Hemodynamic Support in Sepsis: Erratum

In the Clinical Focus Review article titled "Hemodynamic Support in Sepsis," beginning on page 1205 in the June 2024 issue, in figure 1 the text "Central Venous Oxygen Saturation > 70%" has been corrected to "Central Venous Oxygen Saturation < 70%." The corrected figure appears below.

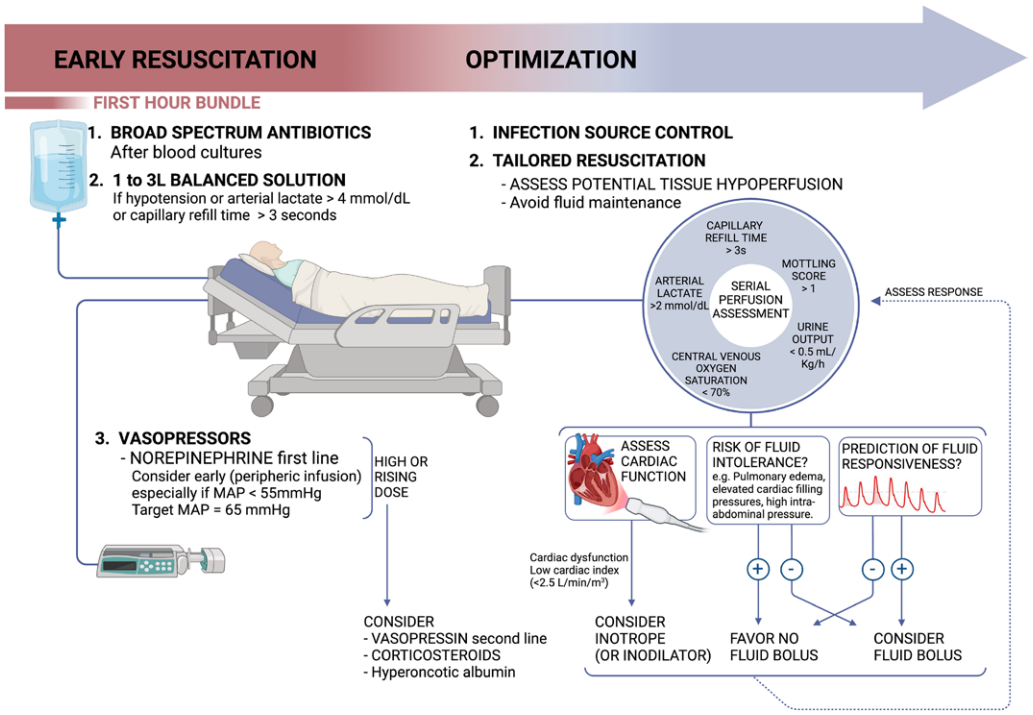

Fig. 1. Hemodynamic management of the septic patient: early resuscitation and optimization phases. The 4-h bundle includes the administration of broad-spectrum antimicrobial therapy after collecting blood cultures; fluid therapy to correct hypovolemia in hypotensive patients or those with signs of severe tissue hypoperfusion; and vasopressor administration, with norepinephrine as the first choice. Early vasopressors should be considered, with the possibility of peripheric vein infusion. During the early resuscitation phase, monitoring may be limited, and a mean arterial pressure of 65 mmHg is considered a reliable target. In patients with rising requirements of vasopressors dose, clinicians should consider a second-line vasopressor (*i.e.*, vasopressin), corticosteroids, and hyperoncotic albumin therapy. The optimization phase includes infection source control and a tailored resuscitation strategy based on serial reassessment. Signs of potential hypoperfusion such as hyperlactatemia, prolonged capillary refill time, skin mottling, abnormal central venous oxygen saturation, and contracted urine output should trigger a comprehensive hemodynamic evaluation and subsequent tailored interventions. The hemodynamic assessment should include bedside cardiac function estimation, determination of patients at risk of poor fluid tolerance (*e.g.*, signs of venous congestion, elevated cardiac filling pressure, pulmonary edema), and fluid responsiveness prediction, to drive inotropes, inodilators, and fluid therapy. Targeting better perfusion should serve as feedback to guide those interventions on individual patients' needs. MAP, mean arterial pressure. The figure was created with BioRender.com.

Additionally, there was an error in Table 1. The correction is as follows:

In the Main Results column of the 65 TRIAL; Lamontagne, 2020 row, the last sentence: "262 of 589 patients (44.5%) in the permissive hypotension and 544 of 1,242 (43.8%) in the usual care group had died at 90 days (absolute risk difference, −2.85%; 95% CI, −6.75 to 1.05; $P = 0.15$)," is amended to: "262 of 589 patients (44.5%) in the permissive hypotension and 289 of 595 (48.6%) in the usual care group had died at 90 days (Relative Risk 0.94 95% CI, 0.84 to 1.04)."

The updated row in the table appears below.

Table 1. Major Randomized Clinical Trials

Publication	Population and Setting	Main Inclusion Criteria	Comparison	Primary Outcome	Main Results	Conclusions
65 TRIAL; Lamontagne, 2020[19]	2,463 older patients with vasodilatory hypotension in 65 ICUs in the United Kingdom.	Patients ≥65 yr of age; with vasodilatory hypotension; within 6h of a vasopressor infusion initiation; with adequate fluid resuscitation (as assessed by the treating clinician); expected to continue vasopressor administration ≥ 6h. Vasodilatory hypotension was defined as assessed by the treating clinician.	Permissive hypotension (MAP target of 60 to 65 mmHg) vs. usual care.	Death from any cause by 90 days after randomization.	500 of 1,221 patients (41.0%) in the permissive hypotension and 544 of 1242 (43.8%) in the usual care group had died in the hospital (absolute risk difference, –2.85%; 95% CI, –6.75 to 1.05; P = 0.15). Patients in the permissive hypotension group had lower exposure to vasopressors compared with the usual care group (difference in median duration, –5.0; 95% CI, –7.8 to –2.2h; difference in median dose in norepinephrine equivalents –8.7 mg; 95% CI, –12.8 to –4.6 mg). Subgroup of patients with septic shock: 262 of 589 patients (44.5%) in the permissive hypotension and 289 of 595 (48.6%) in the usual care group had died at 90 days (Relative Risk 0.94; 95% CI, 0.84 to 1.04).	Among patients 65 yr or older receiving vasopressors for vasodilatory hypotension, permissive hypotension compared with usual care did not result in a statistically significant reduction in mortality.

65 TRIAL, effect of Reduced exposure to Vasopressors on 90-Day Mortality in Older Critically Ill Patients with Vasodilatory Hypotension; ICU, intensive care unit; MAP, mean arterial pressure.

The authors apologize for these errors. The online version and PDF of the article have been corrected.

DOI: 10.1097/ALN.0000000000005168

Reference

1. Antonucci E, Garcia B, Legrand M: Hemodynamic support in sepsis. Anesthesiology 2024; 140:1205–20