Letters to the Editor

The Importance of Keeping Patients with Post-Acute Sequelae of SARS-CoV-2 Infection (Long COVID) Engaged in Work

To the Editor: Post-acute sequelae of SARS-CoV-2 infection (PASC), also known as long COVID, can have lasting effects on patients. A World Health Organization report found that up to 10% of people with COVID-19 are still symptomatic at 12 weeks.[1] Symptoms include excessive fatigue, cough, chest pain, shortness of breath,[2] and cognitive complaints of concentration and memory,[1] which, in the authors' experience, patients may refer to collectively as "cognitive fog."[3] A disability can negatively affect a person's ability to work and perform basic activities of daily living.

The prevalence of persistent PASC symptoms may lead people to leave their jobs temporarily. The American College of Occupational and Environmental Medicine advises that prolonged absence from the workplace is detrimental to a person's mental, physical, and social well-being.[4] A 2006 British government report commissioned by the Department for Work and Pensions introduced the concept of worklessness and noted the strong association between worklessness and ensuing poor health.[5]

The best way to help patients with mild to moderate symptoms of PASC stay functionally engaged is appropriate workplace accommodations and an adjustment to a job or work environment that makes it possible for a person with a health-related disability to make a timely and safe return to work and to perform their job duties effectively. Accommodations are guided by physician-directed restrictions and limitations, broadly defined as:

- Restrictions generally address risk and indicate tasks that a person is capable of doing at work but should not do for medical reasons;
- Limitations generally address capacity and speak to what a person is not currently capable of doing at work for medical reasons.

Primary care and occupational medicine physicians can advise human resources or management leaders on structured, individual return-to-work strategies for patients with PASC.[6] Examples of typical accommodations related to fatigue, which is a common limiting symptom of PASC, include reduced time at work, reduced work volume, starting work later to compensate for sleep disruption, increased liberty to self-pace the workload, avoiding tight deadlines, or being excused from more complex work that has higher cognitive demands.

The long-term prognosis of post-acute sequelae of SARS-CoV-2 infection is unknown; therefore, accommodations should be periodically reassessed and adjusted based on the patient's clinical progress. Appropriate physician accommodation guidance for patients with post-acute sequelae of SARS-CoV-2 infection can preserve their remaining functionality and protect against the secondary effects on the health of worklessness.

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6. Baptista MC, Burton WN, Pawlecki B, et al. A physician's guide for workers' return to work during COVID-19 pandemic. *J Occup Environ Med*. 2021;63(3):199-220.

Email letter submissions to afplet@aafp.org. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors. Letters submitted for publication in *AFP* must not be submitted to any other publication. Letters may be edited to meet style and space requirements.

This series is coordinated by Kenny Lin, MD, MPH, deputy editor.

Primary Care Is Essential in Screening, Treating, and Referring People for Unhealthy Drug Use

Original Article: Evidence Lacking to Support Universal Unhealthy Drug Use Screening [Editorial]

Issue Date: January 15, 2021

Available at: https://www.aafp.org/afp/2021/0115/p72.html

To the Editor: The U.S. Preventive Services Task Force (USPSTF) recommends screening adults 18 years and older by asking about unhealthy drug use; however, the American Academy of Family Physicians (AAFP) disagrees that there is sufficient evidence to assess the benefits and harms of screening in adults except for opioid use disorder. The AAFP justifies this recommendation by noting, "Screening programs should only be implemented if services for accurate diagnosis, effective treatment, and psychosocial supports can be offered or referred."

We are concerned with the AAFP's departure from the USPSTF recommendations and with the framing of Drs. Coles and Vosooney's editorial. Although opioid use disorder is of significant importance and a contributor to the prescription drug overdose epidemic, other substances are also important contributors in unhealthy drug use *(Table 1*[1-3]*)*. Tobacco use is the leading preventable cause of death in the United States, and more people consume alcohol than any other substance.[4] Clinicians have effective modes of diagnosis, treatment, and support for the unhealthy use of these substances.

Although the USPSTF does not include tobacco and alcohol in its definition of unhealthy drug use, the editorial does not clarify this point. Additionally, cannabis use and cannabis use disorder outnumber opioid-related issues; there are clear criteria for cannabis use disorder, and psychosocial approaches are helpful.[5]

Primary care is essential in screening, treating, and referring people for substance use disorders. The title of the editorial may send the wrong message to our colleagues and worsen public health outcomes.

The editorial also suggests that because no resources are available to treat a specific disease in a community, the community should not be screened for the disease. This argument is myopic and actively contributes to the large gaps in care found in low-income rural and urban communities. Screening for unhealthy drug use and opioid use disorders is one way to provide the leverage to bring more resources into these communities. Now is the time that we need to be more inquisitive and attentive to unhealthy drug use because of widespread impacts on public health.[3,4]

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TABLE 1

Use of Substances and Rates of Disorders among Adults

Substance	Number of past-month users (millions)	Past-year use disorder rates
Alcohol	137.3	5.6%
Tobacco	57.1	20%
Cannabis	29.8	1.7%
Cocaine or methamphetamines	3.1	0.4% to 0.8%
Prescription pain reliever misuse or heroin	3.1	0.6%

Information from references 1-3.

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In Reply: Thank you for the comments on our editorial. The USPSTF recently recommended screening for unhealthy drug use by asking about use in adults 18 years and older. The AAFP disagreed and believed that there was insufficient evidence to support screening of adults, except for selective screening for opioid use disorder.[1] The AAFP agrees with the USPSTF recommendations regarding tobacco and alcohol use disorders. The AAFP and USPSTF recommend that clinicians ask all adults, including pregnant people, about tobacco use and offer evidence-based treatments, including behavioral interventions and pharmacotherapy when appropriate.[2] The AAFP and USPSTF agree that clinicians should

screen for unhealthy alcohol use in individuals 18 years and older, including pregnant people.[3]

Excluding tobacco and alcohol use disorders, there are no direct studies of the risks and benefits of universal screening for substance use disorders.[4] The preponderance of data about interventions for substance use disorders is obtained from treatment-seeking populations with opioid use disorder. It is inappropriate to apply these findings to screen-detected populations or patients using other substances. A systematic review commissioned by the USPSTF found that psychosocial interventions were ineffective in preventing drug use or its related consequences for cannabis use disorder in screen-detected populations.[5] Effective treatments and interventions must already be in place for a screening program to benefit the screened populations.

Screening for substance use disorders does not come without risk and potential harm to the screened individual. Risks of screening include labeling, stigmatization, and medicolegal consequences. Individuals are also at greater risk of experiencing discrimination and stigma within the health care system. Health care professionals can have a negative attitude toward individuals with substance use disorders, and these attitudes directly impact a patient's care, feelings of empowerment, trust in the health care system, and clinical outcomes.[6] Without evidence-based clinical care and access to community resources to positively impact the health and experience of the screened populations, screening for substance use may cause further harm rather than help. Further research in screening and investment in evidence-based substance use disorder treatment are imperative, especially in rural and urban underserved areas.

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Editor's Note: Drs. Coles and Vosooney are members of the Subcommittee on Clinical Recommendation and Policies of the AAFP Commission on the Health of the Public and Science.

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All Patients Undergoing Any Surgical Procedure Should Be Assessed for Frailty

Original Article: Preoperative Evaluation and Frailty Assessment in Older Patients [Lown Right Care]

Issue Date: December 15, 2020

See additional reader comments at: https://www.aafp.org/afp/2020/1215/p753.html

To the Editor: We appreciate Dr. Lindsay and colleagues' efforts to address this topic. Primary care physicians often make the decision to refer patients to surgeons, and considering frailty is important. However, the statement, "Patients who are frail and very frail who had lower-stress procedures, such as cystourethroscopy or hydrocele surgery, were shown to have higher 30-day mortality rates than those who had the high-stress procedures, such as lung resection or liver transplant," warrants clarification.

The study referenced by the authors found that patients who are frail and very frail had high postoperative mortality rates regardless of the level of stress of the operative procedure.[1] Although the mortality rate was slightly higher in patients undergoing higher-risk procedures, the authors did not conclude that this was because these procedures are less risky for patients who are frail and very frail. Instead, the authors concluded that surgeons and others in the care team recognized that patients who were frail and very frail needed extra pre- and perioperative attention for the highest-risk procedures. Therefore, the outcomes were not as bad. Another possibility is that surgeons only offered procedures considered to be riskier to patients who were frail and had some other resilience factor that the Risk Analysis Index did not measure.

All patients who undergo any low- or high-stress surgical procedure should be screened for frailty because all surgical procedures are high-risk for a patient who is frail. Another study showed that patients who are frail have worse outcomes even with ambulatory procedures, such as hernia, breast, thyroid, or parathyroid procedures.[2] A subsequent study found that with both low- and high-risk procedures,

the level of frailty is directly associated with failure to rescue (i.e., death after potentially preventable complications).[3] Therefore, the primary care team should recognize this risk when deciding to refer patients for any surgical procedure and determine how to optimize the peri- and postoperative outcomes or whether to forgo the procedure.

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In Reply: I thank Drs. Tamesis and Spencer for emphasizing the importance of screening all patients for frailty who will undergo any surgical procedure. However, I would like to emphasize that screening with the Risk Analysis Index (https://bit.ly/2Mo6ECe) helps physicians make appropriate clinical decisions and mitigate operative risks proactively and is vital for shared decision-making so patients and their families can make informed decisions about the benefits and risks of procedures.[1] Helen Haskell and John James, patient partners for the Lown Right Care series, also suggested that clinicians discuss surgical risk with patients rather than use the term "frailty," which may be a source of distress.

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Reference

1. Shinall MC Jr., Youk A, Massarweh NN, et al. Association of preoperative frailty and operative stress with mortality after elective vs. emergency surgery. *JAMA Netw Open.* 2020;3(7):e2010358.

Corrections

Missing reference text. In the article "Cerebrospinal Fluid Analysis," (April 1, 2021, p. 422) the full citation for reference 60 was inadvertently truncated (page 428). The full citation should have read: "60. Zorofchian S, Iqbal F, Rao M, et al. Circulating tumour DNA, microRNA and metabolites in cerebrospinal fluid as biomarkers for central nervous system malignancies. *J Clin Pathol.* 2019;72(4):271-280." The online version of this article has been corrected. ■