming and costly life cycle assessments, yet provides the framework to map clinical care. The change from warfarin to DOACs reduced the CF of the EDCCV care pathway for patients attending our hospital. ■

Supplementary material

Additional supplementary material may be found in the online version of this article at www.rcpjournals.org/fhj: S1 – Supplemental tables and figures.

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The digital footprint of Philippine eye care centres in the onset of the COVID-19 pandemic

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Editor – As reported in recent articles, the pandemic has accelerated digital healthcare's rise. Following are initial

Table 1. Website and social media footprint of Filipino ambulatory surgicentres and tertiary training centres for ophthalmology, March–June 2020

	Website	Facebook	Twitter	Instagram	YouTube
Ambulatory surgical centres, n=135, n (%)	74 (54.81)	113 (83.70)	38 (28.15)	46 (34.07)	38 (29.15)
Tertiary centres with accredited residency training programmes, n=27, n (%)	24 (88.89)	27 (100.00)	8 (29.63)	7 (25.93)	11 (40.74)

teleophthalmology observations from the Philippines, a lower-middle-income archipelago whose population spends the most time online and on social media, worldwide.^{1–3} Health gatekeeper mechanisms are absent, out-of-pocket financing is >50%, and population indigency is ~30%.³ While teleophthalmology examinations and portable technology have limitations, benefits include advocacy, triage/appointment-setting and care resulting in reduction of in-person visits.^{4–6}

During March–June 2020, we explored website and social media presence/footprints of eyecare centres: 135 private ambulatory surgicentres (ASCs) and 27 tertiary centres with training programmes (TCs). Findings include:

- > majority having websites (88% ASCs; 54% TCs) and being present on Facebook (83%–100%)
- > a low presence on other top social media platforms; lowest in Instagram (25% TCs)
- > COVID-related material (81% TCs) and telemedicine services (20% ASCs; 50% TCs) are posted mostly on Facebook
- > eye/ophthalmic health content present in up to 37% of sites.

We excluded existing telemedicine platforms (eg National Telehealth Center serving distant municipal/rural health facilities and private establishments / health insurance companies serving ~2.3% of the population) and personal professional websites/social media pages.

The telemedicine landscape is largely unexplored, and we found that ophthalmic care providers are populating the space. Further, online platforms were used for pandemic-era issues: tributes to healthcare workers that have died, advocacy for preventive eye care given overwhelmed healthcare systems etc. For individual providers, a recent survey noted similar trends/perspectives seen elsewhere including increasing/majority openness to teleophthalmology, use of modalities other than telephone, increasing use for new patients and decreased confidence in applicability to certain diseases and clinical circumstances.⁷

As elsewhere, we lack insight into population perspectives and outcomes. Impact of provider choice, patient journey, accessibility and improved ophthalmic outcomes are unknown. Negative impacts of content (occasional sparse and dated information), risk for harm/falsehood cannot be excluded.

Telemedicine's potential strengths include convenience and safety. Though currently with inadequacies, its relevance likely

will grow in a disrupted, innovating post-COVID world. It bears potential to leapfrog challenges, particularly in the developing world and gatekeeper-free systems. It is an area of future healthcare that must be examined continually. ■

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