

## Reply to "Pulmonary toxicity by oxygen and COVID-19"<sup>☆</sup>



### Respuesta a «Toxicidad pulmonar por oxígeno y COVID-19»

Dear Editor,

We read with great interest the letter in which the authors talk about the deleterious effect of using a high fraction of inspired oxygen (FiO<sub>2</sub>) in patients with acute respiratory distress syndrome (ARDS) due pneumonia caused by SARS-CoV-2 where they advocate for the use of continuous positive airway pressure (CPAP) to reduce the high FiO<sub>2</sub> used in high-flow nasal oxygen (HFNO) therapy.<sup>1</sup>

We agree with the authors when they talk about planning CPAP or non-invasive ventilation (NIV) as an alternative to HFNO. However, clinical practice guidelines say otherwise and they recommend HFNO and choose invasive mechanical ventilation (IMV) in cases of failed HFNO.<sup>2</sup> Based on these recommendations,<sup>2</sup> a Spanish multicenter registry (n=876 patients) showed a wide use of HFNO (49%) vs NIV, and CPAP (<5% in both modalities). We should mention the high rate of failure in the HFNO group (60%) with mortality rates > 30% in patients who required intubation.<sup>3</sup>

The efficacy of NIV in SARS-CoV-2-induced pneumonia was demonstrated in an Italian multicenter registry (N=110 patients) that compared the NIV-helmet to HFNO. Although the registry primary endpoint—ventilation-free days (20 days vs 18 days, *P*=.26)—was not achieved the NIV group had lower rates of intubation on day 28 vs the HFNO group [28% vs 51%; OR, 0.37 (0.17–0.82), *P*=.02]. At the same time, the NIV-helmet had better oxygenation, and less dyspnea compared to the HFNO group.<sup>4</sup> Consistent with one of the arguments that support the use of HFNO,<sup>2</sup> the patients' tolerance was higher with HFNO compared to NIV.<sup>4</sup> Similarly, in our series of 27 hypoxemic patients due to SARS-CoV-2-induced pneumonia, NIV was used as the first-line therapy in 21 patients (80.8%) basically with NIV specific ventilators in CPAP mode. CPAP failed in 10 patients (48%) with an associated mortality rate of 50%. No health personnel became infected in relation to the NIV as opposed to what has been reported in the clinical practice guidelines.<sup>2</sup>

Therefore, based on these guidelines,<sup>2</sup> we believe that the HFNO plays a key role in the early ventilatory therapy of hypoxemic patients. Unfortunately, the rate of failure

in hypoxemic patients is high,<sup>3</sup> which may have overestimated the true efficacy of HFNO in advanced stages of ARDS. Like the authors say, a high FiO<sub>2</sub> in HFNO added to the pulmonary damage caused by the virus worsens ARDS, and eventually leads to IMV.<sup>1</sup> On the contrary, results from the latest clinical trials,<sup>3</sup> and observational studies<sup>4</sup> pave the way for the safe use of NIV in its different modes (CPAP or NIV) by applying positive end-expiratory pressure (PEEP) that recruits the damaged lung, which allows reaching a non-detrimental FiO<sub>2</sub><sup>1</sup> while avoiding IMV and its deleterious effect.<sup>3,5</sup>

## References

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