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.

References

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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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