

LETTERS TO THE EDITOR

European curriculum for emergency medicine and geriatric emergencies: another step forward for emergency department geriatric care

El Currículum Europeo de Medicina de Urgencias y Emergencias Geriátrica, un paso más hacia la geriatización del servicio de urgencias

To the editor:

As Bellou et al. mentioned, the progressive aging of the population is a global phenomenon^{1,2}. Age often involves chronicity, and may be associated with multimorbidity and disability. Both are associated with an increase in the frequency of visits to emergency services (HES) and hospital admissions. When the geriatric population enters the hospital, it has stays 20% longer than the rest of the population and uses 50% more care resources². In addition, geriatric patients also have special requirements in the field of emergency care, with a greater risk of suffering an exacerbation secondary to multimorbidity, which has a higher level of emergency, which is more serious, that the prognosis is worse, and that the disease often causes dependence, transient or not^{2,3}.

For all these reasons, the scientific societies recommend the adaptation of the HES, which need to be transformed in order to adequately care for the geriatric population. A reorganization of the HES aimed at offering integral geriatric care has advantages for the health of the patients, for the hospital and for the health system itself^{2,4}. Thus, the HES needs to provide standardized tools that allow an early detection of the clinical, functional and social needs of patients in a multidisciplinary approach. It specifies the existence of previously organized ambulatory circuits that allow, after the expert clinical evaluation, to offer different care environments to the hospital (high-speed circuits, referrals to subacute socio-health centres or day hospital, home hospitalization). Achieving the shortest possible stays in the HES, as well as having health care areas adapted to senility, are important elements for the prevention of the risks inherent to hospital stay^{3,6}.

But the key point to perform a comprehensive geriatric care in the ED is to achieve clinical evaluation and decision making adapted to chronicity, which allows determining the best path for each patient, depending on their situation. The European Curriculum for Emergency Medicine and Geriatric Surgery (MUEG) will facilitate the training of emergency professionals in this field. It will improve their training in clinical differences in the elderly, in the management of geriatric syndromes (such as delirium or falls), in the risks associated with drugs and polypharmacy and the benefits of medication reconciliation, and even in ethical aspects (review of anticipated wills, patient autonomy and subrogated decisions). Including all these aspects in the competences of the emergency physicians is essential to develop a therapeutic plan focused on the patient, which adapts the diagnostic and therapeutic intensity to the clinical, social and functional needs and ensures continuity in the care after the stay in the HES. Undoubtedly, the European curriculum of the MUEG is a step forward in the right direction.

Mireia Puig Campmany,
Josep Ris Romeu,
J. Leopoldo Higa Sansone,
Sergio Herrera Mateo,
Héctor Hernández Ontiveros,
Salvador Benito Vales

*Emergency Service and Coordination Transplant,
Hospital de la Santa Creu i Sant Pau, Universitat
Autònoma de Barcelona, Spain.
mpuigc@santpau.cat*

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Zika virus infection acquired through sexual contact: first documented case of local transmission in Spain

Primer caso documentado de infección autóctona por virus Zika en España. Transmisión por vía sexual

To the editor:

The Zika virus (ZIKV) is a flavivirus that causes a flu-like picture, similar to dengue and other viral diseases (fever, myalgia, arthralgias, skin rash)¹, whose main complications are neurological disorders (Guillen-Barré syndrome)² and defects Fetal diseases³ (microcephaly, cerebral calcifications). It is an emerging disease that is spreading throughout the world⁴. It is transmitted mainly through mosquitoes, the species *Aedes aegypti* and *A. albopictus*, but it has also been obser-

ved person to person transmission through sexual contact^{5,6}.

A 17-year-old woman, of Spanish nationality, who attended the Severo Ochoa University Hospital in Leganés, Autonomous Community of Madrid (CAM), due to a fever of up to 38°C, and pruritic skin rash, of 48 hours of evolution. In the directed anamnesis, the patient denied food allergies, drug or toxic substances consumption. I did not have animals at home. I had not travelled outside the CAM in the last month. However, he admitted having had unprotected sex with his partner, diagnosed 2 weeks before infection with ZIKV, which he had purchased on a trip to Brazil. In the physical examination of the patient, a papular maculo exanthema was highlighted on the trunk and upper and lower limbs, which included palms and soles, and which bleached the pressure-digit. He also presented pharyngeal hyperaemia, as well as oedema and erythema of the fingers of the right hand, with mild pain on palpation, with no evidence of arthritis in any joint. Conjunctival hyperaemia was not observed. In the analysis performed, a slight leukopenia (4,290 leukocytes/mL), with a normal formula, and a slight elevation of C-reactive protein (16 mg/L) were noted. The rest of the analytical parameters were normal. Serology and polymerase chain reaction (PCR) were requested in serum and urine for ZIKV, which were sent to the National Microbiology Centre of Majadahonda. Serology and PCR were negative in serum; On the other hand, the PCR of ZIKV in urine was positive. Two weeks later the tests were repeated: serum CRP remained negative, and in the urine it remained positive. In serum, positive IgM and IgG were detected against ZIKV, thus showing seroconversion, which confirmed the diagnosis of ZIKV infection. Her partner underwent a ZIKV PCR in semen, which was positive, showing that the source of infection of the patient was her sexual partner.

So far, in Spain, all the cases of ZIKV diagnosed had been imported,

this being the first documented autochthonous case of ZIKV infection in Spain. In the CAM, where the patient resides, the presence of mosquitoes of the genus *Aedes*⁷ has not been detected. The fact that the patient during the last month had not travelled outside the CAM precludes having acquired the infection through the vector. Instead, he had unprotected sex with a partner diagnosed with ZIKV infection, in whose semen the presence of the virus was demonstrated, confirming that sexual transmission was the mechanism of infection. We would like to highlight the importance of performing PCR determination of ZIKV in urine⁸ since in the case presented it was the positivity of this which initially established the diagnosis, since in serum both PCR and serology were negative in the analytical determination initial. It is also important note that we must advise our patients, as recommended by the World Health Organization (WHO)⁹, the use of protective measures (condoms), or sexual abstinence, for at least 6 months after the diagnosis of Zika virus infection.

Beatriz Valle Borrego,
Kristina Kosanic,
Fernando de Ory,
Francisco J. Merino Fernández,
Blanca Gómez Rodríguez
*Severo Ochoa Hospital, Alfonso X el Sabio
University, Madrid, Spain.
beatrizvb2011@gmail.com*

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