pain clinics within anaesthetic departments across the UK provide significant input into pain management and are often one of the 'last resorts' in the patient treatment pathway.[2,3]

While Eccles and Davies note the presence of cognitive dysfunction in patients with chronic pain conditions, they seem to not acknowledge that chronic pain is a biopsychosocial condition and must be approached as such, as identified within the International Association for the Study of Pain revised definition of pain and the proposed *International Statistical Classification of Diseases and Related Health Problems 11th revision* (ICD-11) classification criteria.[4,5] It is well recognised that psychological contributions to chronic pain and functional conditions are significant.[6,7]

While I applaud the descriptions used by Eccles and Davies to describe various approaches to chronic pain patient management as embraced by different doctors (particularly that used by Dr B), it seems to me that they then proceed further along the biomedical route by exploring hypermobility syndromes, small fibre neuropathy, mast cell activation disorders and inflammatory reactivity. This approach, in my experience, further entrenches 'illness behaviour' and distress among patients with functional chronic pain conditions and fails to approach pain management through a biopsychosocial approach. This then becomes a 'barrier to progress'.[8]

The impact of psychological illness on chronic pain symptom presentation is well recognised and a holistic approach to managing these patients through illness de-escalation and promoting improved self efficacy is, in my opinion, more appropriate. ■

RICHARD SAWYER
Consultant in anaesthesia and pain management and honorary senior clinical lecturer, Oxford University Hospitals NHS Foundation Trust, Oxford, UK

References

1 Eccles JA, Davies KA. The challenges of chronic pain and fatigue. *Clin Med* 2021;21:19–27.
2 Bridges S. *Health Survey for England 2011*. Health and Social Care Information Centre, 2012;1:291–323.
3 Dr Foster Intelligence, British Pain Society, Healthcare Quality Improvement Partnership. *National Pain Audit Final Report 2010-2012*. HQIP, 2012. www.hqip.org.uk/wp-content/uploads/2018/02/EBfI8i.pdf
4 Treede RD, Rief W, Barke A *et al*. Chronic pain as a symptom or a disease: the IASP classification of chronic pain for the International Classification of Diseases (ICD-11). *Pain* 2019;160:19–27.
5 Raja SN, Carr DB, Cohen M *et al*. The revised international Association for the Study of Pain definition of pain: concepts, challenges, and compromises. *Pain* 2020;161:1976–82.
6 Wiech K, Tracey I. The influence of negative emotions on pain: behavioral effects and neural mechanisms. *Neuroimage* 2009;47:987–94.
7 Henningsen P, Zipfel S, Herzog W. Management of functional somatic symptoms. *Lancet* 2007;369:946–55.
8 Main CJ, Spanswick CC. *Pain management: an interdisciplinary approach*. Churchill Livingstone, 2000.

Response

DOI: 10.7861/clinmed.Let.21.2.5

Editor – We thank Dr Sawyer for his interest in our paper 'The challenges of chronic pain and fatigue.' It is, of course, implicit in much of what we say that pain and fatigue have a biopsychosocial dimension. We would not otherwise be advocating a multi-professional management strategy involving significant input from mental health professionals, the avoidance of over-investigation and medicalisation and, in our index case, referral to a dedicated pain-management service. The article contextualises the psychological factors implicated from a biological perspective. Several other manuscripts in the edition give the wider psychological framing.

Many conditions present with impairment of both physical and mental health. We feel strongly that in all cases it will be the evolution of a deeper understanding of the biology and pathophysiology of these illnesses, including myalgic encephalomyelitis / chronic fatigue syndrome (ME/CFS) and fibromyalgia, that will in time lead to the evolution of more rationally-based and effective treatment strategies. Moreover, we feel that is it all too frequently the case that labelling a condition as 'biopsychosocial' or 'psychological' leads to negative perceptions among healthcare professionals, and may unfortunately result in physicians abrogating their clinical responsibilities to affected patients, as in our exemplar, Dr A. ■

JESSICA A ECCLES
Clinical senior lecturer in liaison psychiatry, Brighton and Sussex Medical School, Falmer, UK, Brighton and Sussex University Hospitals NHS Trust, Brighton, UK and Sussex Partnership Foundation NHS Trust, Brighton, UK

KEVIN A DAVIES
Emeritus professor, Brighton and Sussex Medical School, Falmer, UK and medical director, The Advisory Committee on Clinical Excellence Awards (ACCEA), Leeds, UK

SARS-CoV-2 infection despite vaccination: an under-reported COVID-19 cohort

DOI: 10.7861/clinmed.Let.21.2.6

Editor – West *et al* note the potential challenges presented by SARS-CoV-2 reinfections.[1] We argue that there is a far commoner, yet under-reported, cohort of importance, namely those who have been infected with SARS-CoV-2 after COVID-19 vaccination.

The development of COVID-19 vaccines within an unprecedented short timeframe, resulting in the delivery of the first approved COVID-19 vaccine at University Hospitals Coventry and Warwickshire NHS Trust (UHCW) on the 08 December 2020, represents a step-change in our ability to tackle the current pandemic.[2–4] However, sensible caution is still essential.

We conducted a cross-sectional audit of all COVID-19 swab positive patients at UHCW on the weekend of the 13 February 2021 (excluding intensive care admissions). Remarkably, 27 of the 174 (16%) COVID-19 inpatients had previously received a COVID-19 vaccine. The mean age of these inpatients was 82.3 years (interquartile range (IQR) 11.75), with a mean duration between vaccination and positive COVID-19 swab of 18.19 days (IQR 13.25). Eleven patients (41%) had a positive swab within 14 days of vaccination, suggesting possible infection close to the time of vaccination.

Considering these findings in a tertiary NHS hospital, it is important that the public and all stakeholders acknowledge that developing immunity against SARS-CoV-2 following COVID-19 vaccination is not instant, and that vaccinated individuals may remain vulnerable to a SARS-CoV-2 infection particularly following the first COVID-19 vaccine dose. Furthermore, widespread collection of such data is important to support current Public Health England investigations into potentially vaccine-resistant SARS-CoV-2 variants. The use of automated inter-operable digital tools to track such cases is vital. Finally, ensuring that infection control procedures are optimised at vaccine centres is also pivotal to minimise the SARS-CoV-2 infection risk during the vaccination visits, while delivering a high throughput service. Overall, it is vital that we utilise such data/evidence to support public health policies and optimise the effectiveness of this vaccination programme over the coming crucial months. ■

TIM ROBBINS
NIHR clinical lecturer, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK and Warwick Medical School, Coventry, UK

SUDHANSHU BAITULE
Clinical fellow, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK

IOANNIS KYROU
Clinical lecturer and endocrinologist, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK, Warwick Medical School, Coventry, UK and Aston Medical School, Birmingham, UK

PIJUSH RAY
Group clinical director medicine, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK

NINA MORGAN
Chief nursing officer, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK

LISA BERRY
Clinical scientist virology, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK

HARPAL RANDEVA
Director of research and development, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK, Warwick Medical School, Coventry, UK and Aston Medical School, Birmingham, UK

References

1 West J, Everden S, Nikitas N. *A case of COVID-19 reinfection in the UK. Clin Med* 2021;21:e52.
2 Polack FP, Thomas SJ, Kitchin N *et al.* Safety and efficacy of the BNT162b2 mRNA COVID-19 vaccine. *N Eng J Med* 2020;383:2603–15.
3 Folegatti PM, Ewer KJ, Aley PK *et al.* Safety and immunogenicity of the ChAdOx1 nCoV-19 vaccine against SARS-CoV-2: a preliminary report of a phase 1/2, single-blind, randomised controlled trial. *Lancet* 2020;396:467–78.
4 Radford M, Prewitt E, A marathon, not a sprint: COVID-19 vaccine rollout in the UK. *NEJM Catalyst* 2021.