

## Prone positioning

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Editor – I have read with interest the article ‘Prone positioning in COVID-19: What’s the evidence’ by Rajan S Pooni.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup> 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

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Editor – I welcome, very much, the approach taken by Prof Wade.<sup>1</sup> 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.<sup>2,3</sup> 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<sup>4,5</sup>
- > 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.<sup>6</sup> 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.<sup>7</sup>

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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## Guillain–Barré syndrome

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Editor – We read with great interest the article by Sancho-Saldaña *et al.*<sup>1</sup> Firstly, we would like to congratulate the authors who have nicely described a case of Guillain–Barré syndrome (GBS) following a SARS-CoV-2 infection and was found to have a leptomeningeal enhancement in magnetic resonance imaging (MRI) of the spine. Although there is numerous reporting on the neurological involvement of SARS-CoV-2 infection that has been published in the literature, we believe it is still justified to report any extrapulmonary cases of SARS-CoV-2 infection, as we are still learning about the disease. We have written a comprehensive review of literature on all published scientific articles of SARS-CoV-2 infection with neurological involvement and summarised the wide spectrum of presentation which can present with or without respiratory symptoms.<sup>2</sup> However, this article is the first to report leptomeningeal enhancement in addition to the GBS, which warranted further investigation.

Nevertheless, there is some important information that is missing in the article, which is the background history of the patient, especially in terms of her underlying comorbidity and also the list of regular medication that she is taking. We believe this information is vital to determine the aetiology and prognosis of the condition. Apart from that, we believe a follow-up reporting is warranted on the rate and status of recovery after rehabilitation and the presence of other neurological sequelae.

At any rate, we agree with the authors that the causal relationship between GBS and SARS-CoV-2 infection follows the classical para-infectious and post-infectious pattern, as shown in this patient. Moreover, although leptomeningeal enhancement is not uncommon in GBS, we believe that further study and close follow-up is imperative because, apart from being a supplementary diagnostic sign in GBS, it can be linked to the development of a neurological dysfunction, such as multiple sclerosis that can lead to long-term or permanent neurological disabilities.<sup>3</sup> ■

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## Lung ultrasound in COVID-19

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Editor – We thank Smallwood *et al* for their timely article about lung ultrasound (US) in COVID-19.<sup>1</sup> We completely agree that US can rule-in COVID-19 and that there is no published data on lung US and screening for COVID-19. We would gladly participate in the pragmatic research trial proposed, and would be happy to help in the set up. We have recently received numerous new US machines, as have many NHS trusts, have participated in a COVID-19 ultrasound database and published our ongoing experience.<sup>2,3</sup> However, the main sticking point to all of this is the number of practitioners who can and/or are ‘signed off’ to perform a standardised lung US with adequate reporting tools (which hopefully will follow on from the database). I am a respiratory consultant by trade, and very experienced at pleural ultrasound. A few years ago, I had attended a focused acute medicine ultrasound (FAMUS) course with the view to get formally accredited. However, lack of trainers in the north east of England and engagement from radiology colleagues to mentor me locally mean that my colleagues and I are completely self-taught in lung US and know that we are competent and confident. I do not have a set programmed activity for teaching US or any of the governance aspects around it, although we are currently writing up a business case.<sup>3</sup> I am sure that I am not alone in the UK. Furthermore, longitudinal competence programmes for basic point-of-care US do not exist.<sup>4</sup> So, should this pandemic be a time for widespread upskilling of emergency care, acute medicine and respiratory practitioners and not just doctors? Perhaps, but then the governance behind this is mind-boggling, and perhaps hampered by years of underfunding and under-recognition. The recent incorporation of US training into the acute medicine curriculum is welcome but not timely enough.<sup>5</sup> I am afraid there is no easy answer to any of this, and would welcome any further comments from lung US practitioners. ■

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