

## In response

I have clarified some points in response to the letter from Fiorentino et al. The types of ventilation were not considered in the same group but were classified into mask with reservoir, HNFC, NIV, and nasal cannula as shown in Table 1. (Baseline demographic and clinical characteristics of the analyzable population. Comparison between failure groups—those who needed intubation within 48 h after the prone maneuver—and the successful group showed no statistically significant difference.)

Patients were excluded if they were pregnant, were uncooperative, had an altered mental status, or had COPD requiring home NIV or oxygen therapy. As described in the body of the article, medications were used to increase subjects' tolerance, and patients who did not tolerate prone position were excluded according to study flow chart (Fig. 1).

The type of ventilatory support was not defined by the aspect of the tomography; there is still no evidence in the literature or recommendation that suggests that the pattern of the tomography should guide the type of ventilatory support used. Ventilatory support was performed using best practices as deemed by the ICU physician. It has yet to be defined in the literature what constitutes a responder or a nonresponder in awake patients in the prone position. Studies in the literature that classify subjects in this manner extrapolate to 1 h after the maneuver, as is performed in the prone position of intubated subjects. There are no reports in the literature that having more than one prone position can change subjects' response to the maneuver. More studies are needed on this topic to define the scientific evidence.

The protocol used is based on 120 min in the left lateral position, 120 min in the prone position, 120 min in the right-lateral decubitus position, and 120 min in the

supine position, according to the institution's prone protocol. This protocol was repeated every 6 h.

We agree with the authors that there is no agreement or studies that show that the ROX index serves to predict success in the pre-maneuver; this is the first study to our knowledge.

Finally, we agree with the authors that more studies should be carried out; it is not clear in the literature whether this maneuver reduces mortality or whether it just delays intubation. It is not the intention of this study to end the discussion but to encourage interest in carrying out more studies with a more robust design.

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Dr Oliveira has no conflicts to disclose.

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