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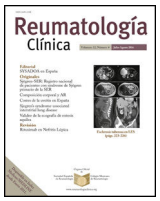

Letter to the Editor

Long COVID-19 and Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Correspondence

COVID-19 largo y encefalomielitis miálgica/síndrome de fatiga crónica: correspondencia

Dear Editor:

We would like to share ideas on the publication "Long COVID-19 and Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS): similarities and differences of two peas in a pod.[1]" Long COVID-19 should be treated as a public health emergency, according to Qanneta. Real prevalence, phenotypes, risk factors, viable therapies, and potential differences with ME/CFS and other overlapping clinical entities must all be determined by well-conducted research.[1] We concur that post-COVID issues could occur and that long-term COVID is currently a significant worldwide health issue. From asymptomatic to life-threatening clinical situations, COVID-19 exhibits a broad spectrum of clinical symptoms.[2] The main COVID-19 symptom may also be connected to the existence of long-COVID-19. Additionally, not all clinical problems are brought on by COVID-19 recovery. The primary COVID-19 symptom may also be associated to long-COVID-19. Additionally, COVID-19 recovery does not cause all clinical problems. The clinical problems brought on by other medical conditions must be eliminated, even though the current study may give a true impression of prevalence. For instance, even after COVID-19, there remains a risk of developing another severe common disease, such influenza, necessitating the use of preventative measures.[3] Therefore, additional medical issues may impede the clinical manifestation. In circumstances where it is practical, a more detailed investigation of the relationships between pre-COVID-19 health data and post-COVID-19 concerns may be possible.

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Conflict of interest

None.

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Comment to: Teleconsultation of infant rheumatology in COVID-19 time

Comentario a: Teleconsulta de reumatología infantil en tiempo de COVID-19

Dear Editor,

I read very carefully the publication by Nieto-González et al.[1] in *Reumatología Clínica*, where they present their experience of teleconsultation in paediatric rheumatology during COVID-19. I would like to express my opinion from an ethical perspective.

The COVID-19 pandemic caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has caused a major health, social, and economic crisis worldwide.[2] In a complex situation involving an extreme need for rationality and common sense, the concept of ethical distress regarding the values of healthcare professionals, a group clearly under great strain and at high risk of exposure and contagion, has re-emerged. Ethical distress is defined as the feeling of professional anguish at not being able to carry out their work with the minimum standards of quality care, caused by a lack of sufficient resources, among other factors. It has resulted in emotional exhaustion, moral suffering, accumulated fatigue, and burnout, but also in good practices of change, resilience, and transformation. This last point is of positive note and is where the teleconsultation initiative experienced by the authors in the context of ethical distress comes into play.

It is also just as important to emphasise that the ethics of corporate values of organisations and the system have been affected by public health (a higher good) in terms of: universality, justice, autonomy, intimacy, privacy, confidentiality, humanisation, communication, etc.[3] In this sense, the pandemic has revealed some shortcomings, prompting new projects to respond to arising needs: adaptation of the organisation, adaptation of care and non-care processes and spaces, and good practices in the relationship with patients and relatives, along with coordination with other levels of

care. This solution presented by the authors during the COVID-19 pandemic has also been reinvented from a corporate and organisational perspective.

Finally, I would suggest that we must rethink the future and recover lost gratitude and self-esteem (as a society and as health professionals), after a pandemic that has been a call for attention and action, to put everything back on track. It is an occasion for examination, learning, and improvement where we can relate to Japanese culture in the concepts of repair (*kintsugi*), reordering (*nankurunaisa*), and harmony (*feng shui*), and take up new challenges in person-centred care.

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Anakinra as a potential alternative in the treatment of severe acute respiratory infection associated with SARS-CoV-2 refractory to tocilizumab: comment☆

Anakinra, una alternativa potencial en el tratamiento de la infección respiratoria grave por SARS-CoV-2 refractaria a tocilizumab: comentario

Dear Editor,

We have read with interest the article by Figuero-Pérez et al. published in the last issue of your journal suggesting the usefulness of anakinra in severe respiratory SARS-CoV-2 infection refractory to tocilizumab[1] and would like to make some observations.

The clinical course of SARS-CoV-2 infection has three distinct clinical phases[2]. In the initial phase there is viral replication with flu-like symptoms and then some patients progress, between day 6 and 13 of symptom onset, to a hyperinflammatory phase with the development of pneumonia that may progress to respiratory distress syndrome.

The pathogenesis of severe SARS-CoV-2 infection involves dysregulation of the immune response with lymphopenia, increased pro-inflammatory cytokines (IL-1, IL-2, IL-6, IL-7 or TNF alpha) and a decrease in gamma-interferon. This leads to a systemic inflammatory syndrome with elevated acute phase reactants such as C-reactive protein and ferritin[3].

Treatment of this inflammatory phase with drugs such as dexamethasone or tocilizumab has been shown to reduce mortality[4,5].

Anakinra, an IL-1 receptor antagonist, has recently obtained EMA approval for treatment in adult patients with COVID-19 pneumonia and risk of progression to severe respiratory failure based on the SAVE MORE clinical trial which demonstrated a reduction in 28-day mortality and hospital stay in those treated early with anakinra[6].

There is little evidence regarding rescue therapy in patients with poor clinical outcome despite corticosteroids and/or immunomodulators. In an article published by our group[7], we analysed 143 patients with moderate/severe SARS-CoV-2 pneumonia and hyperinflammation treated with various regimens based on the protocols of that date. We observed that in those who had not responded to corticosteroids with or without tocilizumab, treatment with anakinra could be a useful alternative. Our patients received 100 mg/12 h on day 1 if they weighed between 50 and 60 kg, 100 mg/8 h between 60 and 75 kg or 100 mg/6 h if they weighed >75 kg. Subsequently all received 100 mg/12 h from day 2 to day 6. After adjustment for age and clinical severity indices, anakinra administration was associated with a reduced risk of mortality (HR; .518, 95% CI .265–.910, $p = .0437$).

In the case published by Figuero-Pérez et al.[1] we consider that it cannot be suggested that the patient's clinical improvement was due to anakinra when a single dose of 100 mg was administered. Given that the half-life of anakinra is 4–6 h and that of tocilizumab around 6 days, it is likely that the patient's improvement was due to the effect of tocilizumab. There is currently no consensus on the optimal doses of anakinra in this clinical setting, but higher and longer doses have been used in the literature[8,9].

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