Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Response to the article: Spread of COVID-19 cases in Africa☆

África tiene una epidemia de COVID-19 menos intensa. Réplica al artículo: Propagación de casos COVID-19 en África

To the Editor,

I would like to take this opportunity to reply to some of the interesting comments made by González Rodríguez[1] on the article Why is the COVID-19 epidemic in Africa less ''intense''?[2]. First, I wrote the article a few months after the start of the COVID-19 pandemic, and did not therefore have the benefit of hindsight.

The article referred exclusively to Africa, and even now, one year on, the data continue to show that the epidemic is less intense in this continent than elsewhere. This is clearly illustrated by Fig. 1 of the article by González Rodríguez[1], where we can see that Africa is the second most populated continent, but the one with the lowest number of cases and deaths from COVID-19. Refining the geographical area even further, we can see from WHO country and global data[3] and Worldometers data[4] that tropical African countries are the least affected than other countries of this continent.

The minimum information needed to determine the impact of COVID-19 in a particular country is the number of cases and the mortality rate. I fully agree with González Rodríguez that COVID-19 cases are under-reported in Africa. This is due to poverty and scarcity of resources. It is true that testing was delayed in several African countries, but the main obstacle is that many patients do not go to the doctor and are not tested because they cannot afford to pay for the service. Interestingly, according to data from Worldometers[4], by 19 April of last year, 946,894 tests/million inhabitants had been performed in Spain compared with only 1582 tests/million inhabitants in the Democratic Republic of the Congo (DRC). This phenomenon also occurs, to a lesser degree, on other continents. With regard to mortality, the criteria used to attribute deaths to COVID-19 are known to vary from country to country. Generally speaking, the death rate is underestimated. This distortion is sometimes due to political motives, and makes it impossible to accurately ascertain the real impact of the SARS-CoV-2 pandemic. A more accurate picture of the real impact can be obtained by studying the excess death rate[5,6]. This parameter is measured as the difference between the reported number of deaths for a given period vs. the number of deaths that would be expected over that period in preceding years. Currently, it is reasonable to assume that excess deaths are mainly attributable to COVID-19, and though not exact, this calculation more closely reflects the real situation. In some countries, COVID-19-mortality rates are consistent with excess death rates, but in most the latter is higher. Spain is one of the countries in which the excess death rate exceeds the number of deaths attributed to COVID-19[5,6].

On the subject of the factors that can explain the low intensity of the pandemic in Africa, at least in the DRC, where I have lived for 2 years, I disagree with González Rodríguez's suggestion this is due to the delayed arrival of the virus on the continent due to the early closure of borders and other social measures. This is because compliance with these measures, as shown by Wimba et al. in Bukavu[7], a large city in eastern DRC, has been sketchy. This is also true of the capital, Kinshasa, which has a population equivalent to more than a quarter the entire population of Spain, and where people walk along the streets without masks, without observing social distancing, in continuous contact with each other in moto-taxis, taxis, crowded buses, and markets, and where confinement measures have hardly been implemented because it is impossible to comply with them. Furthermore, major deficits in health care due to lack of resources (for example, many countries have not yet begun their vaccination campaign), and the lack of sufficient beds and trained personnel to care for critically ill patients also contributes to extremely high mortality rates; however, only 745 deaths have occurred since the epidemic began[4]. In other words, despite the presence of social factors that would favour an exponential spread of the virus, this, paradoxically, has not occurred. Therefore, the lower intensity of the pandemic is really due to the presence of the other factors, although it is difficult to estimate the importance of each of these.

With regard to climate, available data on the influence of temperature, humidity and wind speed on the spread of the epidemic have a positive correlation with many African countries[8]. In fact, in European countries this same effect was observed in 2020 from May until August.

The important role of population pyramids in which a small proportion of the population is aged 65 years of age has also been established[9]; in my opinion, this may be the most important factor in the low mortality observed in these African countries.

There are few data regarding immunity and the role of genetics in COVID-19 resistance. However, there is evidence of a lower incidence of infection among people with the blood group O compared to the other groups. The most prevalent blood group in the DRC is, in fact, group O[10,11].

In my opinion, the higher death rates observed in Africa compared to Europe (see the author's Fig. 2), despite the limitations of underreporting, is an interesting parameter that illustrates the quality of healthcare systems, as well as the evolution of their capacity to respond to the crisis. In the case of Africa, on 25 November 2020, the death rate was 2.39% and 2.64% on 19 April 2021[4].

In conclusion, the COVID-19 pandemic in Africa, despite major limitations and shortcomings, continues to be less intense.

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Diploma on ultrasound training and competency for intensive care and emergency medicine: Consensus document of the Spanish Society of Anesthesia (SEDAR), Spanish Society of Internal Medicine (SEMI) and Spanish Society of Emergency Medicine (SEMES)☆

Documento de consenso de la Sociedad Española de Anestesiología y Reanimación (SEDAR), Sociedad Española de Medicina Interna (SEMI) y Sociedad Española de Medicina de Urgencias y Emergencias (SEMES) para la definición de competencias mínimas de ecografía en Cuidados Intensivos y Urgencias y la obtención del Diploma Acreditativo

To the Editor,

We were particularly interested to read your article ''*Documento de consenso de la Sociedad Española de Anestesiología y Reanimación (SEDAR), Sociedad Española de Medicina Interna (SEMI) y Sociedad Española de Medicina de Urgencias y Emergencias (SEMES) para la definición de competencias mínimas de ecografía en Cuidados Intensivos y Urgencias y la obtención del Diploma Acreditativo*'' (''Diploma in ultrasound training and competency for intensive care and emergency medicine: Consensus document of the Spanish Society of Anesthesia (SEDAR), Spanish Society of Internal Medicine (SEMI) and the Spanish Society of Emergency Medicine (SEMES)''[1].

We agree with the authors that the greater availability of ultrasound in critical care services calls for measures to standardise training in this technique in order to achieve quality care. Despite being a useful, widespread tool, there are still no training programs that guarantee basic knowledge. We believe it is necessary to define certain goals to be achieved during basic ultrasound training.

Although the program presented covers 3 important areas in the management of the critical patient[1], it does not include one of the key skills. Focused assessment with sonography is essential for both the diagnosis and treatment of critical cases, and is one of the first tools used to evaluated these patients. For this reason, we would like to draw attention to the need to compile some basic concepts of clinical ultrasound in order to define the minimum ultrasound skills required in critically ill patients (Table 1), based on consensus statements published by scientific societies[2].

Focused cardiac ultrasound (FoCUS) in critical care specialists can be divided into 2 levels: basic and advanced[3,4].

The goals of basic training include the detection of left and right ventricular systolic dysfunction and the visualisation of pericardial effusion[3,4]. FoCUS can also be used to assess the need for fluid therapy and vasoactive support, and it is the primary assessment tool in patients presenting haemodynamic shock. This is why this technique must be

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