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LETTER TO THE EDITOR

Novelties in pediatric cardiopulmonary resuscitation recommendations

Novedades en las recomendaciones de reanimación cardiopulmonar pediátrica

Dear Editor:

We thank Dr Abel Martínez et al.[1] for their letter in response to our article, ''Novelties in the pediatric cardiopulmonary resuscitation recommendations and lines of development in Spain'',[2] in which they discuss the recommendations of the paediatric life support writing group of the European Resuscitation Council (ERC), of which they are members.[3]

The authors state that some of the novelties in the ERC recommendations that they consider relevant were not discussed in our article, contribute a table detailing them, while, on the other hand, they argue that some recommendations identified as, novelties in our article are in fact not.

Furthermore, the authors remark that the differences between the recommendations of the International Liaison Committee on Resuscitation (ILCOR), the modifications made by the ERC and the proposals of the Spanish Group of Paediatric and Neonatal Cardiopulmonary Resuscitation (GERCPPYN) are not clearly stated, and that they consider it important to be specific about them.

Needless to say, the criteria used to determine what is most relevant or constitutes a novelty may be debatable. The aim of our article was to analyse international and European paediatric cardiopulmonary resuscitation (CPR) recommendations as of 2020, to highlight the most relevant changes and to propose lines of development for CPR training and clinical protocols in Spain. Based on these objectives, the Executive Committee of the GERCPPYN analysed the recommendations of both the ILCOR[4] and the ERC[3] (without focusing specifically on the ERC recommendations) and selected by consensus the novelties considered most relevant for clinical practice.

Leaving aside interpretations regarding their novelty, we considered highlighting some of the recommendations again important, such as the administration of adrenalin as soon as possible after the diagnosis of cardiac arrest if vascular access has already been established, which, despite what the writers argue, is a relevant change compared to the 2015 recommendations[5] whose integration in clinical practice and training we consider essential.

On the other hand, a perusal of Table 2, developed by the authors, evinces that the actual differences between the ILCOR, ERC and GERCPPYN recommendations are, as can only be expected, very small, although the authors seem intent on magnifying them, highlighting differences, for instance, based on whether the recommendation was included in the full text and/or the flow diagram of the algorithm, mere differences in terminology (chest ''thrusts'' vs. ''compressions'' in the management of airway obstruction) or wording or, lastly, slight differences in the dose range recommended for certain drugs (0.1—0.2 mg vs. 0.2 mg/kg for the first dose of adenosine in the management of supraventricular tachycardia or 10 mL/kg vs. 10—20 mL/kg for the initial fluid bolus for volume expansion), when both doses are correct.

Once again, we would like to highlight the importance of adhering to the CPR recommendations based on the international consensus treatment recommendations (ILCOR) with the adaptations proposed by the ERC for Europe and by the GERCPPYN for Spain, and for all paediatricians and health care professionals who deliver care to children to be actively involved in their CPR learning.

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