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The right to be an organ donor is the responsibility of us all[☆]



El derecho a ser donante de órganos es una responsabilidad de todos

Dear Editor,

Spain has been a world leader in organ donation since 1992 and since 2016 has been the only country in the world with more than 100 transplanted patients per million inhabitants each year. However, there remains a waiting list, and therefore between 5% and 6% of patients are still dying while on the transplant waiting list.¹

The contribution of controlled asystole donation in recent times has resulted in an exponential increase in the total number of organ and tissue donors, currently comprising almost 25% of total donors in our setting.²

Without doubt, the incorporation of intensive care to lead the process has maintained and promoted the success of the Spanish transplant model.³

These new scenarios, and the need to reduce waiting lists, mean health professionals, particularly nurses, must be fully involved through their closeness to the patient and his or her family, and be a fundamental link in the care of the family in the grieving process, as well as in helping to make decisions regarding the option of organ and tissue donation.⁴

For all these reasons, updating knowledge and disseminating results are fundamental tasks for hospital transplant coordination in the area of training for professionals and in the social context,⁵ with a commitment to raising public awareness of organ and tissue donation.

It is obvious and inherent to our profession that all professionals must respect the wishes of the patient in end-of-life care.⁶ Therefore, the necessary regulatory structures within the organisation must be organised so as to make it a priority for health professionals to check the patient's wishes in this regard by consulting the register of advance directives.

With regard to the consensus on limitation of therapeutic effort, this must be clear and, although it falls to the doctor to determine when a patient has no curative options to avoid therapeutic obstinacy, article 21 of Law 2/2010 on rights and guarantees of the dignity of the individual in the process of death⁷ determines that this limitation will take place after hearing the nurse's judgement and in agreement with it. It is important to endorse this, making it incontestable that trained and conscientious professionals in this field will honour the true meaning of our profession, which is above all to offer dignified and quality care to the patient at the end of his/her life.

Finally, I would like to take the opportunity to remind readers of the need to extend nursing research in this field, through important journals such as this. I would suggest that it in this context that our profession still has much to contribute.

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To all the nurses who care for us daily in Spanish ICUs.

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Chlorhexidine for reducing catheter-associated urinary tract infection: An effective yet understudied solution[☆]



Clorhexidina para reducir las infecciones del tracto urinario asociadas al catéter: una solución efectiva, aunque poco estudiada

Dear Editor,

The proportion is high of patients hospitalized in the intensive care unit (ICU) who inevitably need a urinary catheter, and catheter-associated urinary tract infection (CAUTI) is one of the most common infections in these patients.¹ Previous research has established that these infections are often associated with increased resistance of microorganisms to antimicrobial drugs and prolonged stays in ICU, as well as increased morbidity and mortality in ICU patients.

Various preventive and therapeutic measures, such as appropriate use of the urinary catheter and its early removal, have been taken to reduce CAUTIs. However, these infections in ICU patients remain problematic. In this regard, measures such as the use of antiseptics, which reduce bacterial colonisation, have been shown to be effective in reducing CAUTIs. However, the guidelines do not recommend the use of antiseptic agents,² because current evidence is inconclusive on the effectiveness of the available antiseptics for cleansing the meatus prior to catheter insertion.^{3,4}

Because urinary tract infections are preventable, more interventions with a greater positive impact on CAUTI rates are needed to reduce these infections in ICU patients. Among the preventive measures, chlorhexidine cleansing of

the meatus has shown promising but contradictory results in reducing CAUTIs.^{4–6} For example, Mitchell et al.⁶ evaluated the effectiveness and cost-effectiveness of chlorhexidine for meatal cleansing prior to urinary catheter insertion at three hospitals in Australia. The authors found that, compared to normal saline, the use of chlorhexidine (.1%) could reduce the incidence of bacteriuria and CAUTIs. In addition, it was associated with shorter hospital stays and treatment costs. Similarly, Huang et al.,⁷ in a secondary analysis, explored the effect of body surface decolonisation on bacteriuria and candiduria in ICU patients. The protocol included chlorhexidine cleansing of the perineum and the area near the urinary catheters. They found that universal decolonization with chlorhexidine baths could decrease candiduria and any bacteriuria in male patients.

In contrast, Düzakaya et al.⁸ compared the efficacy of periurethral cleansing with .05% chlorhexidine and 10% povidone-iodine or sterile water to prevent CAUTIs prior to indwelling urinary catheter insertion in a paediatric ICU of 122 patients. The authors found that, although the differences between the groups were not significant, CAUTIs occurred less frequently in patients assigned to the chlorhexidine cleansing group. Cao et al.⁴ conducted a network meta-analysis to compare the effect of seven different methods of urethral cleansing, including chlorhexidine, in preventing CAUTIs. They found no significant differences between the different methods of urethral cleansing; however, the effect of chlorhexidine was better than that of the other methods. The authors recommended the use of chlorhexidine to cleanse the urethra only in critical patients.

In view of the above, the results of studies examining the efficacy of chlorhexidine are inconsistent. Notably, there are limited studies that examine the efficacy of chlorhexidine in ICUs to reduce CAUTIs. There are several reasons to suggest that the use of topical chlorhexidine merits further clinical research to assess its effectiveness in reducing ICU-acquired CAUTIs. Chlorhexidine is a biguanide with broad-spectrum antiseptic activity, with no significant reported adverse effects, that is used to reduce bacterial infections and multi-drug resistant organisms. It can provide bacteriostatic and bactericidal action over 24 h, after an application of 2 min., and is also active on fungi and some viruses. It is available worldwide, and no prescription is required. It is

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