within 7 days of release of the interim position statements with effective transition into standard care within this time period.[2–4]

In order to evaluate the impact of the COG guidelines, we undertook a trust-wide audit of randomly selected COVID-19 patients admitted between 01 May 2020 and 30 Nov 2020. The majority of patients received appropriate therapeutic interventions during the audit time periods: dexamethasone (93%) and remdesivir (84%). Tocilizumab guidance was received in January 2021 and a further audit suggested that 86% of our patients received this treatment appropriately.

We agree with the authors and feel confident that the establishment of a local MDT has enabled our organisation to provide rapid access to therapeutic interventions in COVID-19 with high levels of concordance with local guidelines. Although NHS organisations have a wide degree of heterogeneity, we believe that the effective implementation of a local COVID-19 MDT group could have beneficial impact across the wider healthcare system. ■

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Probiotics for atopic dermatitis

DOI: 10.7861/clinmed.Let.21.4.8

Editor – We read with great attention the holistic and exhaustive review by Plant and Ardern-Jones about atopic dermatitis.[1] However, we think that the increasing use of probiotics in the prophylactic and curative management of this condition deserves more attention.

In fact, probiotics were increasingly used during the last 2 decades, notably in infants and children; and the cumulated evidence is now conclusive through several systematic reviews and meta-analyses.

Particularly, treatments with mixed-strain probiotics have greater prophylactic and curative effects to both lower the risk of atopic dermatitis and reduce symptoms in children.[2]

Interestingly, regarding the preventive effect of such probiotics, strong evidence-based proofs recently demonstrated that supplementation with probiotics in both the antenatal period (in pregnant mothers) and postnatal period (in breastfeeding mothers then in infants) was efficient to reduce the incidence of atopic dermatitis in infancy and childhood.[3,4]

The era of microbiome-targeting drugs is here, and probiotics ought to be considered as a powerful, adjunct, preventive and curative therapy; especially in the paediatric population. ■

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Novel psychoactive substance

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Editor – We read with interest the article entitled 'Acute neurological consequences of novel psychoactive substance use: a retrospective review in a large UK hospital' by Tanti *et al*.[1] The team have effectively highlighted the high rates of psychiatric comorbidity, unemployment, homelessness and incarceration in this vulnerable group in society. However, the paper may have benefitted from involvement of a clinical or analytical toxicologist to prevent several inaccuracies. Lack of analytical confirmation in any patient is a major limitation; self-reporting of substances of abuse (especially novel psychoactive substances (NPS)) is known to be unreliable. It is misleading to state 'unfortunately, drug screens do not detect novel psychoactive substances' since, while basic point-of-care immunoassay-based tests will not detect

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NPS, analytical confirmation of NPS is now available in several NHS laboratories. The authors refer to testing being possible only 'by specialised techniques like gas chromatography'; most NHS laboratories have moved away from gas chromatography to ultra-performance liquid chromatography (UPLC), tandem mass spectrometry (MS/MS) or time of flight (TOF) for NPS detection.

The abstract states 'Synthetic cathinone users presented with psychiatric disturbance or seizures (55%)'; this percentage does not correlate with the values in Table 2. There are certain errors of nomenclature in the article. The authors refer to 'THC receptors' while the correct terminology is cannabinoid (CB_1 and CB_2) receptors. Synthetic cannabinoids have been abbreviated in the text to SCs, yet 'SCRAs' (synthetic cannabinoid receptor agonists) is the widely accepted acronym used.

Finally, there seems to be some confusion regarding the provision of toxicology guidance and advice to the NHS. The authors refer to 'poisons services like TOXBASE'; the National Poisons Information Service (NPIS) is a service commissioned by the UK Health Security Agency (formerly Public Health England); TOXBASE is the primary clinical toxicology information database written by the NPIS. ■

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Health and work

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Editor – I welcome, very much, the recent review of health and work by Walker-Bone and Hollick.[1] They correctly point out that all physicians, and other healthcare professionals (HCPs), have a responsibility to provide support and advice to disadvantaged individuals (DIs) whose ability to work is impaired due to health or other disadvantage.[2] Often the nature of the disadvantage relates not only to impaired physical or mental health issues but also to other factors (eg poverty or pre-existing disability).[3,4] They helpfully discuss the difficulties that many doctors have in discussing work issues with DIs and perhaps a simpler introduction to this area can be found in *Talking work*.[5]

I strongly support their views that:

- DIs should be encouraged to return to work (RTW) if there are any aspects of their work that they can continue to perform
- reasonable adjustments are an important component of facilitating a RTW
- supportive employers can do much to prevent ill health at work (eg through wellbeing programmes etc).[1]

The inter-relationships between health and work are broader than this review suggests. For those with illness or injury early in life, paediatricians and general practitioners (GPs) need, in addition to supporting education, to encourage such young people to develop self-confidence and gain exposure to role models so that aspirations to enter work are encouraged at an early age.[6,7]

For those who are working and who are subject to an accident or illness, it is important that 'work' is raised with the patient or their family early in the course of the illness in order to advise them to remain in contact with their employer. This is also the time to reassure DIs that there are many ways to facilitate a RTW in spite of severe difficulties.[8] To facilitate a RTW, or remaining in work, in addition to the employers options mentioned by Walker-Bone and Hollick, flexibility at work is very commonly cited as is the ability to work from home (a facility that employers are now much more likely to consider than previously).[1,4,9] Perhaps the most important concept for DIs, HCPs and employers is that RTW does not depend upon a full recovery/health being achieved.

Walker-Bone and Hollick also refer to the lack of occupational health (OH) resources, particularly in smaller businesses. It is important to realise that rehabilitation professionals are also able to facilitate a RTW after illness/injury, although many rehabilitation teams lack expertise in vocational rehabilitation. Consequently, a new industry has developed, mostly funded by the private sector, using case management as a tool to facilitate good rehabilitation and RTW when applicable.[7] Such teams liaise with OH when available.

Once it has been established that an employer is unable to continue to employ a DI in either their old or different roles, then different skills are needed to support the DI back into work. Such assessments will include not only background education and skills but also how many skills are transferable and whether hobbies or other interests can support that individual back into work. While there is an important role for job coaches from the Department for Work and Pensions (DWP) Jobcentre Plus, vocational rehabilitation professionals (from many professional backgrounds) can assist the finding of new work which should not exclude the potential for self-employment.[7] The DWP has a wide variety of schemes to support DIs, possibly the most frequently used being the Access to Work Scheme (AtW; www.gov.uk/access-to-work). Those eligible are offered support based on need, which may include a grant to help cover the costs of practical support in the workplace including towards the costs of special equipment, adaptations or support worker services to assist in the workplace and help getting to and from work. Clinicians should be aware of the scope of assistance available to their patients from the DWP in addition to the correct use of fit notes so ably described by Walker-Bone and Hollick.[1]

For DIs with more complex problems, they should consider liaison with:

- appropriate rehabilitation service where available
- occupational health department where available
- DWP
- the voluntary sector:
  - general advice (eg Scope, Leonard Cheshire Disability or Disability Rights UK)

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