Prone positioning

DOI: 10.7861/clinmed.Let.20.6.4

Editor – I have read with interest the article 'Prone positioning in COVID-19: What's the evidence' by Rajan S Pooni.[1] He writes that prone positioning is a relatively safe intervention that has been shown to improve oxygenation in conscious ward-based patients. He, however, concedes that it is not a substitute for intubated and mechanically ventilated patients. He also says that the existing evidence base is too small to lead to a definitive conclusion.

Respiratory analeptics

Sophisticated ventilators are a somewhat recent development. They have their own limitations and may have adverse effects on patients.

What could have we done, say 50–60 years ago, when there were no ventilators? This is especially important in a situation where there is the possibility of collapse of the respiratory centre.[2] In such a situation there would perhaps be relatively little chance of it taking over while the patient is on a ventilator. The centre could perhaps be stimulated by using a respiratory analeptic.

Nikethamide (Coramine)

Some workers have administered nikethamide intravenously at the rate of 4 mL/min in 15 patients with acute respiratory failure: the patients showed increase in mental lucidity and respiratory drive; there were varying degrees of decrease in arterial partial pressure of carbon dioxide and improvement in minute ventilation.[3] One of greatest paradoxes is treatment for the relief of hypoxaemia may lead to further depression of ventilation. With the use of nikethamide the hypoventilation induced by oxygen breathing was corrected. The average dose varied between 5 and 8 mL (250 mg/mL). In most cases, a dose of 5 mL was adequate The ratio between therapeutic and toxic levels was good. Oxygen was administered through a nasal catheter at the rate of 3 to 5 litres per minute.

If a patient does not respond or gets worse on nikethamide, one can always switch over to mechanical ventilation. This drug has been in use for a long time and continues to be widely available. There is always scope for further studies.[4] Nikethamide and other respiratory analeptics deserve a relook and call for further research. ■

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Rehabilitation after COVID-19: supporting those in employment back to work

DOI: 10.7861/clinmed.Let.20.6.5

Editor – I welcome, very much, the approach taken by Prof Wade.[1] It recognises clearly that medical practice should conclude only when the individual with COVID-19 has returned to as normal a life as is possible; and that this should include employment when applicable.

The importance of understanding employment as part of medical practice has been highlighted by consensus statements firstly in 2008 and recently in 2019 signed by many health professional bodies including the Royal College of Physicians.[2,3] In order to avoid unnecessary job loss for those with long-term consequences of COVID-19, the acute team needs to ascertain whether their patient is in employment and if so they should be advised either personally or through the family:

- to remain in contact with their employer as not all employers have effective absence management[4,5]
- that there are many ways to assist disadvantaged individuals (DIs) back into work, even if this seems unlikely when viewed during the initial stages of illness.

Much of modern rehabilitation practice has been largely adopted by industry either through adopting disability aware processes (eg Business Disability Forum; https://businessdisabilityforum.org.uk/contact-us) or through their practices in addition to the advice given by rehabilitation professionals.[6] Such practices include:

- facilitating a return to work (RTW) before the DI has fully recovered
- part-time working; possibly only a few hours per week initially
- phased (graded) RTW
- working from home
- adjusting work tasks and responsibilities
- allowing time off work for health-related activities eg appointments and rehabilitation
- utilising the Access to Work Scheme or other advice from the Department for Work & Pensions.

The technical aspects of how this is achieved by vocational rehabilitation professionals has been described elsewhere.[7]

The acute teams can, by these simple means, reduce unnecessary worry about future job prospects. Facilitating a successful RTW helps not only the DI and their family but also their employer and the government by converting 'benefit recipients' into 'tax payers'. ■

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