



**Figure 2** Recording of the airway (Paw), esophageal (Pes), gastric (Pgas) and transalveolar (Pt-alveolar) pressure signals. In the Pgas signal we can see the presence of active expiration, and how its release generates the start of the mechanical cycle, followed by effort of the inspiratory muscles as evidenced in Pes. The disappearance of the stimulus generated by active inspiration causes early closure of inspiration and makes the inspiratory effort more manifest, simulating reverse trigger. The vigorous effort on the part of the patient generates Pt-alveolar in excess of 30 cmH<sub>2</sub>O, causing lung overdistension and hyperinsufflation.

the end of inspiration, which causes early closure of the inspiratory valve. The delayed continuous and vigorous inspiratory muscle effort will provoke double-cycling or the appearance of PseudoRT without double-cycling in Paw and flow (Fig. 1).

Fig. 2 shows the real Pt-alveolar, exceeding 30 cmH<sub>2</sub>O, especially in the cycles with double-cycling, and responsible for the excessive volume – double the theoretical value for this patient. Undoubtedly, the overdistension and stretch generated favor the development of P-SILI.

The present case evidences the usefulness of advanced monitoring. Without Pgas monitoring, it would not have been possible to interpret the double-cycling and apparent PseudoRT generated by the active expiration.<sup>10</sup> Following these findings, patient sedation was increased, with a switch to assist-control mode ventilation, correcting the asynchrony, with the disappearance of forced expiration. In our opinion, the expiratory muscle activity was the gateway to abdominal-diaphragmatic discoordination.

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♦ «In memoriam»: Dr. Benítez died on 2 June 2021, at 74 years of age, in full exercise of his functions, while the proofs of this article were being prepared. His kindness, love and inspiration, dedicated to true working spirit, progress and responsibility, have left a permanent imprint upon those of us who were at his side. The loss is irreparable, but his legacy will live on. Rest in peace.

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## Social media and intensive care medicine: To be or not to be<sup>☆</sup>



### Redes sociales y medicina intensiva: estamos o no estamos

Dear Editor:

Traditional mass media are quickly being replaced by different social media (SM) that can be accessed through the Internet

and our mobile devices at anytime from anywhere. The data traffic, knowledge, and training opportunities they generate appear before us as a wide range of possibilities that can seem unlimited.

In the non-healthcare setting, SM are the spearhead of marketing campaigns for companies with unprecedented effectiveness and low cost.

In the healthcare setting, we are also exposed to examples that, although with a teaching purpose in mind, do not meet the regulatory framework. Taking these basic rules into consideration—at the healthcare setting—we cannot stay away from this technological revolution.<sup>1</sup> One way or another we all use SM in our personal lives; however, we—health professionals—have been reluctant to use SM in the professional setting because we did not know much about SM or because we did not have enough tools to implement them

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

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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## Conflicts of interest

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## Temporary pacing with active fixation leads: Should the femoral approach be the access of choice?<sup>☆</sup>



### 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>1</sup>

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.<sup>1</sup> However, the appearance of these complications largely depends on the technique used rather than the access route.<sup>2,3</sup> 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.<sup>2,3</sup> 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 foreseeable effect would be marginal as confirmed by the fact that most

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