of oxygenation improvement. The ultrasonographic semiquantitative scores have also been used to predict the effectiveness of prone position ventilation.

Overall, lung ultrasonography has the potential and unique advantages in the diagnosis, treatment, and prognosis of COVID-19 patients who require gas exchange support. Moving forward, we need well-designed clinical studies to validate the use of lung ultrasonography in facilitating decision-making and improving outcomes in mechanically ventilated COVID-19 patients.

Competing Interests

The authors declare no competing interests.

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Transesophageal Echocardiogram to the Rescue in Diagnosing Ascending Aortic Pseudoaneurysm: Comment

To the Editor:

We read with great interest the article by Yu and Fabbro.[1] However, we found an error in that the labels (Co [suprasternal collection] and Ao [ascending aorta]) in *right image A* and *B* of the original article were all opposite. The reasons are as follows.

The shape of the ascending aorta in mid-esophageal ascending aortic short-axis view should always be round (fig. 1, *blue circle*) rather than oval (fig. 1, *red circle*). In the *right image A* and *B*, the inappropriately low Nyquist limit of 46.2 cm/s overestimated the flow velocity in cavity labeled Co might misguide the authors to regard the laminar flow in ascending aorta as turbulent flow in fluid collection.[2] Besides, the proximal jet width widened steeply after the flow went through rupture site followed by filling the whole cavity labeled Co, which was unconventional. The simultaneous existence of red and blue (laminar flow), brighter color (turbulent flow), even black (no flow) in the color Doppler box, and the accelerated flow began from the opposite cavity wall of the rupture site in the cavity labeled Ao, were also illogical. Crucially, the images *A* and *B* were obtained by xPlane mode, and the flow direction should be from left (ascending aortic proximal site) to right (ascending aortic distal site) in the view (fig. 1B).[3] Hence, the jet direction through narrow rupture site should be from upper left to lower right (fig. 1B), followed by the shunt widening gradually, and the red flow in the cavity labeled Ao might be due to the blood flow diverting direction toward the probe by the hit of the cavity wall.

In short, we suggest that the authors exchange the sites of labels Ao and Co in the *right image A* and *B*. Our viewpoint would be confirmed if the authors offer the video and spectral Doppler of the shunt in rupture site. This article would be more accurate and useful to readers with correct labels attached.

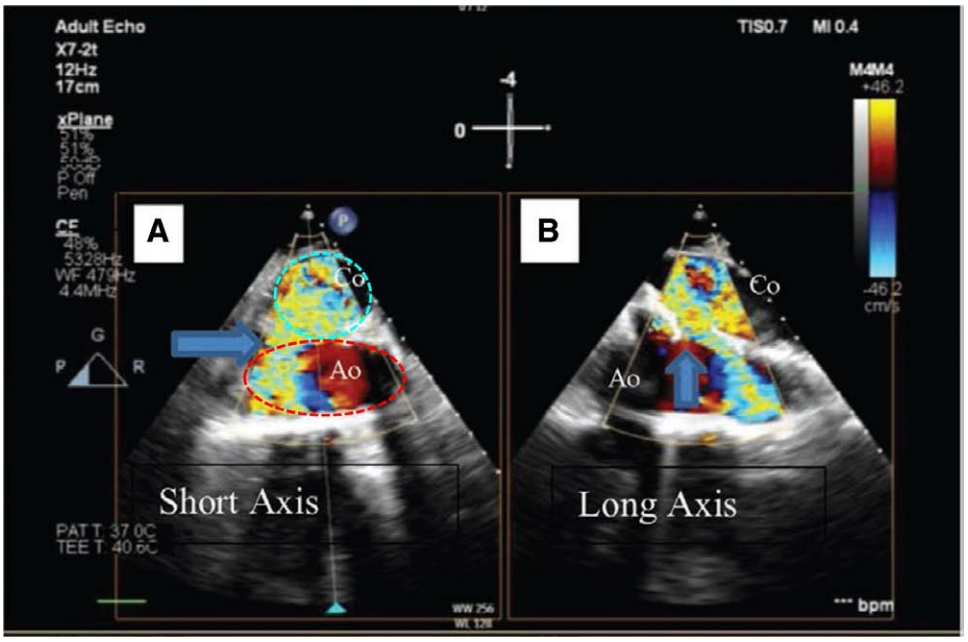

Fig. 1. The mid-esophageal ascending aortic view of the original article. *Blue circle*: round; *Red circle*: oval.

Competing Interests

The authors declare no competing interests.

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Transesophageal Echocardiogram to the Rescue in Diagnosing Ascending Aortic Pseudoaneurysm: Reply

In Reply:

I thank Dr. Chen *et al.* for their comments[1] and for their interest in my article.[2] After review of the images, I agree that the labels Co (pseudoaneurysm collection) and Ao (aorta) in the *right image A* and *B* should be switched. Although Dr. Chen *et al.* bring up important points as to why the labels should be switched, I believe the main reason to switch the labels is that the pseudoaneurysm was anterior to the ascending aorta and should be in the far field or further from the probe.[3] Below is the figure with the corrected labels. Their reason that in the mid-esophageal ascending aortic short-axis view the aorta should always be round does not always apply, especially in postcardiac surgery patients, which is a risk factor for pseudoaneurysm.[4] Also, the recommended range for evaluating the aorta with color flow Doppler is a Nyquist of 50 to 70 cm/s, but Nyquist is affected by the box size and depth.[5] To evaluate the

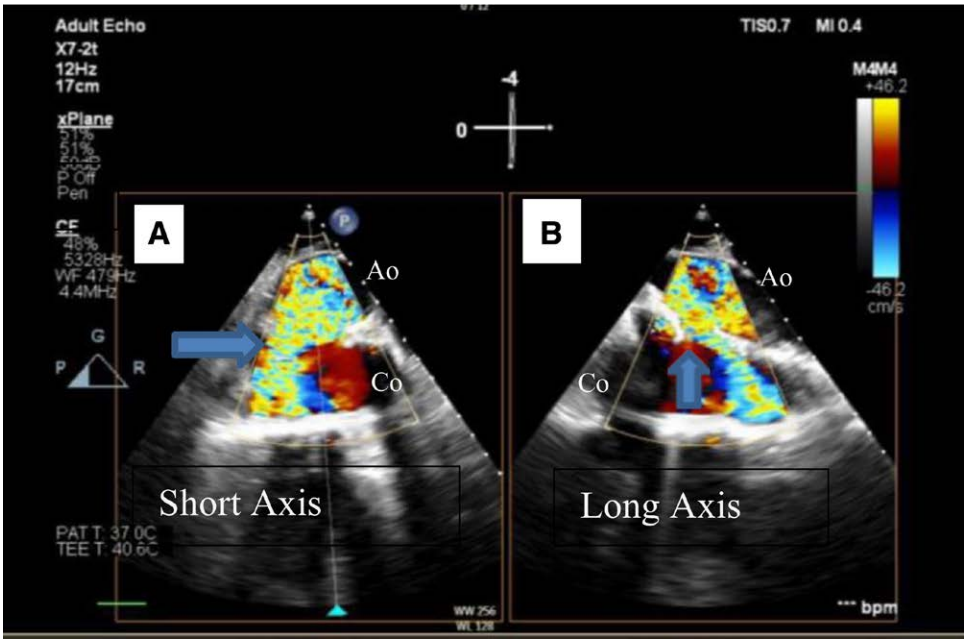

Fig. 1. Midesophageal ascending aorta short axis (*A*) and long axis (*B*). Co, pseudoaneurysm collection; Ao, aorta.

opening of the pseudoaneurysm, a larger box size was used to image the area of flow from the aorta to the pseudoaneurysm. Our Nyquist limit was lower than recommended range, but turbulence flow entering the pseudoaneurysm can be expected as a result of the narrow opening of the pseudoaneurysm.[6]

Competing Interests

The author declares no competing interests.

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Preoperative Frailty Assessment: Comment

To the Editor:

We read with interest the article by Sonny *et al.*[1] comparing two methods for frailty measurement in the ability to predict hospital length of stay after noncardiac surgery.