despite the theoretical benefits SM may have.[2,3] Even the spread of scientific papers is more efficient when the content of these papers is posted on the SM.[4,5]

This theoretical framework—extrapolated to the intensive care unit (ICU) setting—can be the ideal launchpad to increase our visibility. Reaching higher rates of credibility and trust in our actions largely depends on how society sees us, especially in the tragic pandemic we are all going through. Also, this technology opens the door of bidirectional communication with the patients and their families. Something we could use to adapt ourselves to their needs and reflections. On the other hand, our work—that on many occasions benefits from a multidisciplinary and multicenter approach—can use SM to forge alliances and participation in collaborative, cross-sectional studies.

In our setting, health and ICU professionals are beginning to access the world of SM. Results are apparently positive. However, no detailed analysis has ever been conducted on the impact these strategies have despite the different ways of measuring such an impact.

In the intensive medicine setting we cannot turn our backs to this reality. We need training to avoid being behind our time compared to our patients and citizens in general. We live an important moment for our medical specialty. Unfortunately, the SARS-CoV-2 pandemic has brought ICUs to a critical point regarding occupation, and we have had working, almost, to the point of collapse. At the same time, our specialty is seen very positively by society, and we receive letters—almost daily—sent to our units appreciating the work we do. We should draw the positive aspects of the worst global health crisis in recent memory: strengthen the positive image society has now, promote scientific spreading, and increase the awareness towards the work that we do. Therefore, the proper use of the SM is going to be of paramount importance in the years to come.

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Temporary pacing with active fixation leads: Should the femoral approach be the access of choice?☆

Marcapasos transitorios con electrodos de fijación activa: ¿debe ser la vía femoral el acceso de elección?

Dear Editor,

We wish to congratulate Keituqwa Yáñez et al.[1] for publishing the first series on transvenous temporary cardiac pacing using an active-fixation permanent pacemaker electrode via femoral access. The authors confirm the information that–compared to the passive-fixation ones– active-fixation permanent pacemakers minimize one the main complications: electrode displacement.[2] The authors say that with femoral access the venous access commonly used can be spared for definitive pacemaker implantation without more infections and with a minimum percentage of puncture related complications.[1]

Although this study has some limitations due its retrospective nature, here are a few comments on the femoral access:

1 *Puncture related complications:* the authors describe only 1 complication associated with puncture.[1] However, the appearance of these complications largely depends on the technique used rather than the access route.[2,3] Ultrasound-guided vascular accesses have simplified the technique and minimized complications. Compared to subclavian access ultrasound-guided internal jugular access facilitates fast catheterizations and reduces pulmonary complications like pneumothorax or hemothorax. Also, it minimizes vascular complications compared to x-ray guided punctures or punctures guided by anatomical references.[2,3] Similarly, jugular access would facilitate the access of electrodes to the right ventricle making the entire procedure much easier.
2 *Venous access preservation:* most permanent pacemakers are often implanted via left subclavian access even in patients who previously require transient pacemakers. Although femoral access would prevent upper extremity thrombosis, the big picture is that the forseeable effect would be marginal as confirmed by the fact that most

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patients included in the jugular access series would be implanted with a permanent pacemaker.[2]

3 *Infections and thromboembolisms:* it is well-known that femoral electrodes are associated with local infection and sepsis, as well as deep vein thrombosis and pulmonary embolism. Authors report on the limited appearance of infections and lack of thrombotic events. Providing information on whether infectious or thromboembolic prophylaxis was used could shed light on how to understand the study much better.[4,5]

4 *Delay until definitive pacemaker implantation:* finally, we would like to say that most complications increase the longer the time until definitive pacemaker implantation. Although the cause of bradyarrhythmia can be reversible, most patients will end up being implanted with a definitive pacemaker. In this study, 32 out of a total of 35 patients (91.4%) received a permanent pacemaker with a mean time elapsed until implantation of 4.9 ± 4.6 days. Although the authors say that it is a short waiting time, minimizing these times–in case of forseeable nonreversible bradyarrhythmias–could lead to fewer complications by just generalizing these procedures.

In conclusion, we agree with the authors on the utility of usingactive-fixation electrodes to prevent electrode displacement. However, based on the information currently available, we believe that ultrasound-guided jugular puncture and the early implantation of definitive devices should be considered the strategy of choice.

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Dexametasona en COVID-19: ¿un medicamento para todos?

Dexamethasone in COVID-19: does one drug fit all?

Dear Editor,

The COVID-19 pandemic challenged clinicians worldwide to treat a new and unknown disease. With more than 95 million confirmed cases since its beginning[1], a lot of effort has been made to identify the best possible treatments.

The RECOVERY trial[2] provides strong evidence in favor of the administration of 6 mg of dexamethasone for ten days once a day in COVID-19 patients, if requiring at least oxygen supplementation (the incidence of death in the dexamethasone group compared to the usual care group was 23.3% vs 26.2% for patients receiving oxygen, and 29.3% vs 41.4% for patients under mechanical ventilation at the time of randomization). This finding changed the WHO therapeutic guidelines for patients with COVID-19[3] and triggered into clinicians the automatic binomial prescription: oxygen therapy-dexamethasone. In the current pandemic era, where everyone is searching for the magic bullet, and no clear evidence is available on any therapeutic agent capable to reduce mortality, having this option with such a familiar drug gave back to clinicians the feeling of having at least a weapon.

The trial findings were confirmed also in a recent meta-analysis[4] including more than seven thousand patients: overall mortality was significantly lower in the corticosteroids group (26% vs 28%, relative risk {RR} = 0.89 [95% confidence interval {cI} 0.82-0.96], p=0.003). However, for COVID-19 patients not requiring oxygen the meta-analysis suggested an increase in mortality in patients receiving corticosteroids (17% vs 13%, RR = 1.23 [95% CI 1.00-1.62], p = 0.05).

The rationale for the use of dexamethasone is the mitigation of the inflammatory organ injury that may occur during SARS-CoV-2 infection. In the RECOVERY Trial the benefit of dexamethasone was indeed clear when inflammatory lung damage was more likely to be common, that is supposed to be in those patients treated ''more than 7 days after symptom onset''. However, as mentioned by the authors of the trial, only a subgroup of severe COVID-19 patients showed significant elevation in inflammatory biomarkers (such as C-reactive protein and ferritin), and unfortunately the ''inflammatory lung damage'' was advocated but not assessed.

Beside the desired anti-inflammatory effect, dexamethasone is also known for its immunosuppressive properties, that can lower resistance to bacterial and viral infections through a cell-mediated mechanism. Although steroids were recently found not to affect time to negativization of nasopharyngeal swab in a cohort of 280 Italian patients[5], the development of secondary opportunistic infections certainly remains a major issue, affecting patients' outcome.

Furthermore, as well as corticosteroids increase mortality in patients not requiring oxygen therapy[4], it is reasonable to think