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activities that could help to explain why different activities differentially activate various mechanisms of action.

We declare no competing interests.

*Daisy Fancourt, Andrew Steptoe
d.fancourt@ucl.ac.uk

Department of Behavioural Science and Health,
University College London, London WC1E 7HB, UK

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Neuropsychiatric disorders and COVID-19

We read with interest the Article by Maxime Taquet and colleagues that reports on the incidence rates of anxiety disorders after a COVID-19 diagnosis,¹ and we noted from the appendix that this outcome includes codes F40–F48 of the ICD-10. Given the known occurrence of developing post-traumatic stress disorder after admission to an intensive therapy unit,² we wondered if the authors had considered re-analysing their data to assess the incidence of post-traumatic stress disorder in survivors of COVID-19, including both those treated in intensive therapy units and those treated elsewhere?

It is very concerning that 4.72% of patients with COVID-19-related encephalopathy received a first diagnosis of dementia within 6 months. We note that the authors have included F01–F03, G30, G31, and G31.83 when defining dementia, and we wondered whether the authors were able to provide more information on the incidence rates for these different types? We believe that it would be useful to know if a particular type of dementia is observed, both to help understand the pathophysiology and to help assess patients.

In the appendix of the Article, the authors state that “for chronic illnesses, only first diagnoses were counted”.¹ In the case of dementia, were patients with a history of mild cognitive impairment (eg, F06.7) or delirium (F05) excluded? This clarification would help to establish whether COVID-19-related encephalopathy is associated with the rapid onset of dementia, or whether these patients were already a group at risk of developing dementia, considering that delirium and mild cognitive impairment can act as markers of vulnerability to dementia and can themselves lead to dementia.^{3,4}

We wondered if there were any data reporting on the psychiatric outcomes in patients with asymptomatic COVID-19 (given that it is suspected that these patients account for at least one-third of all COVID-19 cases⁵), or in patients with only mild symptoms? This information would be useful for future planning of mental health services.

Finally, given that the estimated incidence of a neurological or psychiatric diagnosis in the 6 months after a COVID-19 diagnosis was 33.62%, we would propose a number of measures. First, we would suggest that questions about past COVID-19 infection become a standard part of clinical history taking. Second, we would propose that psychiatrists become an integral part of long COVID clinics nationwide. Finally, we would like to introduce the notion of reverse redeployment, in which health-care workers from general medicine might support mental health services, given the expected increased demand after this pandemic.

We declare no competing interests.

*Elizabeth Charlton, Feroz Nainar,
Sandra Reyes-Beaman
elizabeth.charlton1@nhs.net

Birmingham Community Healthcare NHS Foundation
Trust, Birmingham B7 4BN, UK (EC, FN, SR-B)

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Maxime Taquet and colleagues reported an increased incidence of neurological and psychiatric disorders in patients diagnosed with COVID-19 (ie, group 1) compared with two matched control cohorts: patients diagnosed with influenza (ie, group 2) and patients diagnosed with any respiratory tract infection, including influenza (ie, group 3).¹ In my opinion, having two control groups containing patients with influenza is a shortcoming of the study, and patients with influenza in group 3 should have been transferred to group 2. The authors suggested that the potential mechanisms for the association of neurological and psychiatric disorders with COVID-19 include viral invasion of the CNS, hypercoagulable states, neural effects of the immune response, and psychological and other implications of a COVID-19 diagnosis for people with common psychiatric disorders (eg, mood and anxiety disorders).¹ Other mechanisms, however, should be considered. One mechanism is that morbidity could have increased if patients did not attend necessary medical appointments during the COVID-19 pandemic because of decreased access to medical services during lockdown and semi-lockdown periods or patients' anxiety at getting infected.

The authors did not report information about the anti-COVID-19 medications that were given to the patients in group 1 during or after