New wine in old skins

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The update for this edition begins with our CME topic, dermatology. An often-overlooked specialty (except before MRCP examinations), it remains an essential specialty of which to have knowledge for the general physician, both because of the frequency of the common dermatological conditions but also for the potential to reveal important aspects of internal disorders. And with the drive for an increasingly technocratic practice of medicine, such careful clinical observation and knowledge is especially vital. We are fortunate to have had Emma Benton from St John's Institute of Dermatology curate a selection of outstanding reviews on common disorders such as eczema and psoriasis as well as the importance of the dermatological clues to systemic diseases.[1–5]

So much for the 'skins' in the title, what of the 'new wine'. There is an emerging range of alluringly named novel psychoactive drugs: spice, whippits or meow-meow. An increased focus on drug awareness, prevention and rehabilitation is one of the options for us as we move to integrated care systems. But for the physician, recognising the acute presentations and having an update on the acute treatment for these patients is key. Tanti and colleagues provide such an article based on a review of their population in Leeds, UK.[6]

A timely paper on a more conventional 'novel drug' comes from the Association of British Clinical Diabetologists with regard to the use of sodium glucose co-transporter 2 inhibitors being increasingly used in primary care and by physicians from a range of non-diabetes specialisms.[7] These drugs have the slight potential to induce diabetic ketoacidosis in people with type 2 diabetes, and need to be used judiciously. The paper provides direct suggestions on how physicians might discuss their use with patients and there is a useful link to a practical document to share with the patient to help them understand safe and effective use of the medication.

Another manuscript we are pleased to include in this edition of *ClinMed* is a committee summary of the update on consent for blood transfusion in light of the 2015 legal guidance on informed consent.[8] That legal precept established that a patient should be told whatever they want to know, not what the doctor thinks they should be told. The duty of care to warn of material risks is especially relevant in the context of blood transfusion and, as such, is of great relevance to all healthcare professionals.

And to conclude on the topic of the old, it may seem eccentric to consider COVID-related material thus. But, by now, all of us in practice have had such an induction into the various aspects of the disease – from the perspective of virology and immunology, global epidemiology, vaccine development, acute clinical practice, rehabilitation and management of chronic symptoms. And certain issues have remained constant throughout, and we continue to publish thought-leads on these topics – optimising personal protective equipment, emerging viral mutations and healthcare worker safety.[9–12] One of the consequences of the epidemic has been to make many doctors think of their work as a potential source of illness, both acutely and in the potential to contribute to burnout. A review by occupational medicine colleagues is a superb introduction to taking a focused work history.[13] As we reflect on how to detect our own health risks from work, it can only be beneficial to extend this to our patients to ensure their safe work participation. The secular moral of the parable of the title is to adapt our practice to prevailing knowledge, which remains at the core of all that is published in the journal.

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