

We are before a unique, once-in-a-lifetime opportunity to do things as best as possible, to cooperate among centers, and to include the greatest number of patients in clinical trials. Before starting to try to innovate, we must search clinical trial registries, such as the Spanish Clinical Studies Registry (REEC, for its initials in Spanish).⁸ As of today, April 2, 2020, there are 13 ongoing clinical trials in the REEC, two of which seek to evaluate the use of steroids, in addition to international initiatives such as the WHO's SOLIDARITY trial. Before including any compassionate use drugs in our protocols, we are ethically obligated to try to join any clinical trial that may be testing its potential.

Within three months, we could have an answer about what drugs will work in future outbreaks, what the right moment to start each of the treatments is, and what their dose and durations are. Alternatively, within three months, we will only have the cacophony of multiple local studies—retrospective and contradictory—that are impossible to interpret; we will be filled with regret in the shadow of a missed opportunity. The choice is in our hands.

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L. Corral-Gudino

Servicio de Medicina Interna, Hospital Universitario Río Hortega, Valladolid, Spain

E-mail address: lcorral@saludcastillayleon.es

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Obesity and 2019-nCoV: A risky relationship[☆]



Obesidad y coronavirus 2019nCoV: una relación de riesgo

Dear Editor,

Obesity is a multifactorial, complex, chronic metabolic disease¹ associated with chronic inflammation that plays an essential role in the development of type 2 diabetes mellitus (DM2), dyslipidemia, hypertension (HT), cardiovascular diseases (CVD), and cancer.²

Currently, the 2019-nCoV coronavirus is devastating the planet. It has diverse clinical manifestations including, most notably, lung disease. The risk factors for infectious diseases depend on the host, the pathogen, and the environment. Various factors associated with the severity and a worse prognosis of 2019-nCoV infection have been described, such as age, presence of chronic diseases such as DM2 or HT, and

diseases that compromise the immune system.³ In the few series that have been published, obesity is also included among these factors, especially for those younger than 65 years of age.^{3–5}

Obesity is associated with a worse immune response and a poor prognosis for respiratory infections, as was observed during the influenza A (H1N1) epidemic in 2009.⁶ At baseline, people with obesity have an associated low grade of chronic inflammation; they have decreased concentrations of anti-inflammatory adiponectin and elevated concentrations of proinflammatory cytokines such as interleukin 6, tumor necrosis factor alpha, and leptin, which are produced in visceral and subcutaneous abdominal fatty tissue, especially in males. All are associated with greater severity of disease caused by 2019-nCoV.⁷ This “inflamed” microenvironment predisposes people with obesity to an abnormal cellular and humoral immune response leading to, on one hand, greater susceptibility to and delay in resolution of the infection and, on the other hand, the onset of severe lung injury and lesser immunization coverage.⁸ Associated with inflammation, obesity predisposes the body to a state of hypercoagulability, in this case boosted by 2019-nCoV. It is also important not to forget abnormalities in respiratory dynamics, also especially of note in males, as it confers greater predisposition to respiratory diseases such as asthma

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or hypoventilation syndromes, aggravated by microaspirations secondary to gastroesophageal reflux disease.

Recent publications have described a relationship between people with obesity and greater contagiousness due to the fact that they may exhale the virus for a longer time or favor the appearance of more virulent strains, both due to the particular proinflammatory microenvironment and lower interferon production.⁹

In this scenario of uncertainty, with the worldwide dissemination of the infection and the obesity epidemic, clinicians must pay close attention and must monitor and treat people with obesity early and aggressively.

Nevertheless, once the 2019-nCoV tsunami passes, we must not forget the lessons learned. The approach to epidemics transcends the healthcare field and requires the involvement of political authorities and civil society. The beneficial effects of moderate physical exercise on the immune system are well-known; it modulates inflammation and insulin resistance, preventing cellular aging and the formation of free radicals.¹⁰ Social policies must be aimed at promoting a healthy lifestyle, regular physical exercise, and achieving a healthy weight, thus breaking the toxic relationship between obesity and infection.

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J. Carretero Gómez^{a,*}, J.C. Arévalo Llorido^a,
F.J. Carrasco Sánchez^b

^a Servicio de Medicina Interna, Hospital de Zafra, Zafra, Badajoz, Spain

^b Servicio de Medicina Interna, Hospital Universitario Juan Ramón Jiménez, Huelva, Spain

* Corresponding author.

E-mail address: juanicarretero@gmail.com
(J. Carretero Gómez).

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Acute poisoning at local hospitals[☆]



Intoxicaciones agudas en hospitales comarcales

Dear Editor,

The article by Baeza et al.¹ provides, in our opinion, an important overview of acute poisonings. Most published series in Spain are currently based on data from patients with poisonings treated only in tertiary or reference hospitals, located in large cities, generally the capitals of

provinces or of autonomous regions. The study by Baeza et al., in contrast, provides epidemiological data on emergency care in hospital centers at lower care levels, one of which is also a characteristic summer tourist area, with its expected seasonal fluctuations, but not previously.¹ Given that it is difficult even for reference hospitals to find emergency care professionals interested in clinical toxicology and involved in epidemiological research, finding them in smaller hospitals with over a period of 5 years is exceptionally commendable.²

In the evolution of the incidence of cases, it is noteworthy how the poisoning rate practically triples in the centers with a significantly lower population coverage, compared with urban hospitals where the poisoning rate remained virtually constant over the 5 years analyzed despite a 10% increase in the number of emergencies treated. The authors do not have an explanation for this difference, which could be due to the type of

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