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Letters to the editor

OVERVIEW

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Stop auscultating and listen carefully instead: the new era of respiratory medicine

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Editor – I still vividly remember the first second that I got my hands on my first-ever shiny stethoscope back in medical school. That day, I recall auscultating tirelessly every single patient in the premises – respiratory or not! It was that art and skill combined that drew me into respiratory medicine in the first place.

Fast-forward to 20 years later, I'm sitting in my office after finishing another ward round on the COVID-19 ward, during which (once again) I did not auscultate at all. My stethoscope has been left in the drawer since the first 'peak' of the pandemic, no longer decorating my neck, losing even the last of its recent uses; indicating who in the hospital premises knows how to auscultate a chest properly (hopefully). Furthermore, after completing >350 virtual consultations, so far, for outpatient respiratory follow-ups and new referrals, I still haven't used it. The lack of direct patient contact has bothered me the most, as this magic skill and art of auscultation rapidly fades away, like the bronze finish on my stethoscope, unused, still in the drawer, banned by the coronavirus.

However, all is not lost. We still have our ears, even without our trusted 'tubing and bell' attached to them, which, for a respiratory consultant, has been a 'mandatory artificial appendage' for so many years. I now rely on listening carefully to what my patients tell me about their symptoms and concerns, concentrating more on their needs, rather than on my own former need to auscultate before offering my pearls of wisdom. It has not hindered any of my investigations or treatment plans, and none of the patients so far has expressed any concerns about the 'lack of auscultation'; however, you can find plenty of complaints around NHS trusts about 'lack of listening'.

I am not sure when (or if) I will actually use my stethoscope again, as for the rest of my clinical encounters, I rely on real-time imaging (ultrasound) as well. I don't know if the pandemic will signal the end of the stethoscope, however, I certainly hope it will signal a new beginning, with a new breed of doctors who listen, even though they don't have a stethoscope around their necks. This is, and always have been, the fundamental art of medicine itself. I guess this is one of the things I've relearned during the pandemic. ■

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Discharge criteria for patients with COVID-19 to long-term care facilities requires modification

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Editor – Residents of long-term care facilities (LTCF) have suffered much in the current COVID-19 pandemic.[1] Current guidance for the discharge of patients with COVID-19 to LTCF requires testing for SARS-CoV-2 by PCR 48 hours prior to discharge, with the result relayed to the receiving organisation.[2] The intention of this guidance is presumably to prevent those who are infectious from entering a shared living space and triggering an outbreak, by either delaying their discharge or isolating them within the LTCF.

Viable SARS-CoV-2 viral cultures, not ribonucleic acid PCR, are the best surrogate markers of infectivity. Studies show that, in most patients, cultures become negative after day 10 of symptom onset in COVID-19 patients, despite PCR positivity being detected up to 21 days and beyond, with the exception of those who are heavily immunosuppressed.[3,4] Unfortunately, viral cultures are no longer used in most UK diagnostic laboratories, due to it being labour-intensive and requiring category 3 / biosafety level 3 facilities. Viral loads, as measured by cycle threshold values, are under investigation as markers for infectivity. However, they are not interchangeable between assays due to heterogenous gene target(s), amplification chemistry and nucleic acid extraction systems.

In short, a 'positive/negative' PCR test prior to discharge to a LTCF is not appropriate because it does not relate to infectivity.

Table 1. Comparison of current Public Health England guidance and our recommended guidance

	Public Health England guidance	Our recommended guidance
Guidance	PCR test 48 hours prior to discharge to LTCF; results relayed to receiving organisation	Patients with clinically recovering COVID-19 can be discharged to LTCF 10 days after their first positive swab or 10 days after clear symptom onset
Consequences	Patients with a positive test may require: > longer hospitalisation, increasing their risk of hospital acquired infection and sarcopenia > isolation in LTCF, which can drain resources	Exceptions to guidance would be those who are heavily immunosuppressed (organ transplant or genetic immunodeficiencies)

LTCF = long-term care facilities.

A negative test may be a false negative with rates up to 30%; a positive test does not mean that the patient is infectious and shedding active virus.[5] Until more reliable markers of infectivity are found, we recommend modifying the discharge criteria to state that patients who have recovered from COVID-19 can be discharged to a LTCF if it is 10 days after their first positive swab or 10 days after clear symptom onset; with exceptions being those who are heavily immunosuppressed (transplant patients or those with severe genetic immunodeficiencies) as shown in Table 1. This is simple and more in line with the UK's self-isolation guidance for those who test positive for COVID-19 in the community, as well as the most recent World Health Organization guidance and should be continuously updated.[6,7] ■

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Persistent fatigue in patients with COVID-19

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Editor – We read with interest the review by Sullivan who described the long-term sequela of patients who acquired severe acute respiratory syndrome coronavirus infection and Middle East respiratory syndrome coronavirus infection.[1] Based on the previous experiences with the two epidemics, the author suggested that patients who recovered from COVID-19 may also suffer from the similar long-term complications which include cardiopulmonary sequelae and fatigue.

We wish to discuss the condition of persistent fatigue following the recovery of COVID-19. In fact, available studies have reported fatigue as the most prevalent symptom that persists in patients who recovered from COVID-19, which has now been termed as 'long COVID'. An Italian study of 179 patients reported that 87.4% of patients had persistence of at least one symptom in 60 days after their initial COVID-19 diagnosis, with fatigue being the most prevalent symptom (53.1%).[2] Likewise, Townsend *et al* which evaluated 128 patients who recovered from the acute phase of COVID-19 reported persistent fatigue in 52.3% of patients at 10 weeks after initial symptoms.[3] Moreover, an analysis of data from 4,182 incident cases of COVID-19 logged in the COVID Symptom Study app revealed that 13.3% of cases had symptoms lasting >28 days, with fatigue being the most commonly reported symptom (97.7%) among those who had long COVID.[4]

We agree with Sullivan that clinicians will need to monitor for long-term complications in patients who recover from COVID-19, especially persistence of fatigue.[1] In patients who are particularly troubled with persistent fatigue, drug therapy including glucocorticoids and methylphenidate could be offered on a case-by-case basis after evaluating risks and benefits. A double-blind, randomised, placebo-controlled trial of 25–35 mg/day of oral hydrocortisone for 12 weeks in 70 patients with chronic fatigue syndrome (CFS) showed modest improvement at the expense of adrenal suppression.[5] In another randomised crossover trial, improvement in fatigue level was observed in response to 5–10 mg/day of hydrocortisone among 32 CFS patients.[6] A double-blind, randomised, placebo-controlled crossover study of 60 CFS patients evaluated treatment with methylphenidate (10 mg twice daily) compared with placebo and reported clinical improvement in 17% of patients.[7] ■

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