Comments on the SEPAR Guidelines for the Diagnosis and Treatment of Drug-Resistant Tuberculosis☆

Comentarios a la normativa SEPAR de diagnóstico y tratamiento de la tuberculosis con resistencia a fármacos

To the Editor,

We are grateful to Dr. Pascual for his insightful comments[1] on our recently published guidelines on the diagnosis and treatment of drug-resistant tuberculosis (TB).[2] His letter addresses 2 points that we would like to discuss further.

We fully agree with the first of his comments, regarding the good anti-*Mycobacterium tuberculosis* activity of bedaquiline and delamanid. As shown in Table 3 of our guidelines,[2] the effectiveness of these new drugs prompted us to include them among the core drugs (our group 4) instead of among the add-on agents (Group D) recommended in the 2016 WHO recommendations[3]; we agree that these 2 drugs should have been included in WHO group C.[3] As early as 2015, our group published an article in the *European Respiratory Journal*, proposing that these new drugs (along with linezolid) should even be positioned above second-line injectable drugs.[4] The reason for not including these drugs in treatment regimens from the outset is not so much financial, but because we feel that evidence for such use is still scant. The inclusion of these drugs in group 4 illustrates our view: they are very good but evidence is still lacking. However, by including them in group 4, we are providing the option for their use in MDR-TB regimens.

As for shorter MDR-TB regimens, Dr. Pascual rightly points out that many issues remained unclear in the 2016 WHO publication.[3] For this reason, and because of concerns surrounding the applicability of these regimens in practice, the WHO subsequently published an article which addressed many of these controversies.[5] In it, they stated that the decision to use shorter regimens should not be based on sensitivity testing to the drugs in the regimen, other than fluoroquinolones or second-line injectables. This is because sensitivity results for these drugs, including pyrazinamide, are unreliable. The authors go so far as to say that even if resistance to pyrazinamide is observed, the clinician can consider using these shorter regimens.[5] Furthermore, our recommendation not to use these regimens in pregnant women and in extrapulmonary TB is based on a lack of evidence, even though we are aware that they are used in these patient groups in some countries.

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José A. Caminero,[a,b,c,*] Joan A. Caylá,[c,d] José-María García-García,[c,e] Francisco J. García-Pérez,[c,f] Juan J. Palacios,[c,g] Juan Ruiz-Manzano[c,h,i]

[a] *Servicio de Neumología, Hospital General de Gran Canaria Dr. Negrín, Las Palmas de Gran Canaria, Las Palmas, Spain*
[b] *Unidad de Tuberculosis con Multi-Drogo Resistencia, Unión Internacional contra la Tuberculosis y Enfermedades Respiratorias (La Unión), París, France*
[c] *Programa Integrado de Investigación en Tuberculosis (PII TB) de la Sociedad Española de Neumología y Cirugía Torácica SEPAR, Barcelona, Spain*
[d] *Servicio de Epidemiologia, Agència de Salut Pública de Barcelona, CIBER de Epidemiología y Salud Pública (CIBERESP), Barcelona, Spain*
[e] *Unidad de Gestión Clínica de Neumología, Hospital Universitario San Agustín, Avilés, Asturias, Spain*
[f] *Servicio de Neumología, Hospital Universitario de La Princesa, Madrid, Spain*
[g] *Unidad de Referencia Regional de Micobacterias, Servicio de Microbiología, Hospital Universitario Central de Asturias, Oviedo, Asturias, Spain*
[h] *Servicio de Neumología, Hospital Universitario Germans Trias i Pujol, Badalona, Barcelona, Spain*
[i] *CIBER de Enfermedades Respiratorias (CIBERES), Barcelona, Spain*

* Corresponding author.
E-mail address: jcamlun@gobiernodecanarias.org (J.A. Caminero).

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GesEPOC Guidelines in the Elderly: Still a Long Way to Go☆

Guías GesEPOC en ancianos: todavía camino por recorrer

To the Editor,

We would like to congratulate the authors of the updated GesEPOC guidelines,[1] a document that when it was first published marked a turning point in the management of chronic obstructive pulmonary disease (COPD) in Spain. These guidelines have now been enriched by contributions from new scientific societies and a more comprehensive and integrated perspective. However, as with many other diseases, the treatment of COPD in the elderly patient is very complex, and it can be particularly difficult to address all the factors associated with aging. We believe, then, that some of the following suggestions may be helpful in subsequent revisions of the document.

When analyzing geriatric syndromes that play a significant role in the different diagnostic and therapeutic procedures, we must look beyond the conventional clinical evaluation. A comprehensive geriatric assessment must include not only social factors, but also situations such as visual and auditory defects, functional and cognitive deficits, and musculoskeletal disorders such as sarcopenia.

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The latter, for instance, can impact on the inhalation technique, impeding the correct use of devices and influencing diagnostic accuracy.

Moreover, while comorbidities have been recognized as a major factor in the management of COPD patients, additional problems such as dementia, including early-stage disease, must be taken into account in the elderly. Exacerbations are associated with cognitive impairment, and can even be a key factor in destabilizing a patient, tipping the scales toward a diagnosis of acute confusional state or dementia.[2] The significant comorbidity burden in this population means that polypharmacy is almost unavoidable, and this increases the risk of pharmacological iatrogeny in an already vulnerable population. Deprescription, the use of corticosteroids and their side effects, and the need for a simpler approach to high blood sugar are some of the aspects that must be addressed in future consensus documents.

A very important factor that must also be taken into account is the concept of frailty. The prevalence of frailty and pre-frailty in this population has been reported in some studies to be 6.6% and 41.3%, respectively.[3] These figures in themselves reflect the importance of detecting this clinical characteristic in order to provide early intervention.[4] Closely linked to the concept of frailty is the concept of functionality. Conventional models are based on the quantitative and qualitative evaluation of diseases, and focus mainly on this paradigm. However, this old-fashioned system of approaching medicine on the basis of isolated diseases has become outdated.[5] The health of elderly individuals must be measured in terms of function and not disease, since functionality is the parameter that determines life expectancy and quality of life, and the support and resources that our patients will require, and is one of the best indicators of health status and a predictor of adjuvant disability.

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Nicolás Martínez-Velilla,[a,b,c,*] Cristina Ibarrola Guillén,[c] José Javier Celorrio Astiz[c]

[a] *Servicio de Geriatría, Complejo Hospitalario de Navarra, IdiSNa, CIBER de Fragilidad y Envejecimiento Saludable, Pamplona, Navarra, Spain*
[b] *Instituto de Investigación Sanitaria Navarra (IdiSNA), Pamplona, Navarra, Spain*
[c] *Servicio de Efectividad y Seguridad Asistencial, Servicio Navarro de Salud-Osasunbidea, Pamplona, Navarra, Spain*

* Corresponding author.
E-mail address: nicolas.martinez.velilla@cfnavarra.es
(N. Martínez-Velilla).

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Non-Invasive Ventilation in Non-COPD Subjects With Pneumonia: Benefits and Potential Complications☆

¿Ventilación no invasiva en pacientes con neumonía sin EPOC? Efectos beneficiosos y aspectos a tener en cuenta para evitar potenciales complicaciones

To the Editor,

Non-invasive mechanical ventilation (NIV) is a common treatment option, but its use in patients with severe acute pneumonia (SAP) admitted to an intensive care unit (ICU) is controversial.[1] Rapid detection of any signs of failure is essential after applying appropriate first-line NIV in carefully selected patients, since delay in performing endotracheal intubation (ETI) is a factor for increased mortality.[2]

We read with great interest the study of Rialp et al.[3] on the use of NIV in patients with SAP but without chronic obstructive pulmonary disease (COPD). However, we believe that some key aspects need to be clarified, due to the practical implications associated with the interpretation and potential application of their findings in routine practice.

Firstly, the interpretation of $PaCO_2$ values in non-COPD patients is controversial. The authors report that $PaCO_2$ was higher in patients treated with first-line NIV than in those who received first-line invasive mechanical ventilation (MV). This bias is unclear, and in our opinion, it is difficult to conclude that none of the study patients included in this study had COPD purely on the basis of symptoms of dyspnea, chronic cough, and expectoration, since spirometric data are essential to establish a diagnosis of COPD. We believe then that other factors must be taken into account that might possibly explain the hypercapnia values in both groups.[4]

Useful key points to consider may be that these higher $PaCO_2$ values were due to variations in the time of starting NIV in the ICU, the types of devices and ventilatory modes used, the criteria used for performing ETI, bicarbonate levels, and associated comorbidities, among others. These variables were not fully reported in the study, and may clarify the high rate of failure of NIV compared to other studies.[1]

Secondly, the speed of the decision to perform ETI is a key factor in therapeutic response. We consider a delay of 22 h before ETI to be very high, and this may have resulted in the higher mortality and response to invasive MV.

Thirdly, the authors consider that NIV failure was associated more with a situation of shock and worse response to NIV, but this topic is controversial and, as shown in a recent European survey, the use of NIV is not absolutely contraindicated and first-line ETI may confer a higher risk.[4]

Finally, we do not know if the authors found an improvement in NIV outcomes after 10 years of use, as reported in other series,[5] so

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