

LETTERS TO THE EDITOR

Advisability of not using a literal translation of "milking phenomenon"*"Compresión extrínseca dinámica de las arterias coronarias" en lugar de "fenómeno de ordeñado"***To the editor:**

Regarding the article by Sánchez Ramón et al.¹, there is no doubt that dynamic extrinsic vascular compressions have an important repercussion in clinical practice. Muscular bridges (MB) in the coronary arteries are a typical example, as is compression of the left coronary artery and others, including the aorta and pulmonary arteries. Static compressions produced by compartmental syndromes and tumours, which affect the blood vessel, arterial or venous, of the affected region, are easier to diagnose. The majority of MBs are asymptomatic, but they represent reduced blood supply to the corresponding myocardial territories which can cause angina, mainly during physical exercise². When a MB results in resting ischemia, it is easily diagnosable by the usual non-invasive tests and is rarely undiagnosed by experienced professionals; however, to clarify, we would indicate that these tests are not diagnostic of MB, only the consequent ischemia³. Milking or "dynamic extrinsic compression of the coronary arteries" is only corroborated during conventional or tomographic coronary angiography and magnetic resonance imaging^{2,3}. Pharmacological treatment, mainly with beta-blockers, is the most widely used method. The success of percutaneous coronary intervention depends on whether the MB is unable to overcome the radial force of the stent; and surgical myotomy, the only therapeutic strategy that eliminates the cause of the disease, is reserved for the most serious cases.

We do not wish to criticize the excellent work of these authors¹, but to stimulate the proper use of our rich language: we suggest that instead of "the milking phenomenon" we could use "dynamic extrinsic compression"; without "systolic" because this compression can occur

in both phases of the cardiac cycle². English is the language of science; but it should not flood our scientific medical language as long as there are words in Spanish that can describe what we mean. Sometimes the translation, although correct, does not clearly express its meaning in Spanish. We must all get our professionals to speak and write better⁴. The Dictionary of the Royal Spanish Academy defines "milking" as the action and effect of this verb, such as 1) extract milk by squeezing the udder, 2) take the olive with the hand surrounding the bouquet to release it, and 3) getting the most out of something or someone. None of these meanings is equivalent to the extrinsic compression of an MB. Only "squeezing" could be worth something; but it means: "to extract the juice or liquid of a thing, tightening it or twisting it", among other meanings that are not applicable. Dirckx⁵ states that: "... in both Spanish and English there are abundant rhetorical figures that derive from the characteristics and behaviours of animals, whether real or imaginary. Although some of the expressions are exactly equivalent in both languages, in each language there are similes, metaphors and idioms alluding to animals that lack exact correspondence in the other".

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Authors' reply*Respuesta de los autores***To the Editor:**

The authors of the letter raise objections regarding the use of certain terms (milking) as foreign and imprecise. We share with them that our language is of great wealth and vitality, but that does not prevent the use of anglicisms¹. In the case of milking, the substitution by "dynamic extrinsic compression" they suggest is much longer than the original word, which is a problem when scientific publications are usually subject to word count limitations. As an example, the word stent², whose origin dates back to the 19th century and comes from the name of the English dentist Charles Stent, is generally used to denote "endovascular metal prostheses in the form of a spring that are placed in the interior of an anatomical structure or body duct to keep it permeable."

According to Moreno-Martínez et al. "None of the meanings given in the Dictionary of the Royal Spanish Academy (RAE) is equivalent to the extrinsic compression of a muscular bridge (MB)." This dictionary, the reference for our language par excellence, is not very rigorous in medical

and veterinary terms. For example, the definition of the word syncope, which we invite you to consult. However, in manual milking, milk ejection is achieved by a contractile effect of the myoepithelial cells, which compress the alveoli, as well as a vacuum effect which expels the milk into the cisterns and ejects it³. This is somewhat like the compromise of coronary artery flow in systole and diastole that occurs in MB⁴. Certainly, to date, as there is no uniform or satisfactory definition of the term in several publications in Spanish, the term milking^{5,6} is frequently used, while in others of equal validity the authors have chosen to use the direct Spanish translation of the word milking⁷⁻⁹. Some authors have also used the term "squeezing effect"¹⁰ as a translation of the milking effect, which favours the imprecision of the term we are debating (according to the RAE, squeezing is "squeezing something or hugging someone"). In any case, it is the scientific community that must arrive at a consensus regarding the term, something that goes beyond the scope of the authors of this article.

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A linguist's response

Respuesta de un lingüista

To the editor:

At the request of the Editorial Committee of EMERGENCIAS, and as an expert linguist in medical language and occasional collaborator with the Journal on aspects of the use of medical language¹⁻³, I would like to contribute my considerations regarding the question that has arisen with the denomination of the phenomenon of the compression or constriction of the coronary arteries, which in English is called "milking".

First of all, I would like to briefly comment on two statements that I

have read in letters addressed to the Editor: it is pointed out that the proposal [to use analytically the name of the phenomenon (dynamic extrinsic compression)] "to stimulate the proper use of our very rich language," and, later on, gives full recognition to English as "the language of science." Neither one nor the other: neither is our language more (or less) rich than any of the other cultured languages nor can English be considered the language of science without qualification, and I will not stop to explain these evaluations, which linguistically would be considered simple topics, for reasons of space limitation^{4,8}. Although my affirmation that such assertions are mere prejudices may lead me to conclude that any of the proposals could in principle be valid and that their normalization must come from acceptance by the Spanish-speaking scientific community. The term "milking" would be fully justified if the circumstance - I do not know if this is so - is that such a term has been so successful that it was already widespread in the medical literature (in English and Spanish) with the sense of "dynamic extrinsic compression of the coronary arteries", in which case translating it literally into Spanish would make no sense, either from a medical or a cultural perspective. It is another matter if the term is in an initial stage of use and we wish to avoid "agricultural" connotations to a scientific name, and, in that case, to use the analytical form "dynamic extrinsic compression of the coronary arteries", or its short and easily pronounced acronym CEDAC, if such a phenomenon were so specific, otherwise it would suffice to name it "arterial constriction"; the word constriction, in addition, is highly frequent (as is the term stenosis with a similar meaning) in the field of medicine.

Language is an arbitrary semiotic system and the relation of signifiers to their meanings is purely conventional (chair means what it means because we have agreed on that and not for any other reason), and although sometimes words can be found in which some kind of motivation is discovered, such as milking in English, I do not think any medical scholar is imagining the result of extracting milk by squeezing the udder, nor, to continue with the livestock simile, are they thinking of cows when we speak of vaccination,

or in the reasons why certain diseases are called priapism, croup, plague or Alzheimer's. By the way, in the texts that I have examined in preparing this note, I observe that the English voice "stent" is used, whose origin, as with Alzheimer and Parkinson, is a proper name, and stent has already become "estent" in Spanish.

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Management of severe sepsis and septic shock in a tertiary care urban hospital emergency department: opportunities for improvement

Acerca de las oportunidades de mejora en el manejo de la sepsis grave y el shock séptico en urgencias

To the editor:

We have read with interest the article by Monclús et al. concerning the opportunities for improvement in the management of sepsis in the emergency department¹, and would like to comment on some aspects. As reflected in the study, a critical point in the attention of these patients is triage, and given the characteristics of the clinical picture of sepsis, the most common systems in our environment, and specifically the "Model Andorrà de Triatge"/Spanish Triage System MAT/SET), show poor detection performance. That is why complementary tools are needed to facilitate its early identification. Taking as a reference the results obtained by the sepsis working group of the Hospital Royo Villanova de Zaragoza, which showed better adherence to guideline recommendations and greater survival rates after the development of a detection system², a Sepsis Code has been progressively implanted in the public hospitals of Aragon. The activation of this code is based on a modification of the MAT/SET to detect the presence of systemic inflammatory response syndrome (SIRS) and organic dysfunction at the time of triage, thus allowing identification of those patients at potential risk of presenting sepsis. The system increases the priority level according to altered parameters regardless of the MAT/SET level. In addition, in all cases a different colour code is assigned to these patients, thus allowing their rapid identification. Once assessed by the physician, if the clinical picture is not compatible with sepsis, there is the possibility of deactivation and reassignment of the priority level.

In this regard, the Consensus Document of the National Sepsis Code, signed by 15 scientific societies³, establishes recommendations on the management of sepsis as from early detection, using different systems and alarms, including the

suggestion of an emergency triage based on major criteria (organic dysfunction) and minor (SIRS) for hospital activation of the sepsis code.

Regarding the low adherence of the professionals to the therapeutic recommendations, in addition to the implementation of a sepsis code, it is necessary, in our understanding, to conduct information campaigns emphasizing that, like ischemic heart disease or stroke, sepsis is a time-dependent disease. One of the potential effects of such interventions may be an increase in false positives. However, given the clinical variability that these patients may present and the lack of a diagnostic test that is determinant in the initial assessment, such as ECG or computed tomography, we believe that sensitive detection systems are necessary to avoid missing possible cases. On the other hand, new definitions of sepsis and the inclusion of some of the SOFA and qSOFA variables in triage may facilitate the detection of these patients⁴. In addition, the disappearance of the term severe sepsis in the new consensus may help this, since that concept lends itself to misunderstanding that there may be sepsis which is "not serious".

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Author's response

Respuesta de la autora

To the editor:

First of all, to congratulate the authors for the initiative carried out in Aragon. We believe that studies on emergency care processes help identify areas for improvement¹. We agree with the authors that sepsis is a dynamic process and early recognition is of vital importance to avoid organic dysfunctions that worsen the prognosis. What is really problematic is to find an indicator that is easy to apply in triage and is sensitive, and, as far as possible, specific. In recent years, the creation of certain 'codes' of care has improved the prognosis of certain pathologies. However, we must not forget that the prioritization of certain patients is detrimental for other patients and that we do not have data about the impact of false positives on the activation of 'codes' in our system sanitary. In this context, it is interesting what the authors propose: the attending physicians can deactivate the 'sepsis code' when, after initial assessment, they consider that the case does not really meet the criteria. We would also draw attention to the need to "drain" these patients after initial stabilization in the ED. The patients included in our study (all of them with severe sepsis or septic shock) were in our ED during an average time over 24 hours, awaiting a bed in critical or semi-critical care units in the hospital. Finally, we agree with the authors that the new indicator, called 'quick-SOFA',

may be useful as a tool combined with triage for the early identification of these patients, but we reiterate the importance of studies that determine both sensitivity and specificity of indicators such as this in populations such as ours^{2,3}.

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Emergency department staff, the limitation of life-sustaining treatment, and the feasibility of organ donation

El profesional de urgencias, la limitación de tratamiento de soporte vital y las opciones de donación

To the editor:

Martínez et al. emphasize the importance for organ donation of an organization that facilitates the detection of patients with catastrophic brain damage in the emergency department (ED), the transfer to intensive care units (ICU) and contact with the transplant coordinators^{1,2}. However, multiple factors inherent to the ICU make this process difficult: the lack of training in the field of donation, the burden of care, the lack of beds in the ICU or the belief that it is a priority to dedicate resources to patients with a chance of survival.

The authors correctly point out that, in those patients with irreversible lesions in which the donation is contemplated, permission must be obtained for intubation and transfer to the ICU¹. We believe that this is a critical point, which sometimes generates ethical doubts in the ED and may lead to a limitation of life support treatment in the ED without evaluating the donation options or, even evaluating them, unilaterally discard them, with the conviction that this way the best care is provided, avoiding instrumentalization and admission to the ICU and facilitating a "good" death for the patient.

But the ED doctor must understand organ donation as a personal choice and a patient's right that needs to be protected. When clinical decisions are made in end-of-life care, the patient's wishes, including organ donation, should be included whenever possible³⁻⁵. The family interview in the ED should not be understood as an advance organ request; rather, it aims to determine the patient's wishes regarding their donation options, in order to guide the clinical decisions of the medical team^{3,5}. This procedure, far from having therapeutic objectives, respects the principles of beneficence and non-maleficence and enhances the autonomy of the patient. The donation should be understood as an option for the patient who is about to die (and therefore a "good" purpose of the clinical actions towards the patient) and not as a benefit for others that requires the "use" of the patient's organs^{3,5}.

In some cases, it will not be possible to obtain sufficient information in the ED or the crisis will not allow an interview of this type. Even on such occasions, the ED physician's procedure may be to transfer to the

ICU, in order to protect and preserve the patient's donation options until there is sufficient time and space for more information. This procedure is widely contemplated in clinical guidelines and conforms to the ethical norms that govern clinical practice³.

We believe that training in the field of donation, ethical aspects, life support decisions and end-of-life care are fundamental to be able to safely carry out clinical practice in the ED and the support of transplant coordinators can facilitate such management and decisions.

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Suspicion of chemical submission in a hospital emergency department: procedures followed and toxicological analyses in a case series

Sospecha de sumisión química en urgencias: procedimiento de actuación y análisis toxicológico en una serie de casos

To the editor:

Chemical submission (CS) is a health problem and a form of violence which, although known since antiquity, is having great media impact today. The term CS comes from the French soumission chimique and is defined as the administration of psychoactive substances to a person without their knowledge, in order to cause a change in their degree of vigilance, their state of consciousness or their judgemental capacity. In Anglo-Saxon countries, it is known as drug facilitated crimes, or drug facilitated sexual assault (DFSA) when associated with sexual assault¹.

Cases of suspected CS have been reported in hospital emergency departments (EDs). In the hospital environment, the need for improvements in the coordination of such cases is evident². In this regard, the Commission Against Violence of the San Carlos Clinical Hospital (HCSC) has developed a guide for clinical use in cases of suspected CS in the ED. The most relevant data from a series of HCSC cases between March 1 and August 31, 2015, including the toxicological analysis performed at the National Institute of Toxicology and Forensic Sciences (INTCF) are shown in Table 1.

Thirteen cases are described, with a mean age of 35 (SD 21) years, seven men, six with foreign nationality, with no remarkable history except four cases with psychiatric illness. Mostly, they report amnesia and/or confusion after drinking alcoholic beverages the night before. In physical examination and complementary tests, no alterations of interest were observed. Toxic analysis identified ethanol, amphetamines and cannabinoids in three patients. Following the procedure, suspicion of CS was recorded, with judicial report of lesions, as well as extraction of biological

samples (blood if exposure to toxins took place in <24 h and urine if there was exposure in <7 days) with prior informed consent and storage following the mandatory chain of custody. In all cases it was recommended in writing to file a legal complaint on ED discharge. In six cases the patient reported robbery of belongings and on four occasions the protocol of violence against possible sexual aggression was activated requesting medical evaluation. In the toxicological analysis of samples submitted to INTCF, ethyl alcohol was detected in seven patients, amphetamine derivatives in two, psychoactive drugs in two, cannabinoid derivatives in one and gamma hydroxybutyric acid (GHB) in another. The toxins detected are common in cases prosecuted for sexual offenses³ and we would highlight GHB as an emerging and imperceptible toxicant in ED toxic screening systems⁴.

In no case was it possible to confirm the suspicion of CS as voluntary consumption of toxic substances could not be ruled out nor was it possible to prove that a crime had been committed. Distinguishing whether acute intoxication can really be a case of CS is not an easy task. The patient does not remember well what happened, does not always consult early or admit the voluntary consumption of toxic substances⁵. In our series, in May, there could be cases of opportunistic CS or chemical vulnerability after voluntary or mixed consumption⁶. We consider that the implantation of the protocol of action on suspicion of CS is a measure of improvement in the ED to complement clinical protocols for action in acute intoxication⁷ by incorporating medico-forensic aspects⁸. Collaboration with the INTCF is key to being able to identify toxins with greater accuracy and medical-legal validity and, thereby, give greater credibility to suspected CS in the ED.

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Table 1. Summary of clinical and analytical data of the 7 cases of suspected chemical submission (CS)

Case	Clinical, care and medical-legal aspects of interest	Toxicological analysis
Nº 1	– Spanish man aged 55 years, with a history of depression, reported amnesia in a place of leisure 48 hours after drinking alcohol with strangers. Normal PE. Without CTs, discharged after 3 h. Suspicion of CS + theft, recommended to report the incident to the police.	– No blood sample was received. – Nordiazepam, temazepam, sulpiride, O-desmethylvenlafaxine, and venlafaxine + in urine.
Nº 2	– Peruvian woman aged 19 years without remarkable medical history, reported euphoria and amnesia in a place of leisure 12 hours before. She woke up confused in unknown company. Normal PE and CT. Discharged after 4 hours. Suspected CS, theft and sexual assault. Medical evaluation requested after police report.	– No biological samples were received (The patient did not give her consent).
Nº 3	– A 19-year-old Colombian woman, with no remarkable history, reported psychomotor restlessness in a recreational area after drinking alcoholic beverages 24 hours before. Normal PE and normal CT, ethanol 1.80 g / L in blood. Discharged after 11 h. Suspicion of CS and theft, recommended to report the incident to the police.	– Ethyl alcohol 1.72 g / L in blood. – Ethyl alcohol 2.13 g / L in urine.
Nº 4	– A 23-year-old Spanish woman with no remarkable history, reported amnesia and confusion at a place of leisure after drinking alcoholic beverages 12 hours before. PE and normal CT. Discharged after 7 hours. Suspected CS, theft and sexual assault. Medical-forensic assessment requested after report to the police.	– Ethyl alcohol 0.73 g / L in blood. – Ethyl alcohol 0.57 g / L in urine.
Nº 5	– Spanish woman aged 78 years with no remarkable history reported amnesia, confusion in a public space 72 h before. Normal PE, without CT, discharged after 3 h. Suspicion of CS and theft, recommended to report the incident to the police.	– No blood sample was received. – Ibuprofen + in urine
Nº 6	– Spanish man aged 21 years with a history of anxiety reported amnesia after ingestion of alcoholic drinks 12 hours before. Headache in PE, normal CT, ethanol 0.75 g / L in blood and cannabinoids + in urine. Discharged after 11 h. Suspected CS, robbery and possible sexual assault. Medical-forensic assessment requested after report to the police.	– Ethyl alcohol 0.39 g / L in blood – Ethyl alcohol 0.88 g / L and 11-nor-d9-THCCOOH (Cannabinoid derivative <0.05 mg / L In urine.
Nº 7	– Moroccan man aged 28 years with a history of anxiety reported euphoria and later blackout in a place of leisure with strangers <2 h before. Low level of consciousness in PE with progressive improvement, normal CT. Discharged after 6 h. Suspicion of CS with no clear crime committed.	– GHB 35.9 mg / L and metoclopramide <0.1 Mg / L in blood. – No urine sample was received
Nº 8	– Moroccan woman aged 24 years reported restlessness and irritability in a place of leisure after drinking alcoholic drinks <3 h before. Palpitations, tachycardia and diaphoresis in PE, normal CT. Ethanol 0.14 g / L in blood and amphetamines + in urine. Discharged after 9 h. Suspicion of CS with no clearly associated crime.	– MDA (<0.1 mg / L) and MDMA + (0.1 mg / L) In blood. – Ethyl alcohol + (0.38 g / L), MDA + and MDMA + in urine.
Nº 9	– Spanish man aged 20 years reported waking up tied up at his home after a date with a stranger 36 hours ago. Lacerations on wrists, normal CTs. Discharged after 16 h. CS suspicion and theft, recommendation of complaint.	– No toxins detected in blood. – No urine sample was received.
Nº 10	– Ecuadorian woman aged 19 years reported amnesia and irritability, in a place of leisure after ingestion of alcoholic drinks 24 hours before. Psychomotor restlessness in PE, normal CT. Discharged after 6 h. Suspicion of CS and sexual assault. Medical-forensic assessment requested after report to the police.	– Ethyl alcohol 0.13 g / L and MDMA 0.13 mg / L in blood. – Ethyl alcohol 1.07 g / L, HMMA, MDA and MDMA + in urine.
Nº 11	– Spanish man aged 68 years with a history of schizophrenia reported amnesia and confusion in a public space 8 hours before. Disoriented and inattentive in PE, normal CTs. Discharged after 6 h. Suspected CS and theft, recommended to report the incident to the police.	– No toxins detected in blood. – Domperidone and quetiapine + in urine.
Nº 12	– A 34-year-old Mexican man reported general malaise after drinking "strange" alcoholic beverage in the street 6 hours before. Drunkenness on PE, normal CT. Discharged after 8 h. Suspicion of CS with no clear associated crime, recommended to report the incident to the police.	– Ethyl alcohol 0.38 g / L, paracetamol <10 mg / L, naproxen 0.2 mg / L in blood. – Ethyl alcohol 0.49 g / L, naproxen and paracetamol + in urine.
Nº 13	– Spanish male of 37 years who reports excessive drunkenness after little intake of alcoholic beverage 24 hours before. PE without alterations, without CT high in 3 h. Suspicion of CS and theft, recommended to report the incident to the police.	– No toxins detected in blood. – Ethyl alcohol 0.13 g / L in urine.

PE: physical examination; CT: complementary tests; MDA: 3-4-methylenedioxyamphetamine; MDMA: 3-4-methylenedioxyethanemane; HMMA: 4-hydroxy-3-Glucuronised/sulphated methoxymethamphetamine; GMB: gammahydrobutyrate.

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The author declares no conflict of interest.

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The authors have confirmed their authorship, the non-existence of funding and the maintenance of confidentiality and respect of the patients' rights in the author responsibilities document, publication agreement and assignment of rights to EMERGENCIAS.

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May-Thurner syndrome

Síndrome de May-Thurner

To the editor:

We would like to congratulate Gómez Carrillo et al. on their article "Extensive venous thrombosis of the lower left extremity in young subjects: should we perform extended tests?" recently published in this Journal¹, but we wish to highlight some therapeutic diagnostic details.

May-Thurner syndrome is a rare clinical condition, with a prevalence ranging from 2-5% of the total number of patients with venous flow alterations in the left lower limb and 18-49% of patients suffer deep vein thrombosis. This syndrome occurs more frequently in women between the third and fifth decades of life. It is an underdiagnosed entity that can cause serious complications: venous ulcers, flegmasia cerulea dolens, chronic edema, venous insufficiency, deep venous thrombosis, pulmonary thromboembolism or varicose veins; so, it should be included in the differential diagnosis of these patients.

The diagnostic test of choice to now has been iliac venography,

which allows us to assess compression of the iliac vein, the presence of collateral circulation and the pressure gradient. However, at this time magnetic resonance angiography and computerized angiography are displacing venography².

Regarding treatment, symptomatic patients should be treated: the endovascular option (venous patch angioplasty and endoprosthesis) is the therapeutic option of choice^{3,4}, with which excellent results can be obtained in iliac venous system cannulation, with minimal surgical risk. Regarding post-treatment, there is no consensus, but most authors advise anticoagulation with heparin for 24-72 h after the procedure, and anti-aggregation (acetylsalicylic acid 75-250 mg/day or clopidogrel 75 mg/day) during six months³.

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