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Letters to the editor

Update to the Consensus Document on Clinical Use of the Polypill: New Dose Containing Atorvastatin 40 mg

Actualización del documento de consenso del uso clínico del policomprimido: nueva dosis con atorvastatina 40 mg

To the Editor,

In 2017 an update was made to the consensus document on the clinical use of the polypill for secondary prevention in cardiovascular (CV) disease, which had been written in 2015 and published in *Revista Española de Cardiología*.[1] This document was the first to establish recommendations on the use of this treatment option and had the scientific endorsement of the Spanish Society of Cardiology (SEC), the Spanish Society of Internal Medicine (SEMI), the Spanish Society of Family and Community Medicine (SemFYC), the Spanish Society of General and Family Practitioners (SEMG), and the Spanish Society of Primary Care Physicians (SEMERGEN).

There were multiple reasons for updating the document: *a)* the publication of new evidence on polypill use in everyday clinical practice, *b)* the introduction of a new dosage form with 40 mg atorvastatin in addition to the existing forms, and *c)* the recommendation in the document "*La actualización del Manual Metodológico para la Elaboración de Guías de Práctica Clínica en el Sistema Nacional de Salud*" (Update to the Methodological Manual for the Development of Clinical Practice Guidelines in the National Health System),[2] issued in 2016, on the appropriateness of carrying out updates at least every 2 years, with the aim of maintaining the value of the guidelines, both for clinical staff and for health care regulators.

The update[3] discussed here was carried out based on the methodological manual mentioned above, [2] which establishes the foundation that should guide the update of recommendations. Broadly, after a nonexhaustive systematic search for new evidence, a bibliographic synthesis was developed that allowed the recommendations update group to propose the new recommendations to be included and those requiring modification. The group that validated the recommendations (28 experts), using a modified Delphi method, proceeded to the validation of the new and modified recommendations; the percentage agreement was higher than that established in the working protocol (> 80%), and consequently a final participative session was not required. All the new and modified recommendations were categorized with the level of evidence and grade of recommendation, according to the modified version of the Scottish Intercollegiate Guidelines Network (SIGN) system.[4]

Of all the recommendations in the 2015 document, 32 were considered still valid, 5 were updated, none were removed, and 1 new recommendation was included. Figure shows the topics updated, which can be summarized as: *a)* earlier prescription for patients with an acute CV event, *b)* the possibility of using the polypill for patients on high-intensity lipid-lowering therapy with a statin other than atorvastatin; *c)* redefinition of the patient profiles for high or very high risk and subclinical CV disease who could take the polypill, and *d)* use in patients with stents.

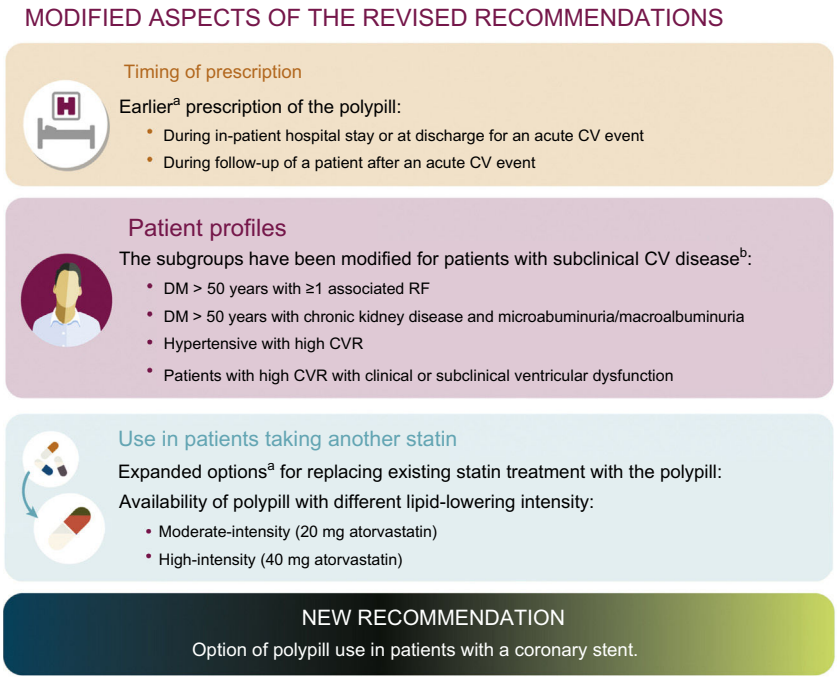

Figure. Topics updated in the consensus document. CV, cardiovascular; CVR, cardiovascular risk; DM, diabetes mellitus; RF, risk factor.
[a]The polypill is now available with 40 mg atorvastatin.
[b]Provided they do not have a high risk of bleeding.

The update document does not contain any changes to the preferred indication criteria for the polypill in the context of secondary prevention of CV disease, although the new evidence on polypill use and the introduction of the new 40 mg atorvastatin dosage form do broaden the therapeutic spectrum of patients who could benefit from its use. Furthermore, these developments justify the update to the consensus document on the clinical use of the polypill as CV risk prevention, which will allow clinical staff more uniformity in making decisions in line with the available evidence.

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CONFLICTS OF INTEREST

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Anglicisms in Spanish: Apropos of "Into the Heart of Terminology"

¿Ligera y severa o leve y grave? A propósito de «Viaje al corazón de las palabras»

To the Editor,

The cardiology community should be extremely grateful for the recently-added section of *Revista Española de Cardiología*, "Into the heart of terminology". The wisdom and experience of Professor Fernando Navarro teaches us something new in each edition of the journal and shows us the rights and wrongs of medical language use.

English, despite what some may believe,[1] is the language of science,[2,3] so modern professionals need to know that language in depth: first, for their professional advancement, and second, to be able to share their knowledge and allow the results of their research to reach a wide audience. However, inappropriate translations have led to the increasing inclusion of foreign-language terms (anglicisms in this case) in our scientific language repertoire, despite there being well-established equivalents in Spanish. Therefore, many physicians and linguists, such as the aforementioned Dr Navarro, have become staunch defenders of Spanish medical language,[4–6] in an attempt to help improve how medical professionals talk and write.

We are not referring to *stent, strain rate, milking, kissing, odds ratio or end point*,[2–4] to name just a few examples that have been gladly accepted because conciseness and the lack of a short, simple equivalent in Spanish favor the use of the English term. However, *patología* instead of *enfermedad* for a disease or "pathology", *admisión* rather than *ingreso* (admission), *balón* instead of *globo* (balloon), *patente* instead of *permeable* (patent), *banding* instead of *cerclaje* or *ligadura*, *cleft* instead of *hendidura*, *leak* instead of *fuga* or *escape*, *flap* instead of *colgajo*, *desorden* instead of *trastorno* or *alteración* (disorder) and *randomizado* instead of *aleatorizado* (randomized), along with many other examples, have become common words, to the detriment of (or perhaps as part of the evolution of) our rich Spanish language. Unfortunately, as Fernando Navarro points out in his excellent article[6] (which we recommend reading), some of the reasons for this are ignorance, laziness, and snobbery.

This reflection raised a question with us: what terms should we use to describe the severity or status of a particular condition or disease, for what would be described in English as mild and severe - *ligera* and *severa* or *leve* and *grave*?

As far as we understand, although *ligera* (literally, *light*) usually describes the weight of objects, *ligera* and *leve* are synonyms and can be used interchangeably in this sense, to describe something slight, subtle, or of little importance; however, this is not the case with *severa* and *grave*. *Severa/o* (from the Latin *sevērus*) is the inappropriate translation of the English term *severe*. In Spanish, it bears no relation to describing the seriousness of a particular condition or disease, which it does in its original language, as the American Heritage Dictionary of the English Language defines it, in one of its accepted uses, as "very dangerous or harmful; grave or grievous".[7] In contrast, the *Diccionario de la Real Academia Española*[8,9] defines the word as an adjective, meaning:

1. *Riguroso, áspero, duro en el trato o el castigo* (strict, harsh, tough in manner or punishment).