Note of the editors: This is a BOWMAN-generated English translation of the officially indexed Spanish-language article, which should be cited as Emergencias 2026;38:78-80. In this translated version, the editors have supervised the process; however, it cannot be ruled out that some errors resulting from the artificial intelligence translation process may have gone unnoticed.

LETTERS TO THE EDITOR

Authors´reply

Respuesta de los autores

To the Editor,

We sincerely appreciate the interest shown by the authors of the letter in relation to our article[1] and value their comments, which we consider constructive and helpful for contextualizing the results.

Regarding the definition of low-acuity visits, we agree that the use of administrative diagnoses may entail some degree of clinical imprecision. Nevertheless, our study employed the most exhaustive list available in the literature (4,908 ICD-10 codes) and applied specific sensitivity analyses by modifying the length of the ED stay thresholds (from 5 to 7 hours) and subsequent hospitalization windows (from 7 to 30 days). These analyses demonstrated notable stability of the results, reinforcing the robustness of the definition used. In the absence of databases with systematic information on triage levels or 72-hour revisits for the entire Catalan population, administrative diagnoses remain the most widely accepted standard for longitudinal population-based studies of this nature.

With respect to the variable "nationality" and potential territorial confounders, our primary model in-

corporated fixed effects for health areas and primary care provider units, thereby controlling for structural differences in context, service availability, and population composition. Indeed, the observed effect of nationality is interpreted cautiously in the article, as a possible proxy for cultural factors or familiarity with the health care system rather than as a direct causal factor. We nevertheless agree on the desirability of including, in future studies, more granular indicators of accessibility and continuity of care—such as appointment waiting times or effective assignment to a primary care physician—provided that such information is homogeneously available across the territory.

As for the observed reduction in low-acuity visits after March 2020, the analysis presented in the article is descriptive and contextual in nature. It was not intended to establish a structural or causal effect of the pandemic period, but rather to document an abrupt change coinciding with the declaration of the state of alarm. We acknowledge that interrupted time-series analyses would represent a valuable complementary approach to distinguish between level and trend effects; in fact, we are currently developing additional studies focused on this temporal perspective.

Finally, we share the concern expressed on the importance of integrating safety metrics and accounting for heterogeneity across emergency departments before formulating broad organizational recommendations. The purpose of our study was to identify population-level patterns and generate hypotheses, rather than to establish definitive causality.

We sincerely thank the authors for their comments, which help enrich the scientific debate on emergency department utilization by older adults and underscore the importance of continued research in this field.

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