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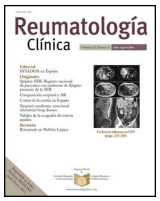

Letter to the Editor

## 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.

### Funding

None.

### 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