Both scientific societies, the Spanish Society of Intensive and Coronary Unit Nursing (SEEIUC), and the Spanish Society of Intensive and Critical Care Medicine and Coronary Units (SEMICYUC) should back the recommendations made by experts and professionals from other specialties to facilitate the reading of glycemic levels, and implement the current evidence available on glycemic control and monitorization.

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Conflict of interests

None reported.

References

1. Rhodes A, Evans LE, Alhazzani W, Levy MM, Antonelli M, Ferrer R, et al. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016. Intensive Care Med. 2017;43:304–77, http://dx.doi.org/10.1007/s00134-017-4683-6.
2. Finfer S, Wernerman J, Preiser JC, Cass T, Desaive T, Hovorka R, et al. Clinical review: Consensus recommendations on measurement of blood glucose and reporting glycemic control in critically ill adults. Crit Care. 2013;17:229, http://dx.doi.org/10.1186/cc12537.
3. Eerdekens GJ, Rex S, Mesotten D. Accuracy of Blood Glucose Measurement and Blood Glucose Targets. J Diabetes Sci Technol. 2020;14:553–9, http://dx.doi.org/10.1177/1932296820905581.
4. García Del Moral-Martín R, Cobos-Vargas A, Rodriguez-Delgado E, Colmenero M. Blood glucose monitoring in intensive care. Results of a survey. Med Intensiva. 2020, http://dx.doi.org/10.1016/j.medin.2020.09.006. S0210-5691(20)30322-3.
5. Raurell-Torredà M, Del Llano-Serrano C, Almirall-Solsona D, Nicolás-Arfelis JM. Arterial catheter setup for glucose control in critically ill patients: a randomized controlled trial. Am J Crit Care. 2014;23:150–9, http://dx.doi.org/10.4037/ajcc2014536.

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The importance of self-protection plans in times of pandemic☆

La importancia de los planes de autoprotección en momentos de pandemia

Dear Editor:

The current pandemic situation caused by SARS-CoV-2 has made hospital boards of directors have to change their management substantially to be able to adapt to the immense flow of patients received to the point that it has looked like practicing medicine in war times.

In this context, hospitals, and intensive care units (ICU) alike have had to keep taking care of all the other ordinary diseases and conditions by adapting the services offered to the new reality. Also, the standard risks associated with safety and the ER at the hospital setting have multiplied following the collapse experienced during most of the pandemic.

Hospitals and ICUs alike have sustained several incidents and catastrophes to the point of having to evacuate these facilities, totally or partially. This has led to the death of patients who could not be evacuated due to the difficulties involved in their transfer, especially critically ill patients whose complexity and vulnerability is much greater. This reality has become complicated during the COVID-19 pandemic because the extreme severity of the patients adds to the problem of biosafety for the healthcare personnel because the high transmissibility and transmission of the virus requires much more complex measures for evacuation purposes.[1,2] As an example of this, we should mention that just when we were being hit by the worst part of the pandemic, several fires were declared in the ICUs of large hospitals, like the fires reported in Saint Petersburg, Russia (May 2020), and Romania (November 2020). A total of 5 and 10 patients, respectively, were killed in these fires, all of them with COVID-19. No one could be evacuated.

It is of paramount important to design a self-protection plan that should include an evacuation plan properly drafted and based on the current legislation. Also, this plan should be compiled in a physical document approved by the competent authorities, delivered to all the healthcare workers involved, and updated on an ongoing basis. Also, following this plan should be mandatory for all hospitals and ICUs, as a matter of fact, to this date, the design of such a plan is highly recommended by bodies like the World Health Organization (WHO).[3]

We have a self-protection program available in our ICU, and a classification or triage system to prioritize evacuations that is implemented by the treating physician of every patient on a daily basis.[4] Therefore, we always take into consideration, on the one hand, the patient's clinical situation and need for life support, and on the other hand, the therapeutic effort received by the patient and type of isolation he requires.

If an evacuation is mandatory in a situation of pandemic, the system of triage works by prioritizing the transfer of

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patients with more chances of survival, and less need for life support. It is of paramount importance to implement the system of triage in normal conditions of medical attention, and not in emergency situations for the evacuation to occur in an orderly fashion and without unexpected events. In our own opinion, this is a need *per se* inside a healthcare system that manages and monitors the quality of the healthcare it provides.

References

1. King MA, Niven AS, Beninati W, Fang R, Einav S, Rubinson L, et al. Task Force for Mass Critical Care; Task Force for Mass Critical Care. Evacuation of the ICU: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement. Chest. 2014;146 4 Suppl:e44S–60S.
2. Christian MD, Devereaux AV, Dichter JR, Rubinson L, Kissoon N. Task Force for Mass Critical Care; Task Force for Mass Critical Care. Introduction and executive summary: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement. Chest. 2014;146 4 Suppl:8S–34S.
3. Sánchez-Palacios M, Lorenzo Torrent R, Santana-Cabrera L, Martín García JA, Campos SG, Carrasco de Miguel V. Grupo de Trabajo del Plan de Autoprotección para el Servicio de Medicina Intensiva. Plan de evacuación de la unidad de cuidados intensivos: ¿un nuevo indicador de calidad? Med Intensiva. 2010;34:198–202.
4. Santana-Cabrera L, Sánchez-Palacios M, Lorenzo Torrent R, Martín García JA, Carrasco De Miguel V. Sistema de triage de evacuación de pacientes críticos ante un eventual desastre. Rev Calid Asist. 2012;27:65–6.

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First and second wave of coronavirus-19 disease: A comparative study in patients hospitalized in an ICU of a third-level university hospital☆

Primera y segunda oleada de enfermedad por coronavirus-19: un estudio comparativo en pacientes hospitalizados en una UCI de un hospital universitario de tercer nivel

Sir,

The first COVID-19 wave caused by SARS-CoV-2 helped us to understand the course of this previously unknown disease, with its particular characteristics – including very severe acute respiratory distress syndrome (ARDS), a need for deep sedation and neuromuscular block, maneuvering in prone decubitus, an increased risk of thrombotic events, and prolonged mechanical ventilation.[1] The data obtained from different studies made during that period led to subsequent changes in the management strategy applied to critical patients with COVID-19. In this regard, the inefficacy of antivirals such as lopinavir and ritonavir, as well as of hydroxychloroquine, appears to have been confirmed.[2,3] On the other hand, remdesivir could offer some benefit in shortening the duration of symptoms in patients with more milder forms of the disease, but does not seem to significantly modify the course of severe COVID-19 or reduce the mortality rate.[4] More controversial data have been obtained in relation to tocilizumab in terms of the lowering of mortality or reduction of the severity of COVID-19.[5] On the other hand, with regard to the potential impact of corticosteroid use upon the course of patients infected with SARS-CoV-2, the RECOVERY[6] trial is one of the most consistent studies available to date.

It therefore seems reasonable to assume that the experience gained in the course of the first wave, and the availability of data on the different treatments used on an experimental basis during that period, may have contributed to a different management approach to critical COVID-19 patients admitted during the second wave of the pandemic, with modification of the clinical outcomes.

We retrospectively analyzed the characteristics of all the patients admitted with SARS-CoV-2 infection to the Intensive Care Unit (ICU) of a third-level university hospital in Spain in the period between 15 March and 5 December 2020. All patients admitted up until 7 June were regarded as corresponding to the first wave of the pandemic, while all those admitted from 21 July onwards were taken to correspond to the second wave. We evaluated patient age and gender, comorbidities, laboratory test data, the need for ventilatory support, the medication prescribed (corticosteroid use was recorded on a dichotomic basis as either No or Yes, if the patient received at least 40 mg of methylprednisolone or its equivalent, during a period of at least 5 days to treat the inflammation associated to viral pneumonia), the duration of stay, and the mortality rate at 28 days.

The data were obtained through the COVID-19 patients registry of the Department of Intensive Care Medicine, following approval by the local Research Ethics Committee and the obtainment of written and/or telephone consent from the patients or their representatives.

A descriptive analysis was made of the study sample, reporting categorical variables as percentages, and continuous quantitative variables as the mean and standard deviation (SD). Comparisons between groups were made using the Pearson chi-squared test or the Fisher exact test

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