Los resultados observados de estas medidas consisten en una mayor empatía con el paciente y disminución del estrés y sintomatología de trastornos psicológicos que la hospitalización genera,[5] así como el fortalecimiento en la relación médico-paciente-familiar para aminorar el estigma que existe hacia la enfermedad de parte de quien la padece y del mismo personal de atención.

Por lo tanto, se presenta una propuesta para la realización de estos enlaces a través de videollamadas entre los pacientes y familiares, con los ajustes y adecuaciones que pueden requerirse según las necesidades del momento (figura 1).

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Empathetic remote death notification in the context of Covid-19

Dear editor: At the time of writing, June 08, 2020, it is estimated that around 400 000 people have died of Covid-19, and it is predicted that the number of deaths will continue to rise.[1] During clinical training, healthcare professionals receive little guidance on how to transmit death notifications; this has been correlated with negative psychological effects for the family members receiving the information and even for the healthcare professionals transmitting it. Despite its heterogeneity, training for healthcare workers on how to communicate bad news has allowed them to significantly improve their skills, confidence, and empathy when put into practice.[2] Nevertheless, there is no specific protocol for death notifications in the Covid-19 context. However, recommendations based on protocols used prior to the pandemic can be offered. Therefore, the purpose of this paper is to provide a brief and clinically practical adaptation that helps healthcare professionals to communicate death notifications within this context.

Recent reports on Covid-19 point out that remote communications can be great resources in facilitating contact in this context.[3] Below we describe nine steps adapted from the GRIEV_ING protocol[4] widely used in Emergency Medicine to communicate death notifications, which could help healthcare professionals transmit death notifications remotely (by video call or telephone). Table I[4] shows the steps with relevant examples: 1) before making contact, gather information about the case, find a private space, and carry out any physical and emotional self-care actions; 2) make sure you introduce yourself; 3) ask the family member what information he/she already has about the health of their relative; 4) continue the timeline of events that led to the patient's death starting from where the family member ended their story; 5) use preparatory phrases and then clearly express that the person has died; 6) give the family member a moment to give his/her emotional response. If needed, use empathetic phrases and psychological first aid;[3] 7) inform the family member of the post-mortem process, and explain the importance of checking him/herself for any possible Covid-19 symptoms; 8) answer any questions and offer to refer them to support within their local healthcare system; 9) after ending the call, clean your workspace and assess your emotional wellbeing.

By following the recommendations in these nine steps, it is likely that healthcare professionals will transmit death notification more clearly, respectfully, and empathetically in a context that so urgently needs it.

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Table I
Steps, recommendations and examples for delivering death notification remotely

Steps	*Recommendations or examples*
(1)	Clean your workspace and make sure there is good telephone or internet connection. Use breathing techniques (e.g. diaphragmatic breathing) to regulate your stress.
(2)	Speak slowly, clearly, and calmly. If possible, involve loved ones.
(3)	Gather any sociodemographic information about the family member and identify any potential risks when conveying the news. Use open-ended questions to find out what he/she knows about the health of his/her relative.
(4)	"As you mentioned, Mr./Ms. [say the name of the family member], we received patient [name of the patient] in these conditions: [describe the conditions avoiding any jargon]. We followed these procedures: [avoid jargon]. Don't tell them about the death yet!
(5)	Other preparatory phrases could be: "[name of the family member], I'm sorry to tell you that," or, "I wish I could give you better news," and immediately after express clearly that the person [name of the patient] "died," or "passed away". Avoid euphemisms such as "he/she is gone," and "is no longer with us." This could confuse the family member.
(6)	When using empathetic phrases, be genuine in your interactions. Make sure the family member feels that he/she can trust you and that you are on his/her side. Avoid value judgements, and, when possible, create common goals which can realistically be achieved. If the family member experiences a crisis or shock connect him/her to a specialized mental health support group.
(7)	Empathetically inform the family member of all local processes to manage the diseased patient be empathetic when conveying this information. Restate the importance of the family member remaining in self-isolation and checking whether he/she develops any Covid-19 symptoms.
(8)	Have the phone numbers of available local support for the physical, social, and mental wellbeing of the family member at hand.
(9)	Clean any devices you used. Regulate your stress. If needed, seek support from a specialized mental health group.

Note: These steps were adapted from the original GRIEV_ING protocol[4]

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Variabilidad genética y epigenética, y la pandemia de Covid-19

Señor editor: México y la mayoría de los países se han visto afectados por la pandemia provocada por la infección del virus SARS-CoV-2. Empero, por la capacidad trágicamente selectiva de esta enfermedad surgen varios cuestionamientos: ¿Por qué algunos pacientes son asintomáticos o presentan síntomas leves? ¿Por qué aunque la mayoría de los enfermos críticos reportados suelen ser personas adultas mayores –o que tienen una patología asociada como cardiopatía, obesidad, hipertensión, diabetes, entre otras– algunas personas fallecidas son jóvenes y aparentemente sanas? ¿Esta variación en el comportamiento clínico y geográfico de la Covid-19 estaría relacionada con la variabilidad genética?

La variabilidad genética especifica la diversidad en las frecuencias de los genes y mide, por lo tanto, la tendencia de los genotipos, por lo que describe también las distinciones entre individuos o poblaciones.[1] Equivalentemente, se debe considerar el rol que desempeña la epigenética que está fundamentada en la metilación del ADN y la modificación de histonas, entre otros mecanismos, y que es habitual en virus que suelen viciar estos mecanismos y producir una desregularización en la célula huésped.[2]

Por lo anterior, sería importante analizar el genoma de los pacientes graves de Covid-19 que no tengan ninguna enfermedad subyacente y compararlo con aquellos paucisintomáticos o asintomáticos,[3] con el objetivo de detectar en el ADN variantes genéticas del receptor ACE2, y/o de mutaciones en el cromosoma 6, donde 40% de los aproximadamente 128 genes está implicado con el sistema del antígeno leucocitario humano (HLA, por sus siglas en inglés). Para dicho fin, se inició el diseño de un mapa de susceptibilidad para el SARS-CoV-2 donde se identificó que los individuos con el alelo HLA-B*46:01 eran más vulnerables al virus, mientras que los que expresaban HLA-B*15:03 eran resistentes.[4] Sin embargo, es necesario analizar también los haplotipos virales para determinar sus variaciones, como en el caso de Islandia, en donde los identificados inicialmente fueron