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LETTER TO THE EDITOR

Intensive Care Medicine: Quiet leadership versus protagonist in times of SARS-CoV-2 pandemic crisis☆

Medicina Intensiva: Liderazgo callado frente al protagonismo en tiempos de crisis por la pandemia causada por SARS-CoV-2

Sir,

The SARS-CoV-2 pandemic has evidenced human frailty in the face of Nature, and we have seen that the modern healthcare systems of the Western world are not as widely capable as we had come to believe.

It seemed little imaginable that the scarcity of healthcare resources suffered in the Europe of today would prove reminiscent of the situation experienced almost a century ago during the Copenhagen polio epidemic.[1] We not only lacked structural resources during the hardest days but also suffered or feared possible shortcomings in crucial areas such as personal protection equipment, consumables and even drugs - forcing us to ration the available resources and reorganize ourselves under precarious conditions.

It is in such situations of extreme need when professionals - in the maximum sense of the word - emerge. The medical and nursing staff of the Intensive Care Units have worked to exhaustion during the hardest days, in an act of sacrifice until there was practically nothing left.

We have learned on the run from the immediately preceding experiences of our colleagues in other countries, and even from other Spanish regions that were particularly heavily affected in the first days, and who were combating the ''snowball'' effect we were witnessing, with an exponential increase in the number of cases. The social networks proved crucial in the process of sharing information among professionals, and as such constituted a truly unprecedented form of communication.

Within the profession we also witnessed a negative phenomenon from the deontological perspective: a desire for protagonism. Particularly in the social networks, but also in the communications media, we have seen interviews of healthcare professionals seeking their moment of glory in the midst of the crisis – making a populist and scantly professional use of information, and acting as prophets moved more by inspiration than by science. Another example of such opportunism has been the demand on the part of some individuals – in the hardest times of the crisis – for a personal place in the interventional organogram designed to cope with the disease, attributing themselves with capacities not consistent with their own specialization. A truce in this classical power struggle between specialties would have been desirable, as an act of elegance and in respect for the victims and the profession. It is in the great historical moments – and this has been one such moment – when the role of the professionals takes on special significance and importance.

The specialty of Intensive Care Medicine has participated in the crisis exerting a quiet leadership evidenced at the point of care and by the generation of documents of enormous value – not only in view of the moment in which they were published,[2,3] but also due to the prudence and rigor of their contents and the teamwork of the working groups of the Spanish Society of Intensive Care Medicine.[4,5] The public appearances fundamentally rested upon the Chairperson of the SEMICYUC and the main coordinators of the national contingency plan and the working groups. It was not a moment to seek protagonism and public notoriety but rather to establish alliances with other specialties which – through the coordination of the intensivists – afforded crucial collaboration in the care of the critically ill. The organizational capacity shown in the situation of crisis has been notorious, in the same way as professional friendship in the compassionate care of the patients and the companionship and gratitude towards the colleagues of other specialties who adapted their activities in order to help in the hardest moments. The vocation to serve and the capacity demonstrated are a support allowing us to prepare for the next situation in which our work again becomes so necessary.

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Conflicts of interest

None.

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SEDAR-SEMICYUC consensus on the management of haemostasis disorders in severe COVID-19 patients☆

Consenso SEDAR-SEMICYUC sobre el manejo de las alteraciones de la hemostasia en los pacientes COVID-19 graves

Dear Editor,

Infection due to the SARS-CoV-2 coronavirus, which causes COVID-19, tends to predispose patients to hypercoagulability, with an increased risk of thrombotic disease of a multifactor origin. In view of the need to establish a series of recommendations for the management of coagulation disorders in severe COVID-19 patients, the working groups of the Spanish Society of Anesthesia-Resuscitation and Pain Therapy (*Sociedad Española de Anestesiología-Reanimación y Terapéutica del Dolor* [SEDAR]) and the Spanish Society of Intensive and Critical Care Medicine and Coronary Units (*Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias* [SEMICYUC]) decided to join our forces and knowledge and develop a consensus document with the aim of providing guidelines for dealing with these patients. As the result of intense work, with the posterior participation of review committees from both Societies, a manuscript was developed that has just been published by the *Revista Española de Anestesiología y Reanimación* (REDAR).[1] For different reasons unrelated to the authors, joint and simultaneous publication in MEDICINA INTENSIVA has not been possible. We believe that the most important aspect of any article – and particularly of a consensus document – is its diffusion for knowledge and subsequent clinical application in those cases where it is indicated. We therefore would like to highlight some essential aspects of the mentioned document (Fig. 1), and invite those readers who are interested to consult the full open-access original on the website of the REDAR.

Thrombotic risk in COVID-19 patients:

- Assessment of thrombotic and bleeding risk is recommended in all COVID-19 patients in which the seriousness of the disease requires admission to hospital.
- Thrombophylaxis is recommended in all admitted patients, with low molecular weight heparin (LMWH) being the drug of choice.
- In those patients in which a procoagulant profile is confirmed, elevation of the LMWH dose from prophylactic (40-60 mg sc/24 h) to intermediate levels (100 IU/kg/24 h) is suggested, particularly in patients admitted to the Intensive Care Unit (ICU) and subjected to mechanical ventilation.
- Elevation of the LMWH dose from intermediate to therapeutic levels (150 IU/kg/24 h or 100 IU/kg/12 h) is suggested in those cases where pulmonary thromboembolism is suspected (e.g., sudden worsening of oxygenation or a sharp and unexplained drop in blood pressure) and no firm diagnosis can be established.
- Testing to confirm pulmonary thromboembolism is recommended in suspect cases due to progression of the hemostatic parameters (fundamentally D dimer) or on the basis of the clinical course of the patient, whenever possible. If confirmation is established, anticoagulation with LMWH is recommended as standard treatment.

Adjustment of anticoagulant and antiplatelet medication:

- The maintenance of anticoagulation is recommended where required, preferably prescribing LMWH at therapeutic doses.
- The maintenance of antiplatelet treatment is recommended, administering acetylsalicylic acid in those

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