



Correspondence to “Intracranial Pressure Monitoring and Unfavorable Outcomes”

Correspondência a “Monitorização de pressão intracraniana e resultados desfavoráveis”

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Correspondence

We would like to express our surprise after reading the reply to Dr. Chiara Robba's *Intracranial pressure monitoring and unfavorable outcomes* correspondence, written by Brazilian physicians Welling et al., in which the possibilities and tools available for intracranial pressure monitoring in both national and international scenarios are described, stating that “*intracranial pressure monitoring is not included in the management strategy for neurocritical patients*”, using BEST TRIP¹ as such reference. Our astonishment lies in the fact that we, authors of this letter, use intracranial pressure (ICP) monitoring as a daily practice in our neurocritical care unit. As representatives of The Neurocritical Care Committee of the Brazilian Association of Intensive Care Medicine (AMIB, in the Portuguese acronym), we recommend monitoring intracranial pressure in neurocritical patients, since monitoring-guided treatment of intracranial hypertension is associated with a potential improvement in treatment outcomes.

It is important to highlight that Brazil is an enormous country, as big as the European continent itself, and to generalize a medical conduct in a country this big, with different social and geographical realities, is at the very least

inconsequential. Intracranial pressure monitoring has been performed in Brazil since 1990,² and current protocols are based on guidelines or consensus statements published in the medical literature. It is undeniable that neurointensivism knowledge is applied in clinical practice according to a structured and properly trained medical team, as well as to the availability of resources and technologies, both in developed and developing countries. Thus, ICP monitoring is administered differently both in different centers in the same country and in different countries, for reasons related to the local reality and infrastructure.^{1,3}

We believe that it is important not to undervalue BEST TRIP just as much as overestimate SYNAPSE-ICU,³ but it is necessary to understand the limitations of BEST TRIP¹, since in modern medicine and intensive care unit patient care, other methods need to be included and personalized. A sole ICP value and strategy is not suitable for every single individual, especially when considering our critical care patients with highly compromised cerebral autoregulation.^{4,5}

The magical number that defines high ICP has greatly digressed in medical literature. The current 22 mmHg has previously varied between 15 and 25 mmHg, leading to the questions: does one size fit all? Are all hypertensions equal?

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Should oligemia and hyperemia receive the same treatment? We can conclude with three key elements: point of care, multimodality monitoring, and nongeneralization.

Conflict of Interests

The authors have no conflict of interests to declare.

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