

Preferences and acceptability of telemedicine in Belgian IBD patients

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Abstract

Introduction: Inflammatory bowel diseases (IBD), in particular Crohn's disease (CD) and ulcerative colitis (UC), are chronic conditions that have a considerable impact on patients' quality of life and healthcare resources, as they require frequent visits and hospitalisations. Telemedicine offers a potential advantage by enabling remote healthcare. Studies have shown that telemedicine can improve quality of life and reduce healthcare use, although results vary depending on study design and location. Our study investigates the views of French-speaking Belgian IBD patients on telemedicine. It aims to assess acceptability and preferences to guide future implementation.

Methods: We designed a questionnaire available online (between October 2023 and June 2024) for which any patient with IBD followed up in an adult gastroenterology consultation was eligible. The 69-item questionnaire was validated by test patients and distributed via Epic®, social media and printed forms. Data were collected using REDCap® and analyzed using SPSS®, applying univariate and multivariate analyses to identify factors influencing acceptance of telemedicine.

Results: 257 respondents validated their questionnaire. The majority were women (54%) with an average age of 45 years [17-85]. Most patients had Crohn's disease (63%) and were using immunosuppressive therapy (44%) and/or biologics (30%), with a high compliance rate (98%). Although 68% had discovered telemedicine because of our survey, 82% were interested in remote consultations, citing time savings and reduced absence from work as advantages, while expressing concerns about reduced personal contact and technical problems. Acceptance was significantly associated with time saved and frequency of visits ($p < 0.05$).

Conclusion: Our study reveals strong acceptance of telemedicine, regardless of previous experience, with a preference for video over telephone consultations. It also demonstrates openness to follow-up without direct human contact (e.g., application-based tools), although concerns remain about the potential loss of personal interaction. The results underline the importance of addressing patient concerns and ensuring a solid human and technical infrastructure for the expansion of telemedicine. (*Acta gastroenterol belg.*, 2026, 89, 55-64).

Keywords: Telemedicine; IBD, Remote monitoring; Patient satisfaction.

Introduction

Inflammatory bowel diseases (IBD), i.e. Crohn's disease (CD) and ulcerative colitis (UC), are chronic immune-mediated diseases characterized by an alternating course of remission and relapse (1,2).

Beyond the organic damage to the digestive tract, these diseases have a social, psychological and professional impact (1,2). Given their lifelong nature and the absence of a curative solution, IBD patients require long-term follow-up including treatment, outpatient visits and hospitalizations. During the course of their disease, half of CD patients and one third of UC patients will require hospitalization within 5 years after diagnosis¹. Additionally, the incidence and prevalence

of IBD is expected to grow, leading to nearly one in 100 individuals requiring medical monitoring, in many Western countries, including Belgium, by 2030 (3). Therefore, IBD represents a high burden in terms of the direct cost of treatment and patient follow-up and the indirect cost related to work incapacity (1).

Interest has therefore arisen in reducing the burden of monitoring IBD patients, both from a patient and a socio-economic point of view (4). One option being considered is to shift from traditional monitoring—where patients are seen in consultation a fixed number of times per year and additionally in case of clinical deterioration—to remote monitoring, in which follow-up can be conducted at a distance, particularly when the patient is clinically stable. The traditional on-site approach involves many caregivers, either for patients whose disease is under control or to organize faster care for unexpected situations (5,6).

Telemedicine, as defined by the World Health Organization as a healthcare service provided remotely to the patients through information communication technologies (7), has been studied as a solution to offer proactive follow-up for closer monitoring and global assessment of the disease (6).

Many technologies, including telephone/video consultations, mobile apps, and connected devices, have been tested in more than 20 randomized controlled trials (RCTs) around the world. These RCTs were recently the subject of two meta-analyses demonstrating an improvement in quality of life and knowledge about IBD, as well as a reduction in outpatient visits and emergency consultations (5,7) without any significant negative change in activity scores or clinical remission (5).

From an economic point of view, telemedicine has been shown to be cost-saving in a RCT (8) and cost-effective in patients not receiving biological treatment in a registry study (9).

Patient satisfaction and expectations regarding telemedicine have been studied mainly after its implementation. The telemedicine in question was sometimes imposed as a constraint due to the COVID-19

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pandemic, which forced many centers to organize remote monitoring (10).

The various studies carried out are marked by heterogeneity both in terms of the intervention and the geographical and socio-economic constraints of the countries in which they were carried out (5,7).

These data highlight the need to implement telemonitoring in a way that is adapted to local contexts. To facilitate such implementation, it is essential to understand patients' preferences and their degree of acceptability.

The aim of our study is therefore to assess the degree of acceptability and the preferences of French-speaking Belgian IBD patients to clarify their expectations and define the best conditions for implementing future follow-up by telemedicine.

Methods

Study Design and Study Population

All French-speaking IBD patients followed in any Belgian adult gastroenterology clinic were eligible for participation. Eligible patients had access to an online questionnaire from October 2023 to June 2024.

Development of the Questionnaire

The questionnaire was developed by the authors based on the available data on telemedicine, especially in IBD, and on the authors' experience. The questionnaire comprising 69 items has been subdivided into the following parts: personal data (while remaining anonymous), consultation habits, digital access/digital skills, telemedicine experience and patients' views on telemedicine.

Items for the questionnaire were written in French. Responses consisted of either short answers, multiple choices or grading scales. The questionnaire is provided in Appendix 1.

The questionnaire was then tested through a pilot completion by two test-patients (members of the patients' association "ASBL Crohn R.C.U.H."), who provided feedback and suggestions for modification that were subsequently reviewed by the authors.

The questionnaire was then encoded in REDCap® to facilitate its distribution.

Data collection

The questionnaire was made available via a single link sent in several ways: by email via the hospital's Epic® platform, published on patient association social media, and distributed at the Cliniques Universitaires Saint-Luc on printed sheets containing the link to the online questionnaire.

The questionnaire was completed anonymously by patients using the link provided (the same link regardless

of the recruitment method). In order to preserve complete anonymity of respondents, we did not collect data on how each patient accessed the questionnaire (e.g., via social media, email or the printed version). Patients could respond to the questionnaire in several stages, with no time limit.

The data was then recorded on the REDCap® platform.

Statistical Analysis

Only questionnaires answered to the last question and validated as complete were considered for analysis. The data collected via REDCap® were then exported for analysis using SPSS (version 29.0.1.0).

Categorical data were defined by percentage (number for which the data are present out of the total number of patients for which the data were described [n/N (%)]). Continuous data were expressed as means and standard deviations. For the univariate analysis, continuous data were analyzed using the student's t-test and categorical data using the Chi-square test. A multivariate analysis was performed using a binary logistic regression to correct for confounding factors. A Pearson correlation test was used to assess the correlation between two continuous variables. A p-value < 0.05 was considered statistically significant.

Results

Baseline characteristics

A population of 321 patients responded to the questionnaire, of whom 257 validated all their responses. These patients, mainly women (54%), had an average age of 45 [17-85] and were mostly higher education graduates, holding a post-secondary degree (70%).

In terms of disease, 63% of patients suffered from CD and 36% from UC. They had an average disease duration of 20 years and 14 years, respectively. They were mainly on immunosuppressive therapy (44%, including 5% in combination therapy) and had therefore an outpatient treatment plan (59%).

More than two-thirds of these patients reported seeing their gastroenterologist at least twice a year, with the average distance between their home/workplace and the doctor's office being 30 kilometers (km) [0-100].

The vast majority (98%) reported adhering to both outpatient follow-up and prescribed treatment.

The remaining baseline characteristics are shown in Table 1.

Digital awareness

Most patients (94%) reported being familiar with digital tools, all of whom had an internet connection that they used daily.

In terms of connected devices, the majority owned a smartphone (96%), followed by a computer (92%); to varying degrees, they also owned a tablet, a smartwatch, and/or a smart scale (Figure 1).

Teleconsultation experience and patients' points of view

Nearly one-third of patients surveyed (32%) had already received remote follow-up care, two-thirds of them by telephone and half by videoconference.

Regardless of whether they had already used telemedicine, 82% of patients surveyed said they were interested in remote monitoring by telephone and/or video consultation (Figure 2). This proportion increased to 89% among patients with prior experience of telemedicine.

Eighty-nine percent of patients responded that they would agree to complete a remote questionnaire about their health status prior to the teleconsultation, with 86% preferring multiple-choice questions with predefined answers (rather than rating scales or open-ended questions).

When it came to the benefits of this kind of follow-up, patients most often mentioned saving time overall, followed by fewer work absences and the hope of closer monitoring (Figure 3).

Patients estimated that they would save an average of 108 minutes (± 70 minutes) [0-375] per visit compared to conventional follow-up, and 69% of them estimated that they would benefit economically (in terms of work time, transportation costs, etc.).

In a Pearson correlation test, distance and time saved showed a moderate and significant correlation ($r = 0.561$, $p < 0.001$).

On the contrary, the most frequently mentioned concern was that of greater distance between the caregiver and the person being cared for, the inability to isolate oneself for a remote consultation, and fears of Internet connection problems (Figure 4).

However, 39% of patients believed that their relationship would remain unchanged, while 9% and 26% thought it would improve or deteriorate, respectively.

Similarly, 51% of patients believed that their medical quality of care would remain unchanged, while 16% and 17% believed that it would improve or deteriorate, respectively.

Among patients who had already benefited from a teleconsultation, the proportion of those who thought that the relationship and medical follow-up would be worse fell to 16% and 11% respectively (Table 2)

In what context should a teleconsultation be carried out? One in two patients (51%) believe that telemedicine

Table 1. — **Baseline characteristics.**

Age (mean (years old) (\pm standard deviation) [extremes])	45 (± 14) [17-85]
Gender % (n/N)	
Male	46% (117/256)
Female	54% (139/256)
Level of education % (n/N)	
Primary school	2% (4/254)
Secondary school	28% (73/254)
Post-secondary	70% (177/254)
Type of IBD % (n/N)	
Crohn's disease	63% (161/256)
Ulcerative colitis	36% (91/256)
Indeterminate colitis	1% (4/256)
Disease duration (mean (years old) (\pm standard deviation))	18 (± 12)
Ongoing treatment % (n/N)	
None	11% (28/248)
5-ASA	23% (58/248)
Steroids	8% (19/248)
Immunosuppressive therapy	44% (108/248)
Biologicals	30% (75/248)
Small molecules	<1% (1/248)
Outpatient treatment % (n/N)	59% (99/242)
Frequency of outpatient consultation % (n/N)	
Less than 1x/year	7% (18/257)
1x/year	14% (35/257)
2x/year	37% (94/257)
More than 2x/year	42% (110/257)
Distance between home/office and doctor's office (mean (kilometers) \pm standard deviation [extremes])	30 (± 28) [0-100]
IBD inflammatory bowel disease, 5-ASA 5-aminosalicylic acid	

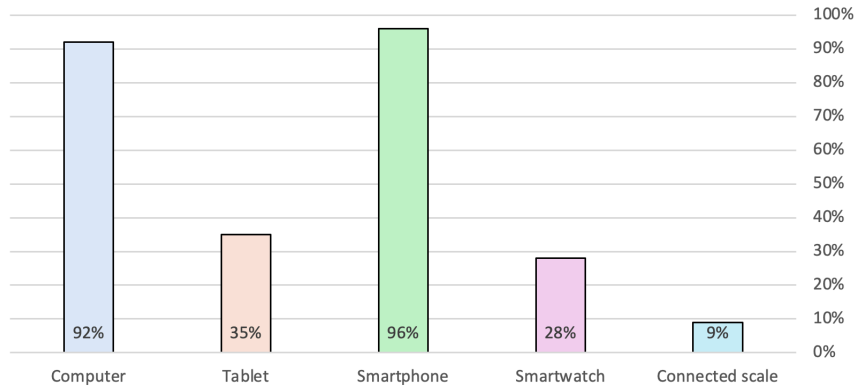


Figure 1. — Digital devices owned by the patients.

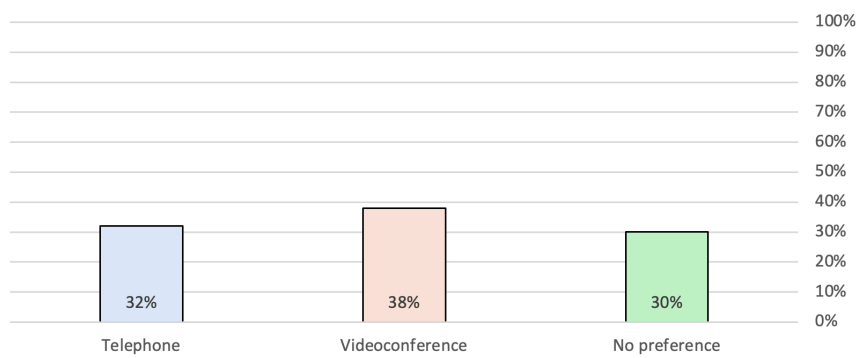


Figure 2. — Teleconsultation mode of choice.

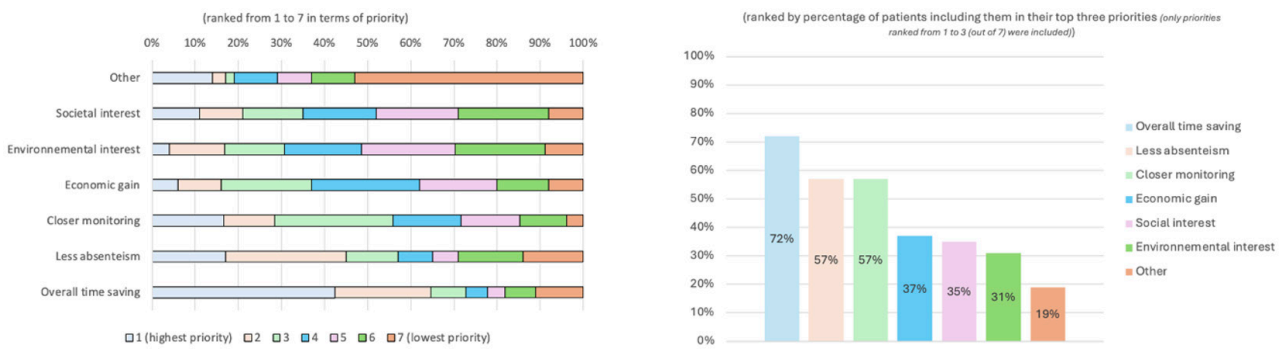


Figure 3. — Expected benefits from telemedicine.

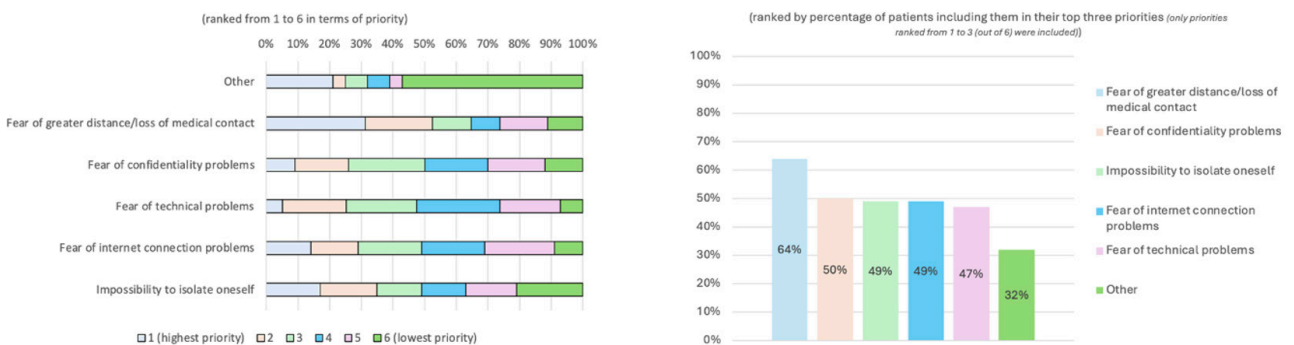


Figure 4. — Expressed fears about telemedicine.

should be used when the disease is inactive, and around one-third (30%) consider it an intermediate step before a traditional consultation. In addition, 19% of patients believe that remote follow-up would be more beneficial when the disease is active.

Only 16% of patients believed that teleconsultations would generate additional work for healthcare staff. While 82% supported reimbursement at the same rate as traditional consultations, a substantial proportion felt that remote consultations should cost less: 46% for telephone consultations and 28% for videoconference consultations.

Baseline characteristics

Seventy percent of patients believe that IBD should only be monitored by a healthcare professional, although 65% of all patients would accept the use of telemedicine tools without direct contact (web/mobile applications, online questionnaires, connected devices, etc.), with connected devices being less popular (10%).

Disease activity, followed by extra-intestinal manifestations and treatment adherence, were the three domains most frequently ranked among the patients'

top three priorities for the proposed tool (Figure 5).

The use of artificial intelligence would be acceptable for 47% of patients, while an algorithm pre-established by the medical team in response to a change in disease activity scores would be reasonable for 50% of patients.

When asked about the optimal frequency of use for these tools, 58% of patients believe that this should be determined by the doctor, based on the patient's current state of health. The others prefer a predefined schedule ranging from once a month to once every six months (20%) or an on-demand schedule initiated by the patient (22%).

A large majority (95%) would like the tool to provide access to up-to-date and verified information about their disease and treatment (patient education), and 84% would also like to have a glossary of terms used. Sixty-five percent of patients do not want to receive training on how to use the tool offered by their doctor.

In addition, 78% of patients say they are willing to perform a fecal calprotectin test at home.

Table 2. — Estimated changes after teleconsultation implementation.

	TM exposed/naive	TM exposed*	TM naive*
Relation % (n/N)			
Unchanged	39% (99/253)	57% (47/82)	31% (52/170)
Better	9% (23/253)	11% (9/82)	8% (14/170)
Worse	26% (66/253)	16% (13/82)	31% (52/170)
Don't know	26% (65/253)	16% (13/82)	31% (52/170)
Quality % (n/N)			
Unchanged	51% (130/253)	55% (45/82)	50% (85/170)
Better	17% (42/253)	23% (19/82)	14% (23/170)
Worse	17% (43/253)	11% (9/82)	20% (34/170)
Don't know	15% (38/253)	11% (9/82)	17% (28/170)

* 7 participants did not indicate whether they had already benefited from teleconsultation; TM = telemedicine.

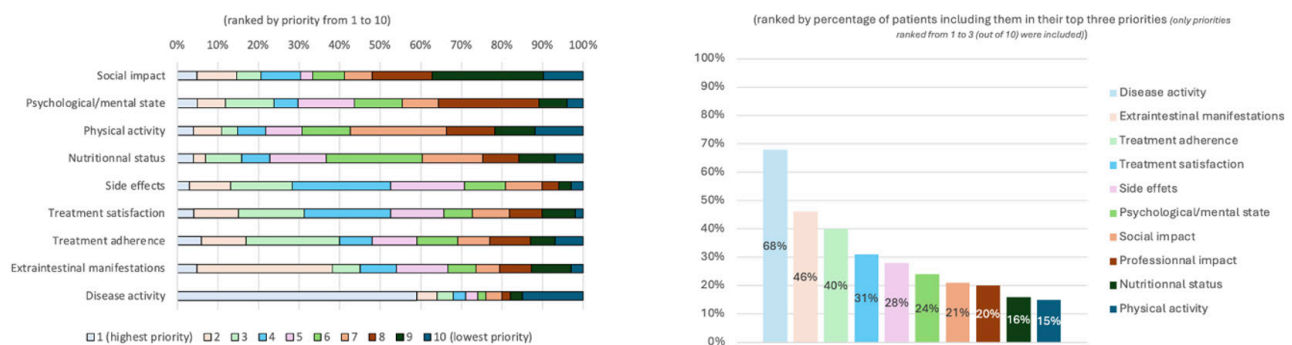


Figure 5. — Areas to be investigated by a telemedicine tool.

Univariate and multivariate analysis for acceptance of telemedicine

In a univariate analysis, patients that would accept a future telemedicine estimated the time gain significantly higher than those that wouldn't (115 minutes +/- 70 in comparison to 69 +/- 65).

In the multivariate analysis, acceptance of telemedicine was found associated with not only a higher estimated time gain ($p < 0.001$) but also with a frequency of outpatient visits of one or more per year (Table 3).

Discussion

This study is one of the first to look at patients' expectations and concerns regarding telemedicine,

focusing both on those who have already used it and on those who have never experienced telemedicine follow-up. This proactive approach aims to define patients' preferences and expectations.

Although the COVID-19 pandemic necessitated intensive use of telemonitoring (11), 68% of these patients had never participated in a teleconsultation. Regardless of previous telemedicine experience, 82% of patients surveyed indicated that they would be willing to participate in a teleconsultation, and 65% were open to the use of a telemedicine tool without direct human contact. This preference for face-to-face consultations, albeit at a distance, is in line with the findings of previous European and American studies (10).

Among patients who had already used teleconsultation, 89% said they were willing to include this type of consultation in their regular follow-up care.

Table 3. — Univariate and multivariate analysis of factors linked to potential acceptance of telemedicine follow-up.

	Univariate analysis			Multivariate analysis	
	Acceptance		p value	OR (95% CI)	p value
	Yes	No			
Age (mean (years old) \pm SD)	45 (\pm 14)	47 (\pm 13)	0.410*	1.001 (0.960-1.044)	0.952
Gender (% (n))			0.398†		
Male	87 (99)	13 (18)		1	-
Female	81 (112)	19 (27)		1.693 (0.673-4.254)	0.263
Type of IBD (% (n))			0.749†		0.620
CD	81 (131)	19 (30)		1	-
UC	85 (77)	15 (14)		0.797 (0.282-2.252)	0.669
IC	75 (3)	25 (1)		0	0.999
In hospital treatment (% (n))			0.586†		
Yes	84 (83)	16 (6)		1	-
No	81 (116)	19 (27)		1.554 (0.597-4.043)	0.367
Self-assessed digital awareness (% (n))			0.333†		
Yes	83 (197)	17 (40)		1	-
No	73 (11)	27 (4)		0.128 (0.007-2.439)	0.172
Past telemedicine experience (% (n))			0.057†		
Yes	89 (73)	11 (9)		1	-
No	79 (138)	21 (36)		1.161 (0.421-3.203)	0.773
Distance between home and doctor's office (mean (km) \pm SD)	30 (\pm 29)	27 (\pm 25)	0.553*	1.017 (0.994-1.040)	0.153
Estimated time savings per visit (mean (minutes) \pm SD)	115' (\pm 70)	69' (\pm 65)	< 0.001*	0.978 (0.967-0.989)	< 0.001
Time since diagnosis (mean (years) \pm SD)	18 (\pm 13)	17 (\pm 11)	0.644*	1.001 (0.952-1.053)	0.965
Frequency of consultation (% (n))			0.082†		
< 1x/y	61 (11)	39 (7)		1	0.062
1x/y	88 (31)	12 (4)		0.040 (0.003-0.577)	0.018
2x/y	83 (78)	17 (16)		0.135 (0.021-0.856)	0.034
> 2x/y	84 (92)	16 (18)		0.092 (0.013-0.632)	0.015

† Chi-square test
*Student's t-test
CD Crohn's disease, IBD inflammatory bowel diseases, IC indeterminate colitis, km kilometers, OR odds ratio, SD standard deviation, UC ulcerative colitis, y.o. years old, x/y times per year, ' minutes.

These figures are consistent with those of two recently published European studies on teleconsultations during the COVID-19 pandemic (4,12), where at that time, the need to comply with social distancing and fear of contagion may have influenced patient satisfaction levels.

In line with this finding, high satisfaction rates were also reported in two US studies published before the pandemic (13,14). The first, which focused on general consultations, reported satisfaction rates of between 94% and 99% (13), while the second, which focused specifically on IBD in veterans, found no significant difference between the satisfaction levels of patients followed conventionally and those followed remotely via teleconsultation (14). Interim results from a Belgian study also reported satisfaction rates of 92% after implementation (15).

These high satisfaction rates should be viewed in relation to the expected and actual benefits of remote monitoring. In the French study by Guillo et al. (4), several advantages of teleconsultation were highlighted, including time savings, reduced travel, lower costs, and greater flexibility in monitoring. Similarly, an Israeli study conducted by Lahat and Shatz (16) identified time savings (31.3%), accessibility (26.1%), and doctor availability (25%) as advantages.

In our study, the main benefits expected were time savings, reduced absenteeism, and the hope of closer monitoring. However, these benefits were tempered by fears of losing personal contact, which was the main concern of 31% of patients, although only 17% of them believed that their medical follow-up would be poorer, with this figure being lower among patients who had already benefited from telemedicine. In previous studies (4,16), this fear was often linked to the lack of physical examination, which was considered a disadvantage of telemedicine by 69.8% of patients in the study by Lahat and Shatz (16). However, it is interesting to note that 19% of our patients would prefer to have a teleconsultation during an active phase of the disease, which contrasts with the medical view that emphasizes the need for clinical follow-up and physical examination during this acute phase. This preference may reflect the comfort and convenience of remaining at home during a period of active disease.

In our study, which surveyed mostly patients who were new to telemedicine, we sought to identify factors associated with greater acceptance of telemedicine follow-up beyond the expected benefits and concerns.

Only the estimated time savings and the number of visits per year showed a significant difference. This result is probably related to our predominantly educated and active population, which also ranked reduced absenteeism (school and work) among the most important benefits. As a reminder, a systematic review by Youssef et al. found that two-thirds of patients with IBD were professionally active; unfortunately, we do not have this data for our own population (17). However, it

is interesting to note that although time savings are cited by patients as an advantage and are a factor significantly associated with greater acceptability, patients are nevertheless willing to spend time completing a questionnaire before the teleconsultation.

A study conducted by Storan et al. (10) identified other factors associated with higher satisfaction rates, such as financial savings, shorter duration of illness, and an open personality. The personality trait "openness to experience" is characterized by active imagination, a preference for variety, and intellectual curiosity, and this trait was an important predictor of satisfaction with virtual consultations. In contrast, lower satisfaction was associated with active illness and a "pleasant" personality. This trait, which encompasses kindness, warmth, sympathy, and cooperation, was associated with relatively low levels of satisfaction, which may indicate a need for more personal and direct interactions with healthcare staff among this type of individual. Our questionnaire did not allow us to define personality types.

As a reminder, the cost of treating IBD is significant for both patients and society. Previous studies have shown that app-based telemedicine could be an option for reducing the economic burden of follow-up care (8,9). Video consultations have also been shown to be cost-efficient, with savings primarily attributable to reduced travel expenses (18). In our study, the average distance between home and the place of consultation was relatively short, with an average of 30 kilometers, which can be explained by Belgium's geography and the density of its hospital network (19).

With regard to consultation fees, since September 1, 2024, the Belgian healthcare system has set the rate for a telephone consultation at 24% of a standard consultation and 55% for video consultations (20). Reimbursement for telephone consultations has recently been suspended. While this difference benefits the healthcare system, it has a negative economic impact on healthcare professionals, whose workload remains largely unchanged (same consultation time, organization of the consultation, etc.). In our study, over 80% of patients indicated that teleconsultation should be reimbursed in the same way as a traditional consultation.

Telemedicine encompasses a wider range of services beyond teleconsultations, such as non-human monitoring via web interfaces, mobile applications, etc (5). These interventions have proven to be both effective and cost-effective (5,7-9). However, they require a high level of digital literacy. It is therefore essential to assess not only the availability of these tools for patients, but also their ease of use. Several teams are currently developing scales to measure digital maturity (21,22). If validated, these scales should probably be used before implementing a telemedicine tool in everyday practice. In this study, 94% of respondents reported being comfortable with digital technologies. This figure may

be skewed by the fact that our survey was conducted online, using mainly digital distribution methods (social media, email). As a result, it was mainly patients who were comfortable with technology who responded to the survey.

Once implemented and used correctly, online tools have demonstrated high satisfaction rates (23-25). However, they vary in terms of form, presentation, and, above all, content. In addition to disease-related aspects, follow-up must now cover all areas affected by IBD (e.g., fatigue, socio-professional issues, etc.) (26). In our study, however, patients prioritized the manifestations of their disease, followed by issues related to treatment and side effects. The holistic aspects of the disease were considered less important. From the physician's point of view, collecting all this information requires additional time (27), but telemedicine tools offer the advantage of collecting this data before a (tele) consultation, allowing the session to focus on the most urgent or relevant concerns.

More advanced digital tools also raise concerns related to internet connectivity or technical issues, which were cited as barriers in Kruse et al.'s systematic review of barriers to telemedicine (28). However, previous studies show that technical problems are rare (25,29). In our study, concerns about connection problems and technical issues were not among the main concerns expressed by the patients surveyed, who were also comfortable with digital tools.

)From a financial perspective, there is currently a procedure in Belgium for requesting funding for a medical application. However, there is no framework for reimbursing medical activities related to the management of medical responses provided.

)In addition to the selection bias associated with the digital recruitment and survey method, our study was limited by a lack of information regarding the response rate. We do not know how many patients received the questionnaire link through the different distribution channels, nor the distribution channel that generated the most responses (e.g., social media, mailing lists, or paper version). Some of the patients via our Epic® platform are patients who ended up in a tertiary center due to the severity of their condition and tend to travel longer distances and therefore may have benefited more from teleconsultation, which may have influenced the results. Finally, as the questionnaire was entirely self-administered and anonymous, we had no control over how the questionnaires were completed (for instance, it was not possible to address any potential questions that might arise during completion).

Another consideration is that our study population consisted conjointly of self-enrolled patients—recruited notably via social media, patient association mailing lists—and patients followed in secondary and tertiary center, making it a non-traditional hospital cohort. This recruitment method led to a patient profile different from that typically seen in hospitals and tertiary centers, with

a higher proportion of patients on immunosuppressive therapy and fewer receiving biologics. While this may limit comparability with hospital cohorts, it also represents a strength of our study, as it captures the perspectives of patients who may be less familiar with telemedicine and clinical trials. This broader inclusion helps to better understand telemedicine acceptability across a wider spectrum of IBD patients. However, given that only questionnaires in French were sent out, the results cannot be generalized to the entire Belgian population with IBD under follow-up.

Another limitation of this study is the inability to analyze the severity of the disease in the patients who responded and to determine whether this affects their acceptance of telemedicine. Patients with more severe conditions may have different needs and preferences than those with milder symptoms. Further study of these factors could provide a better understanding of the barriers to telemedicine adoption and help tailor interventions to better support different patient groups.

In conclusion, we demonstrate that French-speaking Belgian patients with IBD have a high level of acceptability for teleconsultation follow-up, regardless of whether they have already benefited from such follow-up. They prefer video consultations over phone consultations and focus on the manifestations of their disease rather than on holistic aspects. They also demonstrate an acceptance of follow-up techniques that do not involve direct human contact (e.g., application-based tools), which are currently the main modalities investigated in the literature, notably regarding cost-effectiveness. Time savings and the number of consultations per year are statistically associated with greater acceptability. However, patients express concerns about the loss of personal contact and technical problems. It is therefore essential to discuss these factors with patients before starting telemedicine follow-up.

The benefits of telemedicine are undeniable for both patients and society. Given the growing need for medical resources to treat an increasing number of people with IBD in Belgium, its implementation in everyday practice is a major asset. The various tools associated with telemedicine (teleconsultation, digital tools, chat boxes, AI, etc.) can also be tailored to patients based on their preferences, expectations, concerns, as well as best practice guidelines³⁰. However, before operational implementation, investments in digital infrastructure are necessary, which could be supported by a more robust reimbursement framework.

Conclusions

In young, healthy volunteers breathing spontaneously, the Q-NRG in canopy mode performed similarly to the Deltatrechanically ventilated patients, the current findings provide assurance for its application to spontaneously breathing subjects.

Declarations

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Conflicts of interest: KT: received speakers, travel or consultancy fees from: Abbvie, Alfasigma, Celltrion, DrFalk, Eli Lilly, Takeda.

HP: no COI.

OD: received speakers, travel, grants or consultancy fees from: Abbvie, Alfasigma, Biogen, Celltrion, Ferring, J&J, Lilly, Pfizer, Takeda.

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APPENDIX 1 - (PDF version of online questionnaire)

Questionnaire Télémédecine Maladies Inflammatoires Chroniques des Intestins

Page 1

Cher Patient,

Merci de participer à cette enquête qui permettra de mieux cerner vos attentes, craintes et souhaits en matière de télémédecine.

Merci de ne remplir ce formulaire qu'une seule fois, mais vous pouvez provisoirement sauvegarder vos réponses et y revenir plus tard avant de les envoyer.

Dr Killian Troch

Prof. Olivier Dewit

Données personnelles

Informations générales

Quelle est votre année de naissance ?

Quel est votre sexe

- Homme
 Femme
 autre

Quel est le dernier diplôme que vous avez obtenu ?

- Primaire
 Secondaire
 Supérieur (haute école, université ...)

De quelle maladie inflammatoire chronique intestinale êtes-vous atteint ?

- Maladie de Crohn
 Rectocolite ulcéro-hémorragique (RCUH)
 Colite indéterminée

En quelle année avez-vous été diagnostiqué ?

Quel traitement suivez-vous actuellement ?

- Aucun
 5-ASA (5-aminosalicylés : Pentasa, Colitofalk ...)
 Corticoïde (Medrol, Entocort, Budénofalk, Clipper)
 Immunosuppresseur (azathioprine/Imuran, Purinethol, Methotrexate)
 Biologique
 Petite molécule

Biologique: précisez

- infliximab (Remicade, Remsima, Flixabi...)
 adalimumab (Humira, Imraldi, Hulio)
 golimumab (Simponi)
 vedolizumab (Entyvio)
 ustekinumab (Stelara)
 risankizumab (Skyrizi)

Petite molécule: précisez

- tofacitinib (Xeljanz)
 tilgotinib (Jyseleca)
 upadacitinib (Rinvoq)
 ozanimod (Zeposia)

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Si vous suivez un traitement, celui-ci est-il administré à l'hôpital ?

- oui
 non

Habitudes de consultation

A quelle fréquence consultez-vous votre gastro-entérologue ?

- Moins d'une 1x/an
 1x/an
 2x/an
 Plus de 2x/an

A quelle distance habitez-vous (ou travaillez-vous, choisissez la distance la plus courte) du cabinet médical ou de l'hôpital dans lequel vous êtes suivi ?

Si nécessaire vous pouvez calculer cette distance par <https://www.google.com/maps/>



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