a better survival rate.\(^2\) Although all patients received antiviral treatment, in the seasonal outbreak, a 1-day delay (5 days instead of 4 days) in the antiviral administration was observed. This apparent treatment delay could be associated with a corresponding difference in the time from symptoms onset to hospital (4.9 days vs 4.3 days, \(P < .01\)) or ICU admission (2.3 days vs 1.8 days, \(P < .01\)).\(^3\) All of these variables must be considered to explain the higher mortality rate observed in patients undergoing invasive mechanical ventilation during the seasonal outbreak of An(H1N1) (42.6%) compared with patients with A(H1N1) (34.2%, \(P < .001\)).\(^3\) APACHE II score (OR = 1.1; 95% CI, 1.06-1.12), invasive mechanical ventilation (OR = 8.3; 95% CI, 4.32-15.91), hematologic disease (OR = 3.0; 95% CI, 1.66-5.49), HIV infection (OR = 3.9; 95% CI, 1.38-11.51), and antiviral therapy (OR = 0.45; 95% CI, 0.28-0.73) were variables independently associated with mortality. Finally, only 6.2% of patients admitted to the ICU during the seasonal outbreak were mechanically ventilated, and they seemed to have a more favorable outcome with shorter ICU stay (3 days) and fewer days under invasive mechanical ventilation (3 days).

Seasonal flu during the winter of 2010 to 2011 was dominated by the An(H1N1) virus and survival of infected patients was >60%. Delay in diagnosis, a low rate of vaccination, and suboptimal antiviral therapy indicate the need to improve educational measures and public information management for the coming years.

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**Which Mask for Noninvasive Ventilation in Acute Respiratory Failure?**

To the Editor:

We read with great interest the recent report in CHEST (May 2011) by Oszsancak et al\(^1\) comparing the total face mask (TFM) with the oronasal mask (ONM) for the treatment of acute respiratory failure by noninvasive mechanical ventilation (NIV).

The authors found similar early NIV discontinuation rates in the TFM and ONM groups (16 of 29 vs 12 of 31, respectively). They also found that the median duration of NIV with the TFM was significantly shorter than with the ONM (6.05 h vs 15.7 h, excluding the total duration of NIV performed with the TFM and after the switch to the ONM). Figures 5 and 6 of their article showed similar improvement in dyspnea, respiratory rate, and oxygen saturation for both groups at 0.5, 1, and 3 h. However, the figures do not show the trend of PaCO\(_2\), although its improvement was indicated as similar in the text, with \(P > .05\).

We would like to know what the mean improvement time of PaCO\(_2\) and the mean duration of effective NIV (ie, not discontinued early [\(n = 12\) of 29 TFM, 18 of 31 ONM]) were for each group in order to understand whether the TFM or the ONM permitted significantly quicker changes both in symptoms and in hemogas analysis. We also ask because none of the 12 patients using an ONM who discontinued use early from NIV was switched to a TFM. We believe that these points would permit us to better realize the advantages of one of the two masks in an acute setting.

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