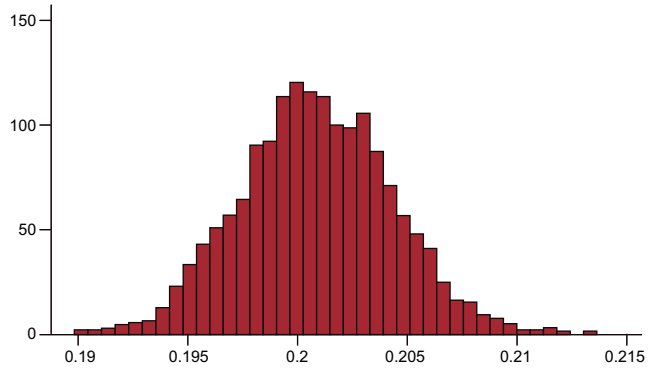

Figure. Histogram representing the obesity variable after 12 500 Markov chain Monte Carlo iterations using the Metropolis-Hasting algorithm.

persons aged between 18 and 64 years in their sample was 19.78%. If Bayesian statistics were used, it would then take these data as existing information to subsequently obtain deeper knowledge by calculating the credible interval.

In this approach, for example, if one takes a beta distribution as the *a priori* probability of obesity (1 898.7700),[4] with the variable obesity and a Bernoulli distribution, and if one then adds the data obtained by Aranceta-Bartrina et al.,[1] after 12 500 iterations and a burn-in period of 2500, one would obtain an *a posteriori* obesity prevalence of 20.1% with a 95% credible interval of 19.4% to 20.8%. That is, this time there would indeed be a 95% probability that the overall prevalence of obesity in Spain is between 19.4% and 20.8%. The Figure shows a histogram representing the distribution of obesity according to Markov chain Monte Carlo simulations.

This coincides almost exactly with the confidence interval provided by Aranceta-Bartrina et al.[1] (19%-24.2%), because when studies are similar in design, the confidence interval and the credible interval tend to be similar,[2] although this is not necessarily the case. If Bayesian statistics are not used, there are 2 options: pay attention to only 1 of the studies and ignore the other (even if the methodology of both is appropriate) or conduct a third study that generates more evidence and acts as a "tie breaker", even in the knowledge that it will not answer the original question.

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Why Not Use Existing Knowledge: Bayesian Statistics. Response

Por qué no utilizar el conocimiento previo: la estadística bayesiana. Respuesta

To the Editor,

We would like to thank Hernández-Vaquero et al. for their interest and comments on our study.[1] We agree that a Bayesian approach could enhance the analysis of data from the ENPE study (Spanish acronym for the Nutritional Study of the Spanish Population), and we will consider this for future publications. The debate on Bayesian vs frequentist methods has been open for some time.[2,3]

We used frequentist inference to analyze data collected from a random probability sample (n = 3966), with a careful methodological protocol and quality controls. All the studies we used as reference and context, conducted in Spain and other countries, used this approach. Hernández-Vaquero et al. state that their Bayesian estimate coincides almost exactly with our frequentist estimate, which often happens when the studies are of similar design and the sample size is large.

We share the view of many other authors, that neither approach is superior: each has its advantages and limitations. It is true that interest in Bayesian methods is increasing, as reflected in the changes in the number of publications retrieved when searching the term "Bayesian" in PubMed.[4] In studies from the last 6 years (2010-2015), 16 665 publications include "Bayesian" in the title or abstract, and 81 321 include "obesity", but only 71 records contain both "Bayesian" and "obesity". Most epidemiological research has been done (and continues to be done) using a frequentist approach, without jeopardizing the knowledge acquired. Many authors use both approaches, depending on the research question, the study design, the size and design of the sample, the type of data, etc.[5] We advocate a pragmatic approach, based on reasoning, reflection, and contextualization of the data.

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CONFLICTS OF INTEREST

S. Lázaro-Masedo and N. Ramos-Carrera are linked to SPRIM, who carried out consulting activities for the *Fundación Eroski*.

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Does Implementation of the Infarction Code Lead to Changes in the Treatment and Prognosis of Patients With Non-ST Elevation Acute Coronary Syndrome?

¿La implantación del código infarto implica cambios en el tratamiento y el pronóstico de los pacientes con síndrome coronario agudo sin elevación del ST?

To the Editor,

We read with interest the article by Cordero et al.,[1] which analyzed the effects of implementing an infarction code program on the treatment and prognosis of patients with acute coronary syndrome.

Firstly, we would like to congratulate the authors for the elegant description of the benefits that such programs have on the management of ST-elevation acute coronary syndrome (STEACS). They achieved outstanding results, with the rate of primary angioplasty in STEACS patients increasing from 51.9% to 94.9% in their hospital.

We would also like to point out that the implementation of such networked care systems for the emergency management of STEACS could have led to NSTEACS patients being pushed into the background, even though these patients form the majority of acute coronary syndrome patients admitted to our hospitals.[2] We would like to further congratulate the authors for the inclusion of these patients in their study. We agree that, although theoretically the main objective when implementing an infarction code program is to improve STEACS management by facilitating access to primary angioplasty, as this study demonstrates, implementing standardized protocols and care networks can also improve NSTEACS management. However, we would like to make some comments we feel are pertinent.

The benefits of implementing an infarction code for patients with STEACS have already been described; therefore, the most interesting part of this study is, in our opinion, the analysis of the changes in treatment and prognosis for patients with NSTEACS. From the authors' description, it appears that implementation of the code had no significant effect on the NSTEACS subgroup. In fact, it appears that the reductions in hospital stay and intensive care stay and the increased revascularization rate in the first 48 hours correspond only to patients with STEACS; in patients with NSTEACS there were no differences in the time to revascularization or in revascularization rate.[1] Although these variables were unchanged for the group of all NSTEACS patients, there may have been some differences in high-risk NSTEACS patients, who require early invasive treatment[2] and therefore should benefit more from the implementation of such a protocol. If such differences were present, this could partly explain the reduction in overall mortality in high-risk acute coronary syndrome patients. It would be interesting to know how many patients with NSTEACS were considered high risk according to current clinical practice guidelines,[2] and if implementation of the program led to an increase in the percentage of these patients receiving coronary angiography and revascularization in the first 24 hours.

If such differences in high-risk NSTEACS patients were not present, the trend seen toward reduced mortality in NSTEACS patients but not in STEACS patients would be remarkable, considering that there was no increase in the early revascularization rate in NSTEACS patients, and that the patient risk profile was higher in the second study period, according to the GRACE score.[1] It would be interesting to know the authors' opinions regarding changes in medical treatment after implementation of the program and other factors that may have played a role in this finding.

Regarding the reduction in mean stay for STEACS patients, we would also like to ask the authors about one of the more contentious organizational aspects of this type of networked care: organizing patients' return transfer to their original referring hospitals after primary angioplasty. It would be interesting to know more details, such as if these patients were ever admitted to the intensive care unit after primary angioplasty and before