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**Authors' reply**

We are grateful for the letters received regarding our Article,<sup>1</sup> which highlight the interest in this field and raise relevant clinical hypotheses. These letters illustrate a fundamental question: does infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) lead to psychiatric and neuropsychiatric morbidity merely because COVID-19 is a severe illness or because of specific factors related to this infection?

There are numerous—but still comparatively rare—examples of specific neuropsychiatric presentations of COVID-19 being collated in an online blog for the *Journal of Neurology, Neurosurgery & Psychiatry*.<sup>2</sup> Yi-Min Wan and colleagues are correct that anosmia requires more

attention, as do stroke and other neurological conditions. Current literature has not often systematically assessed anosmia,<sup>3</sup> and pathological studies have been unable to elucidate whether this symptom is due to direct infection or secondary to mucosal involvement.<sup>4</sup>

Vijay Pattni and colleagues correctly observe that the frequency of post-traumatic stress disorder (PTSD) following admission to an intensive treatment unit is high, regardless of the illness. However, it is also probable that factors specific to the current pandemic are relevant, such as extreme social isolation, staff wearing full personal protective equipment, health-care professionals working outside their primary area of expertise, treatment with corticosteroids, and use of second-line agents for sedation. Current naturalistic studies struggle to disentangle these issues.

Any recommendations should be proportionate and evidence-based. Pattni and colleagues suggest screening to identify patients at risk of developing PTSD, but we should exercise caution,<sup>5</sup> since outcomes could be variable and targeting individuals who have yet to develop a psychiatric disorder could have unintended consequences.<sup>6</sup>

Before implementing novel interventions, further research is required to identify an evidence base and subsequently establish clinical guidelines for minimising psychological harm after infection with SARS-CoV-2. Equally important, as suggested by Latha Velayudhan and colleagues, is implementation of existing evidence, such as appropriate management of delirium, which is likely to be seen frequently.

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