



# Case Discussion In Mechanical Ventilation

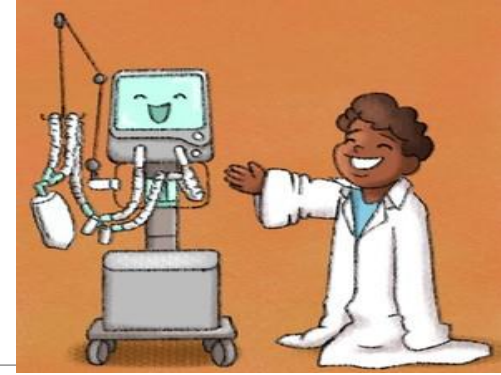
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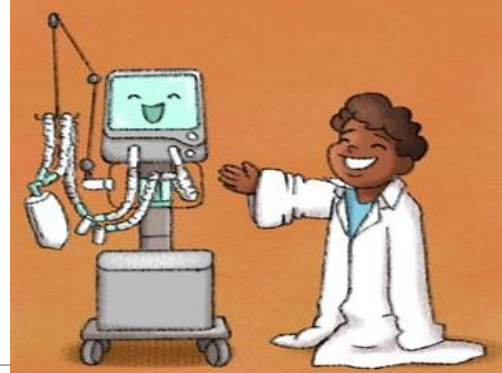
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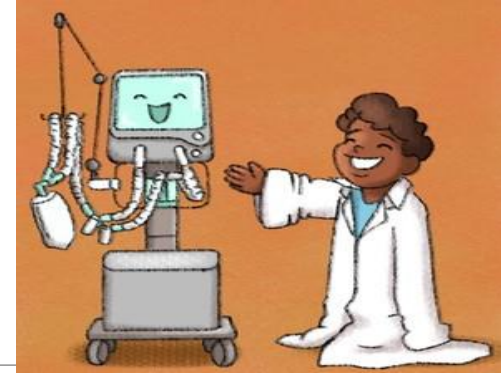
- The **most common reason** for instituting MV is to treat respiratory distress in patients who are unable to achieve effective gas exchange
- This goal can be accomplished by setting an appropriate tidal volume ( $V_T$ ) and respiratory rate ( $f$ ) to achieve a desired minute ventilation ( $V'_E$ )

# Initial Ventilator Settings

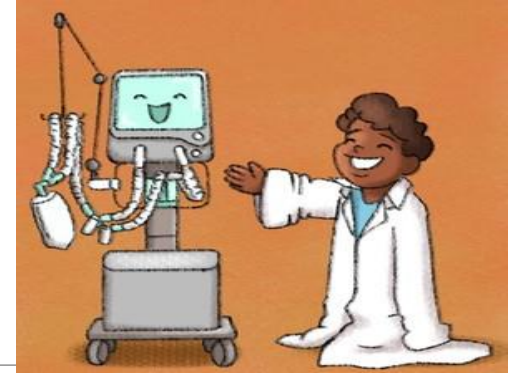


✓ Including :

- $\dot{V}_E$  settings ( $V_T$  and  $f$ )
- Inspiratory gas flow and  $FIO_2$
- Flow waveform
- (I:E) ratio
- Pressure limit
- Inflation hold (inspiratory pause)
- Inspiratory pressure
- Positive end-expiratory pressure (PEEP)



- The primary goal of VC-CMV is to achieve a  $\dot{V}_E$  that matches the patient's metabolic needs.
- A typical healthy person at rest has a total **oxygen** consumption of about **250 mL/min**, and a **CO<sub>2</sub>** production of about **200 mL/min**
- As the patient's metabolic rate increases, ventilation must change to meet the need for increased oxygen uptake and CO<sub>2</sub> removal



## Minute Ventilation ( $V'_E$ )

Men  $V'_E = 4 \times \text{body surface area (BSA)}$

Women  $V'_E = 3.5 \times \text{BSA}$

## Tidal Volume ( $V_T$ )

Minimum of 6 mL/kg ideal body weight (IBW)

## Respiratory Frequency (f)

$$f = V'_E / V_T$$

Ideal body weight (men) = 50 kg + 2.3 kg x (height, in - 60)

Ideal body weight (women) = 45.5 kg + 2.3 kg x (height, in - 60)

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*Women: IBW (lbs) = 105 + 5(H - 60),*

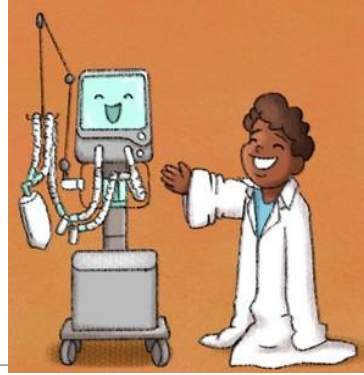
where *H* is height in inches.

For example, the IBW of a 66-inch-tall woman is  $105 + 5(66 - 60) = 105 + 5(6) = 135$  lb (61.4 kg). (To convert to kilograms, divide by 2.2.)

*Men IBW (lbs) = 106 + 6(H - 60).*

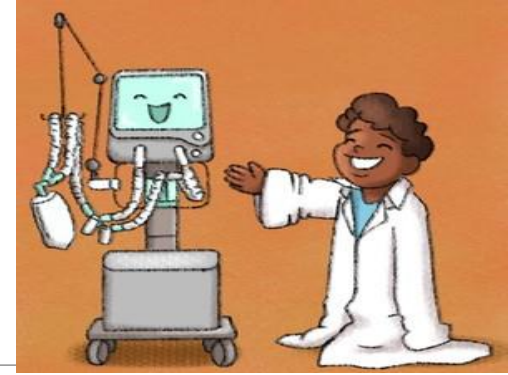
For example, the IBW of a 66-inch-tall man is  $106 + 6(66 - 60) = 106 + 6(6) = 142$  lb (64.5 kg).

# Initial ventilator settings for specific patient situations



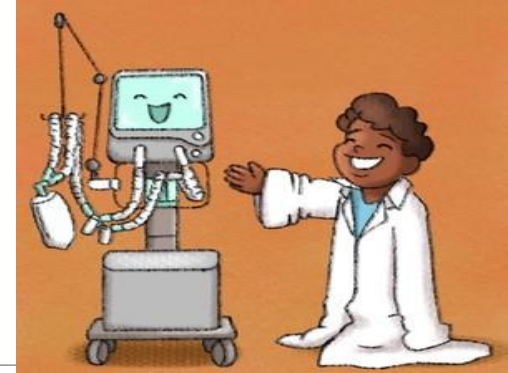
## Chronic Obstructive Pulmonary Disease

- Patients with COPD have increased Raw and CL, which, when combined, cause significant expiratory obstruction, lengthen the time constant, and lead to air trapping
- COPD require MV ...with another problem, such as a respiratory infection...acute on chronic respiratory failure.

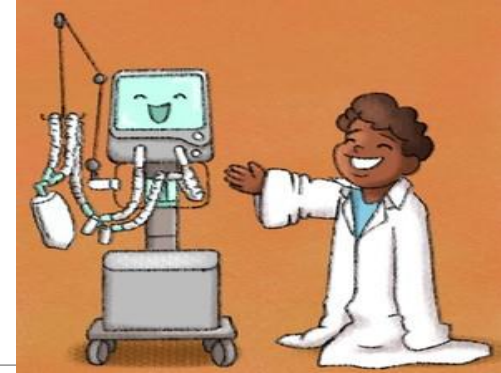


- **MV in COPD** ...increased morbidity ...air trapping, nosocomial infections, barotrauma and volutrauma, cardiac problems, aspiration, and difficulty weaning.
- The **goals of MV** are to maximize patient-ventilator synchrony, reduce WOB and patient anxiety, and avoid the complications associated with MV , such as VAP and ventilator induced lung injury(VILI)

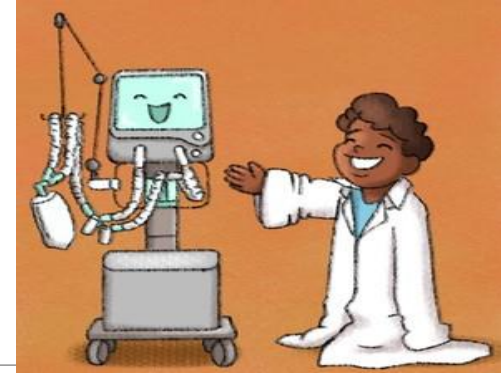
# Guidelines for patients with COPD



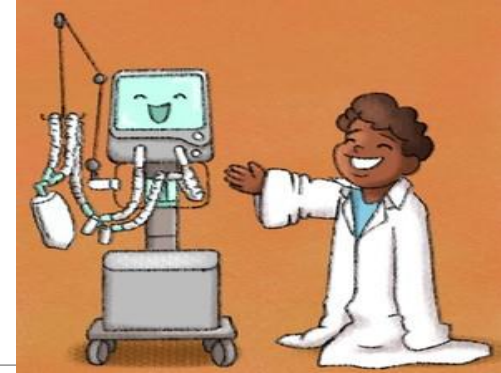
- If possible, use NIV to avoid problems associated with artificial airways.
- Bilevel positive airway pressure (**bilevel PAP**) is ideal for patients with chronic pulmonary disorders
- A ventilator mode that you feel most familiar



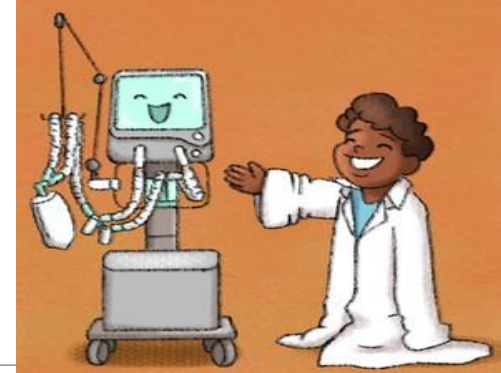
- VC- or PC-CMV may unload the work of the respiratory muscles more than IMV
- Using patient-triggered CMV in an alert patient with COPD may increase the risk of hyperinflation and elevated lung pressures
- This mode should be monitored carefully.



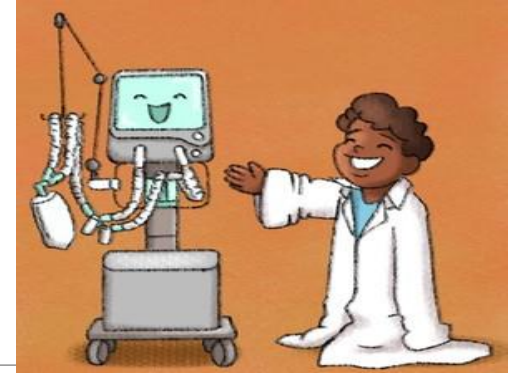
- Adjust the peak inspiratory flow to meet the patient's demand in VC-CMV using the descending flow pattern: **flow >60 L/min**.
- In patients with **COPD and asthma**, where airway obstruction and resistance are high, an initial  **$V_T$  of 6 to 8 mL/kg** with a **rate of 8 to 16 breaths/min**, and  **$T_I$  0.6 to 1.2 sec** is acceptable.



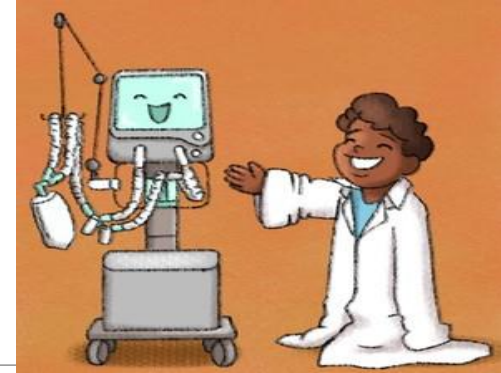
- **PEEP 5 cm H<sub>2</sub>O or lower**, or about **50% of auto-PEEP**, should be used initially.
- Monitor for and minimize dynamic hyperinflation (auto-PEEP) by setting the lowest possible  $\dot{V}_E$  that produces acceptable gas exchange targeting the patient's baseline PaCO<sub>2</sub> and PH.
- Provide the longest ( $T_E$ ) possible. This may include decreasing  $T_I$ , increasing  $T_E$ , reducing  $f$  or  $V_T$ , and accepting hypercapnia
- Patients with COPD are usually ventilated in their normal PaCO<sub>2</sub> range (e.g., PaCO<sub>2</sub> = 50 to 60 mm Hg; pH 7.3 to 7.4.)



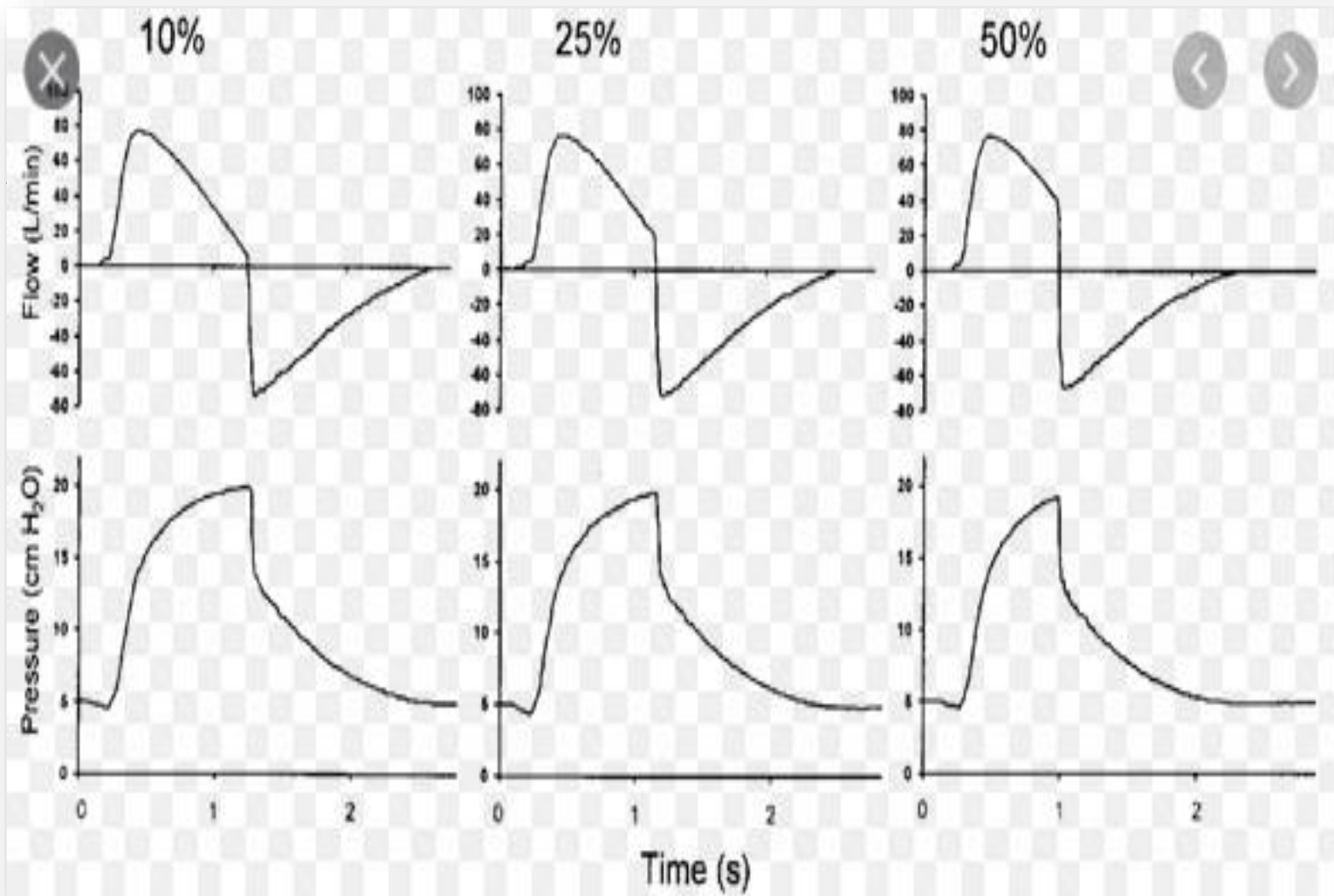
- Set PEEP near 80% of the auto-PEEP level, but do not exceed it (3 to 5 cm H<sub>2</sub>O is often adequate). If PIP begins to rise because PEEP is increased, the safe PEEP level has probably been exceeded and will result in lung overinflation.
- $P_{plat}$  should be maintained < 30 cm H<sub>2</sub>O to avoid alveolar overdistention and lung injury.
- Accurate measurement of  $P_{plat}$  may require sedation and paralysis

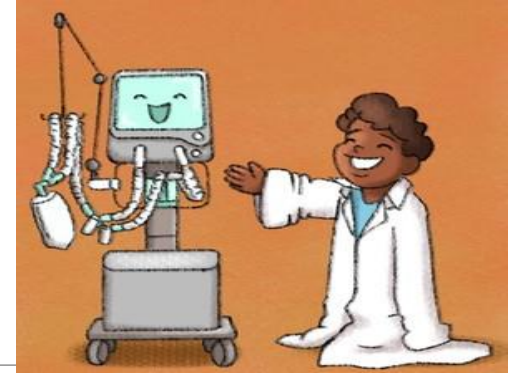


- Maintain PaO<sub>2</sub> at 55 to 75 mm Hg or near the patient's normal PaO<sub>2</sub>, with FIO<sub>2</sub> less than 0.5, unless the patient's condition worsens and requires more oxygen.
- Pressure control ventilation (**PC-CMV**) may be **ideal** for this group of patients for several reasons
- PC-CMV provides flow on demand to meet the patient's needs

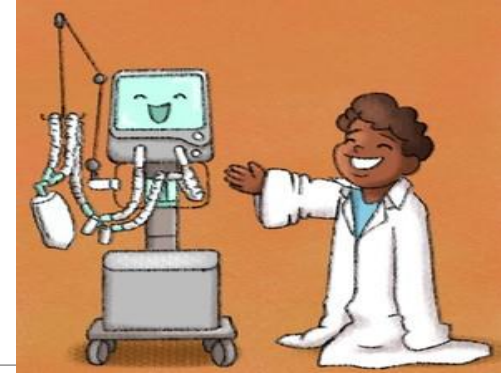


- PC-CMV has a distinct advantage over **PSV** for this patient population because inspiration during PSV can be too long or too short, depending on the patient's active breathing patterns.
- This can result in **increased WOB and poor patient-ventilator synchrony**. Auto-PEEP can be a lethal complication. Current ventilators that allow an **adjustable expiratory flow cycle** may allow for the use of PSV in COPD



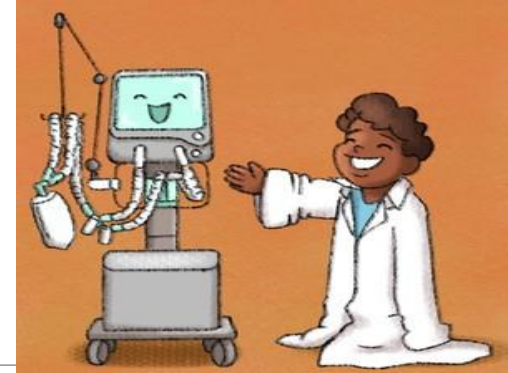


- Volume-assured pressure support (VAPS) or volume support (Servo-i) can also provide pressure ventilation with a set targeted volume delivery .
- Although these modes are also well suited for patients with COPD, **clinicians must be familiar** with their use.

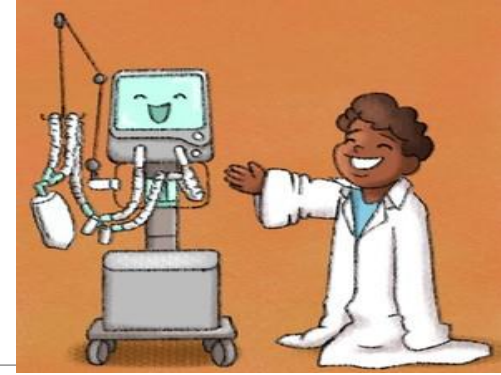


- An important part of patient care is providing **adequate hydration** and **pharmacologic therapy** (i.e., bronchodilators and corticosteroids) to reverse airflow limitation.
- **Secretions** must be mobilized and removed, and if infections are present, appropriate antibiotic medication must be administered.
- The **primary problem** necessitating ventilation must be corrected to ensure that weaning will be successful.
- Because many of these patients are malnourished, an **evaluation of their nutritional needs** must be part of any follow-up program

# Asthma



- Exacerbation of acute severe asthma that requires mechanical ventilation are among the most difficult to manage.
- Increased Raw from bronchospasm, increased secretions and mucosal edema increase the incidence of **air trapping**.
- Trapped air can cause uneven hyperexpansion of various lung units, which can rupture or compress other areas of the lungs, leading to pneumothorax, pneumomediastinum, subcutaneous emphysema and barotrauma.

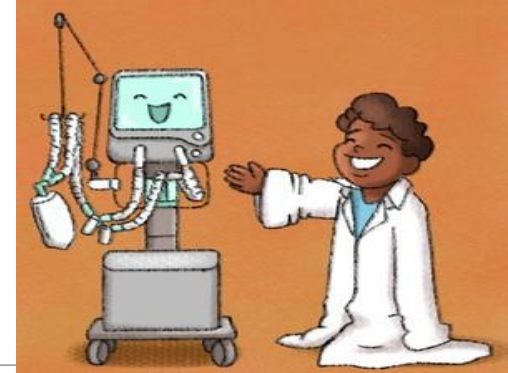


- **Progressive hypoxemia** further enhances the patient's drive to breathe and compounds anxiety.
- Even aggressive treatment with **bronchodilators and steroids** might not be enough to reverse the course of an acute asthma exacerbation.

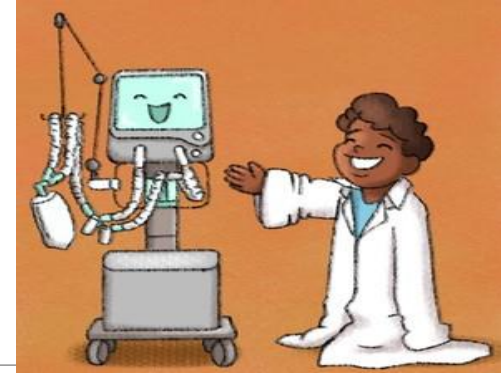
# Indications for MV in Acute Exacerbation of Asthma

1. Exhaustion (e.g., respiratory rate progressively decreases and level of consciousness is altered), with developing metabolic acidosis, and decreasing pH in the presence of a normal or rising carbon dioxide pressure ( $P_a\text{CO}_2$ ).
2. If audible, bilateral wheezes become distant as air trapping increases (e.g., breath sounds absent, chest hyperresonant to percussion or fixed on palpation).
3. Severe hypoxemia while receiving oxygen (e.g., inability to oxygenate with supplemental oxygen).
4. Chest radiograph with depression of the hemidiaphragms and increased radiolucency, suggestive of air trapping.
5. Altered mental status, confusion, or decreased level of consciousness.
6. Life-threatening dysrhythmias.
7.  $P_a\text{CO}_2$  rises while pH declines (e.g.,  $\geq 40$  mm Hg;  $\text{pH} \leq 7.25$  [progressive respiratory acidosis superimposed on a metabolic acidosis]).
8. Cardiac or respiratory arrest.

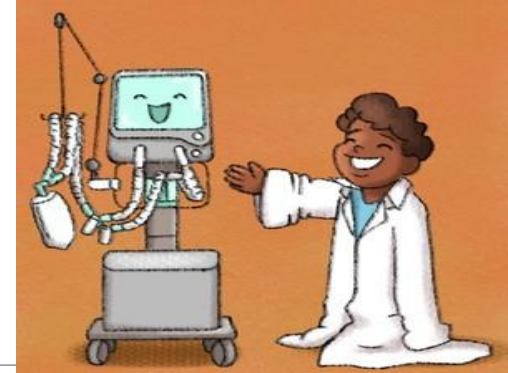
# Guidelines for patients with asthma



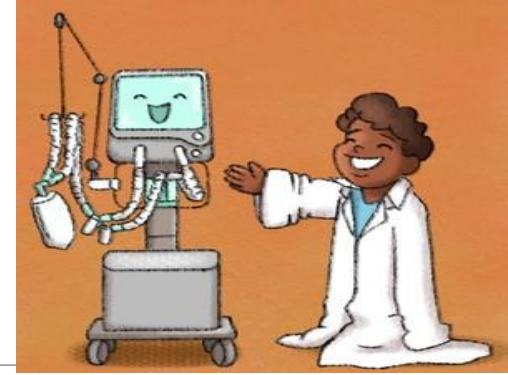
- **VC- or PC-CMV** are acceptable modes immediately following intubation
- It is easier to control airway pressure with PC-CMV.
- Maintain peak and plateau pressures at minimal levels. PIP may be high due to the high Raw and the use of high inspiratory gas flows.
- Alveolar (plateau) pressures must still be maintained at  $<30$  cm H<sub>2</sub>O



- Ensure that the patient's oxygenation status is adequate by using an FIO<sub>2</sub> as needed to achieve a PaO<sub>2</sub> from 60 to 100 mm Hg (usually FIO<sub>2</sub> ≥0.5). Monitor hemodynamic status to ensure cardiac output is stable.
- Permissive hypercapnia (PaCO<sub>2</sub> 45 to 80 mm Hg) is acceptable as long as pH is acceptable (i.e., ≥7.2)
- Tris-hydroxymethyl-aminomethane [THAM] or bicarbonate is administered by some physicians to keep pH >7.2



- If the ventilator settings cannot accommodate the patient's needs, the use of sedatives and paralytics may be necessary
- When patients are spontaneously breathing and having trouble triggering breaths, setting the  $PEEP_E$  at about 80% of  $PEEP_I$  may allow for easier triggering of ventilator breaths.



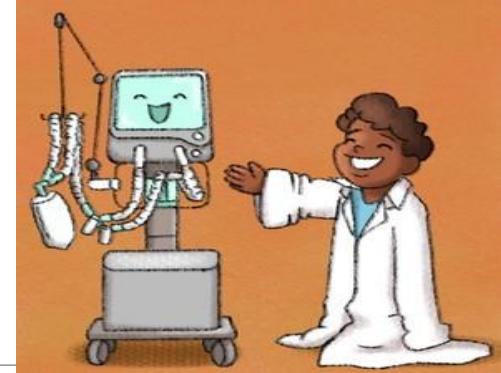
Reduce the incidence of air trapping by providing long expiratory times:

- $f = < 8$  breaths/min
- $V_T = 6-8$  mL/kg
- $T_i = < 1$  sec
- inspiratory gas flow = 80 to 100 L/min
- descending flow waveform

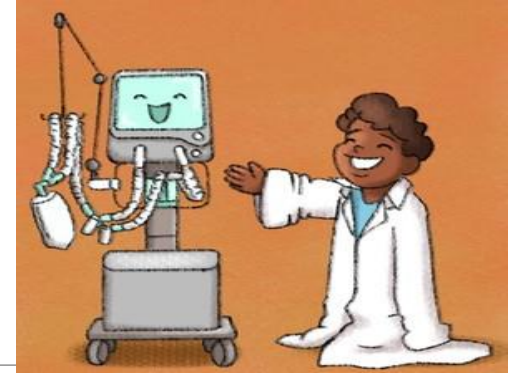
# Neuromuscular disorders

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- Myasthenia gravis, amyotrophic lateral sclerosis, muscular dystrophy, postpolio syndrome, guillain-barré syndrome, tetanus, cervical spinal cord injury, and botulism
- Have a normal ventilatory drive and normal or near-normal lung function.
- Respiratory muscle weakness, limit these patients' abilities to cough and clear secretions
- Atelectasis and pneumonia

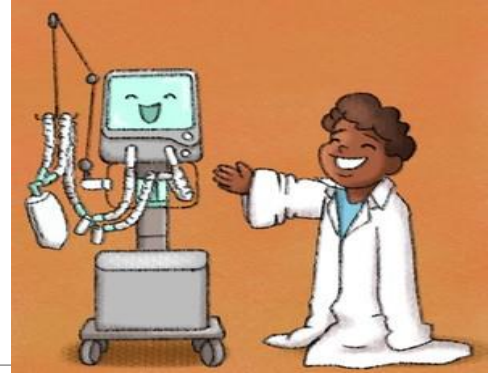


- PPV is most often selected and can be either noninvasive or invasive.
- Because these patients often have normal lung function, they are at **low risk for barotrauma** and are most comfortable when ventilated with **higher  $V_T$**  values (i.e., 6 to 8 mL/kg) and **high inspiratory flow rates** greater than 60 L/ min using a **constant flow or descending flow** pattern when VC-CMV is used.

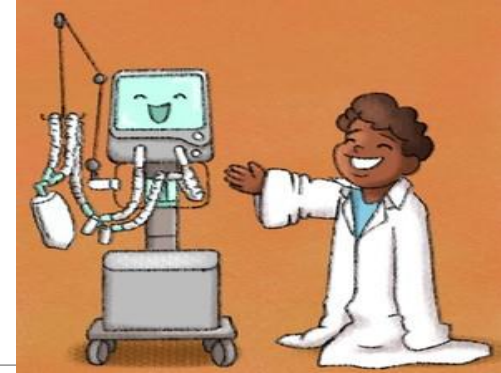


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- Some clinicians prefer starting with a lower  $V_T$  and adjusting the volume as needed

# Guidelines for patients with neuromuscular disorders

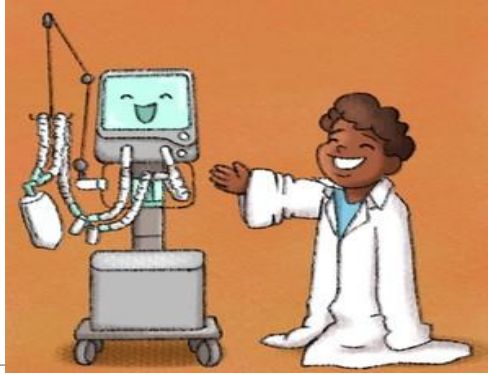


- Full or partial support
- Negative or positive pressure ventilation
- Noninvasive or invasive ventilation
- Assist/control mode (CMV)
- Volume control ventilation
- VT (6 to 8 mL/kg) while maintaining the  $P_{\text{Plat}}$  at less than 30



- $f = 8$  to 16 breaths/min
- Inspiratory flow rates  $\geq 60$  L/min to meet patient need ( $T_i$  about 1 second to start)
- Flow waveform: constant or descending flow pattern
- PEEP = 5 cm H<sub>2</sub>O may be needed to relieve dyspnea
- $FIO_2 = 0.21$

# Closed head injury



- $CPP = MAP - ICP$
- Normal values for MAP are 90 to 95 mm Hg and ICP less than 10 mm Hg
- Normal CPP is 80 to 85 mm Hg
- Values of CPP lower than 60 mm Hg indicate poor cerebral perfusion

# Indications for MV in patients with head injuries

## **Assisted Ventilation**

1. Respiratory depression associated with injury. It may be manifested as Cheyne-Stokes respiration, central neurogenic hyperventilation, or apnea.
2. Additional injuries to the chest, abdomen, back, or neck.
3. Use of medications that depress respiration.
4. Neurogenic pulmonary edema (an acute respiratory distress syndrome [ARDS]-like pattern that can occur following head trauma).
5. Impending or actual cardiac arrest.
6. Upper airway compromise (e.g., presence of stridor or loss of airway clearance mechanisms).
7. Aspiration at the time of loss of consciousness.

## **Airway Management (Intubation)**

1. Head injury (particularly with Glasgow Coma Score\* of  $\leq 8$ ).
2. Face, jaw, neck injuries with bleeding.

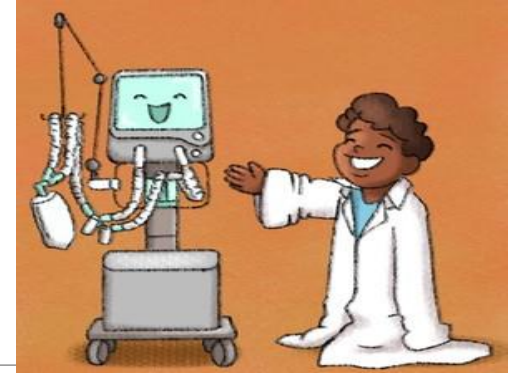
## **Oxygen Delivery**

1. Head injury.
2. Pulmonary contusion, edema, or both.

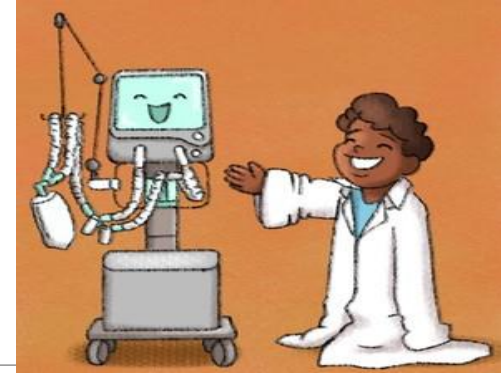
# Guidelines for patients with a closed head injury

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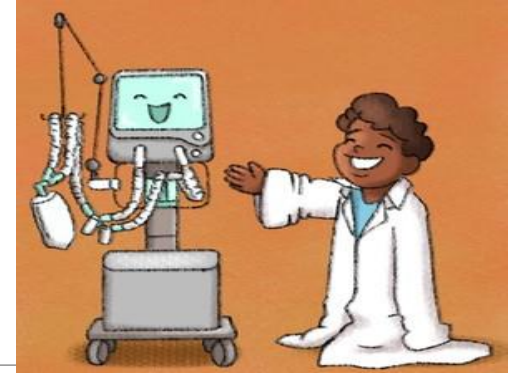
- There is a high risk for vomiting and aspiration
- Orotracheal intubation is often required.
- PC-CMV and PEEP can actually increase ICP.
- These patients often have normal lungs, so high  $P_{alv}$  can be transmitted to the blood vessels, thus affecting venous return from the head.



- When there is acute uncontrolled increased ICP, maintain PaCO<sub>2</sub> from 25 to 30 mm Hg or titrate the ICP if it is being monitored.
- Provide full ventilatory support to start.
- Either PC- or VC-CMV can be used.
- Maintain V<sub>T</sub> from 6 to 8 mL/kg IBW while maintaining P<sub>plat</sub> at less than 30 cm H<sub>2</sub>O.
- An f of 15 to 20 breaths/min to provide normal acid–base status, as long as auto-PEEP is avoided

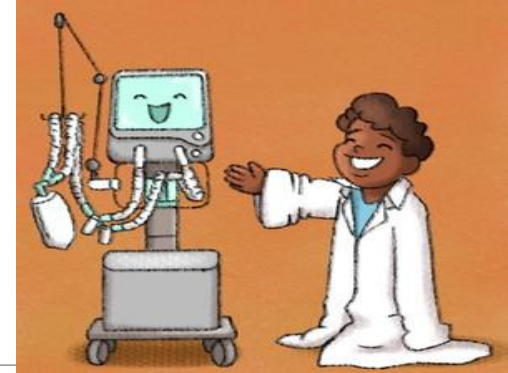


- $FIO_2 = 1.0$  initially and titrate as needed to keep  $PaO_2$  from 70 to 100 mm Hg to avoid hypoxemia.
- High inspiratory flow ( $>60$  L/min) to keep  $T_i$  short, about 1 second (avoid auto-PEEP) using a descending ramp pattern or constant flow pattern.
- PEEP = 0 to 5 cm H<sub>2</sub>O, as long as ICP is being measured and is 10 mm Hg or less
- Because PEEP can increase ICP, it is used only if necessary to avoid severe hypoxemia.



- Suctioning and chest physiotherapy can dramatically increase ICP but maintaining a clear airway is also essential
- Monitor for complications of pulmonary infections and pulmonary emboli.

# Acute Respiratory Distress Syndrome



## **PART I: VENTILATOR SETUP AND ADJUSTMENT**

- 1. Calculate predicted body weight (PBW)**  
**Males =  $50 + 2.3 [\text{height (inches)} - 60]$**   
**Females =  $45.5 + 2.3 [\text{height (inches)} - 60]$**
- 2. Select any ventilator mode**
- 3. Set ventilator settings to achieve initial  $V_T = 8 \text{ ml/kg PBW}$**
- 4. Reduce  $V_T$  by 1 ml/kg at intervals  $\leq 2$  hours until  $V_T = 6 \text{ ml/kg PBW}$ .**
- 5. Set initial rate to approximate baseline minute ventilation (not  $> 35$  bpm).**
- 6. Adjust  $V_T$  and RR to achieve pH and plateau pressure goals below.**

**OXYGENATION GOAL: PaO<sub>2</sub> 55-80 mmHg or SpO<sub>2</sub> 88-95%**  
 Use a minimum PEEP of 5 cm H<sub>2</sub>O. Consider use of incremental FiO<sub>2</sub>/PEEP combinations such as shown below (not required) to achieve goal.

**Lower PEEP/higher FiO<sub>2</sub>**

<b>FiO<sub>2</sub></b>	<b>0.3</b>	<b>0.4</b>	<b>0.4</b>	<b>0.5</b>	<b>0.5</b>	<b>0.6</b>	<b>0.7</b>	<b>0.7</b>
<b>PEEP</b>	<b>5</b>	<b>5</b>	<b>8</b>	<b>8</b>	<b>10</b>	<b>10</b>	<b>10</b>	<b>12</b>

<b>FiO<sub>2</sub></b>	<b>0.7</b>	<b>0.8</b>	<b>0.9</b>	<b>0.9</b>	<b>0.9</b>	<b>1.0</b>
<b>PEEP</b>	<b>14</b>	<b>14</b>	<b>14</b>	<b>16</b>	<b>18</b>	<b>18-24</b>

**Higher PEEP/lower FiO<sub>2</sub>**

<b>FiO<sub>2</sub></b>	<b>0.3</b>	<b>0.3</b>	<b>0.3</b>	<b>0.3</b>	<b>0.3</b>	<b>0.4</b>	<b>0.4</b>	<b>0.5</b>
<b>PEEP</b>	<b>5</b>	<b>8</b>	<b>10</b>	<b>12</b>	<b>14</b>	<b>14</b>	<b>16</b>	<b>16</b>

<b>FiO<sub>2</sub></b>	<b>0.5</b>	<b>0.5-0.8</b>	<b>0.8</b>	<b>0.9</b>	<b>1.0</b>	<b>1.0</b>
<b>PEEP</b>	<b>18</b>	<b>20</b>	<b>22</b>	<b>22</b>	<b>22</b>	<b>24</b>

## **PLATEAU PRESSURE GOAL: $\leq 30$ cm H<sub>2</sub>O**

**Check P<sub>plat</sub> (0.5 second inspiratory pause), at least q 4h and after each change in PEEP or V<sub>T</sub>.**

**If P<sub>plat</sub> > 30 cm H<sub>2</sub>O: decrease V<sub>T</sub> by 1ml/kg steps (minimum = 4 ml/kg).**

**If P<sub>plat</sub> < 25 cm H<sub>2</sub>O and V<sub>T</sub> < 6 ml/kg, increase V<sub>T</sub> by 1 ml/kg until P<sub>plat</sub> > 25 cm H<sub>2</sub>O or V<sub>T</sub> = 6 ml/kg.**

**If P<sub>plat</sub> < 30 and breath stacking or dys-synchrony occurs: may increase V<sub>T</sub> in 1ml/kg increments to 7 or 8 ml/kg if P<sub>plat</sub> remains  $\leq 30$  cm H<sub>2</sub>O.**

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**pH GOAL: 7.30-7.45****Acidosis Management: (pH < 7.30)**

**If pH 7.15-7.30:** Increase RR until pH > 7.30 or PaCO<sub>2</sub> < 25  
(Maximum set RR = 35).

**If pH < 7.15:** Increase RR to 35.

If pH remains < 7.15, V<sub>T</sub> may be increased in 1 ml/kg steps until pH > 7.15 (P<sub>plat</sub> target of 30 may be exceeded).

May give NaHCO<sub>3</sub>

**Alkalosis Management: (pH > 7.45)** Decrease vent rate if possible.

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**I: E RATIO GOAL:** Recommend that duration of inspiration be < duration of expiration.

**PART II: WEANING**

**A. Conduct a SPONTANEOUS BREATHING TRIAL daily when:**

1. FiO<sub>2</sub> ≤ 0.40 and PEEP ≤ 8 OR FiO<sub>2</sub> ≤ 0.50 and PEEP ≤ 5.
2. PEEP and FiO<sub>2</sub> ≤ values of previous day.
3. Patient has acceptable spontaneous breathing efforts. (May decrease vent rate by 50% for 5 minutes to detect effort.)
4. Systolic BP ≥ 90 mmHg without vasopressor support.
5. No neuromuscular blocking agents or blockade.

## **B. SPONTANEOUS BREATHING TRIAL (SBT):**

**If all above criteria are met and subject has been in the study for at least 12 hours, initiate a trial of UP TO 120 minutes of spontaneous breathing with  $FiO_2 \leq 0.5$  and  $PEEP \leq 5$ :**

- 1. Place on T-piece, trach collar, or CPAP  $\leq 5$  cm H<sub>2</sub>O with PS  $\leq 5$**
- 2. Assess for tolerance as below for up to two hours.**
  - a.  $SpO_2 \geq 90$ : and/or  $PaO_2 \geq 60$  mmHg**
  - b. Spontaneous  $V_T \geq 4$  ml/kg PBW**
  - c.  $RR \leq 35$ /min**
  - d.  $pH \geq 7.3$**
  - e. No respiratory distress (distress= 2 or more)**
    - HR > 120% of baseline**
    - Marked accessory muscle use**
    - Abdominal paradox**
    - Diaphoresis**
    - Marked dyspnea**
- 3. If tolerated for at least 30 minutes, consider extubation.**
- 4. If not tolerated resume pre-weaning settings.**

# Ventilator Management of Patients with ARDS

## FLUID MANAGEMENT

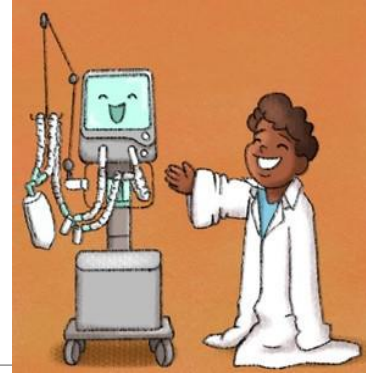
- Once patients are out of shock adopt a conservative fluid management strategy.
- Use diuretics or fluids to target a central venous pressure (CVP) of  $<4$  or a pulmonary artery occlusion pressure (PAOP) of  $<8$ .

## LIBERATION FROM MECHANICAL VENTILATION

- Daily interruption of sedation
- Daily screen for spontaneous breathing trial (SBT)
- SBT when all of the following criteria are present:
  - (a)  $FiO_2 < 0.40$  and  $PEEP < 8$  cm H<sub>2</sub>O
  - (b) Not receiving neuromuscular blocking agents
  - (c) Patient is awake and following commands.
  - (d) Systolic arterial pressure  $> 90$  mm Hg without vasopressor support
  - (e) Tracheal secretions are minimal, and the patient has a good cough and gag reflex.

## SPONTANEOUS BREATHING TRIAL

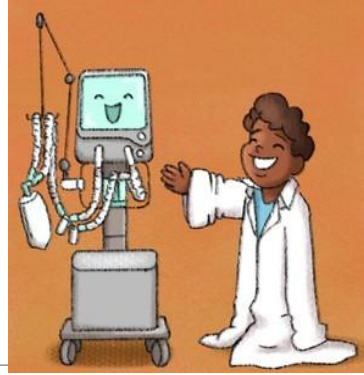
- Place patient on 5 mm Hg pressure support with 5 mm Hg PEEP or T-piece.
- Monitor HR, RR, oxygen saturation for 30-90 minutes.
- Extubate if there are no signs of distress (tachycardia, tachypnea, agitation, hypoxia, diaphoresis).



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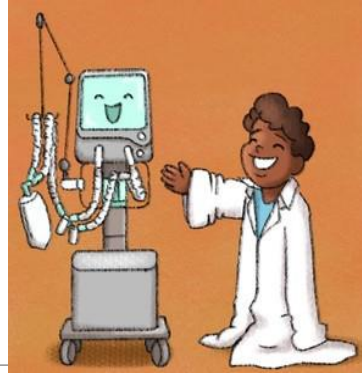
# Clinical and physiological considerations in the management of patients with COVID-19-associated ARDS

# Timing of intubation



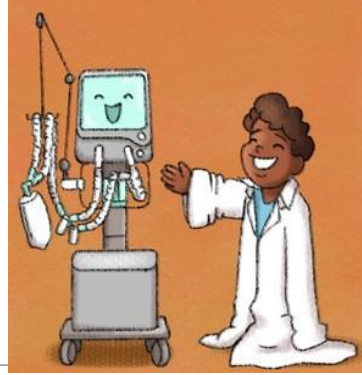
- No high-quality clinical trial evidence addressing optimal timing of intubation in ARDS is available
- Intubation might be beneficial in patients with high respiratory drive and at high risk of patient self-inflicted lung injury
- NIV has been associated with worse outcomes when  $\text{PaO}_2/\text{FiO}_2$  ratio  $<150$
- Detrimental consequences of intubation and invasive ventilation (eg, related to sedation, paralysis, and endotracheal tube complications) might outweigh benefits, especially in patients with mild hypoxemia and without high respiratory drive or work of breathing

# Tidal volume



- Low VT ventilation results in improved outcomes in patients with and without ARDS and should be the starting point for ventilatory management of patients with ARDS (ie, 6 mL/kg PBW)
- Lower VT as needed to 4 mL/kg PBW to keep plateau pressure <30 cm
- Liberalise VT (up to 8 mL/kg PBW) in patients who are double triggering, or if inspiratory airway pressure decreases below PEEP, keeping plateau pressure <30 cm Ideally, keep driving pressure  $\leq 14$

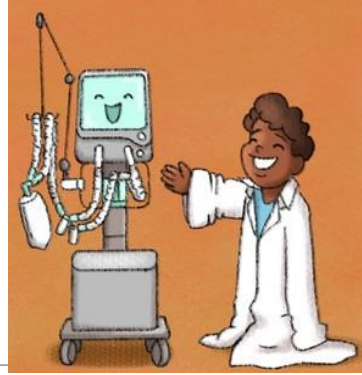
# PEEP



## ■ Individualise PEEP

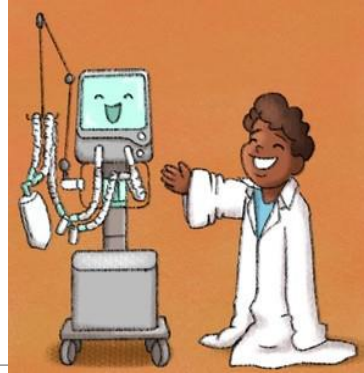
- consider higher PEEP in patients with evidence of higher potential for recruitment (eg, as suggested by CT scan or recruitment to inflation index) or with a body habitus or clinical exam that suggests high pleural pressures are likely
- Higher PEEP can be harmful in patients with low recruitability, who have hypoxemia due largely to pulmonary vascular pathology; high PEEP can lead to adverse hemodynamic effects or barotrauma

# Prone positioning



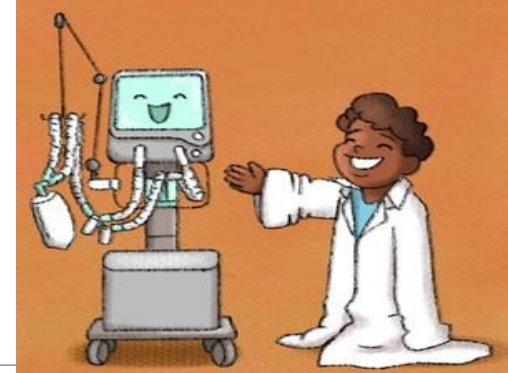
- Prone positioning is associated with improved outcomes in patients with moderate or severe ARDS, with improved ventilation or perfusion matching, more homogeneous distribution of ventilation, and reduced risk of ventilator-induced lung injury
- In the absence of contraindications, use prone positioning in mechanically ventilated patients with  $\text{PaO}_2/\text{FiO}_2$  ratio  $<150$

# Acute cardiogenic pulmonary edema and CHF

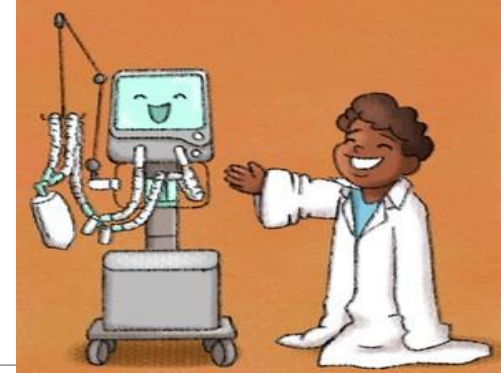


- Many patients can be successfully managed with drug therapy and do not require MV support
- However, MV may be indicated when severe heart failure leads to increased myocardial work, increased WOB, and hypoxemia.
- In patients with left ventricular failure the use of positive pressure, particularly PEEP can effectively reduce the size of the heart and therefore reduce venous return and reduce preload to left ventricles

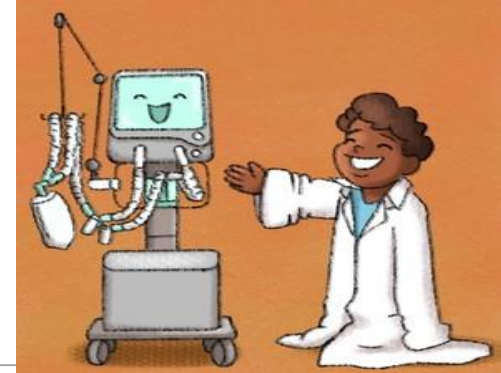
# Guidelines for patients with CHF



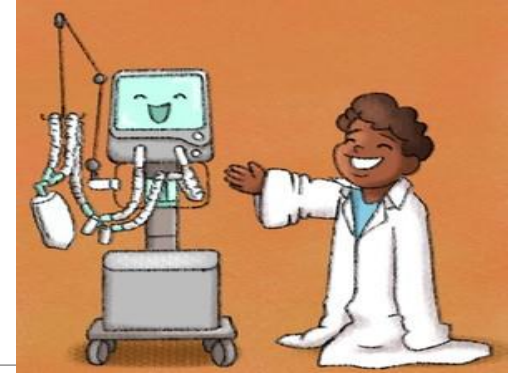
- Select a mode of ventilation that reduces WOB
- This may be as simple as noninvasive mask CPAP
- NIV by mask CPAP may improve oxygenation, reduce PaCO<sub>2</sub>, reduce the WOB, and reduce myocardial work
- NIV in patients with CHF may allow sufficient time for pharmacologic treatment to become effective.



- When life-threatening hypoxemia occurs with severe CHF, PEEP or PPV may have beneficial effects on myocardial function and improve oxygenation
- Careful evaluation of the effects of PPV on hemodynamics is essential
- This may include the use of a pulmonary artery catheter in severe cases, particularly if  $PEEP_E$  greater than 10 to 15 cm H<sub>2</sub>O is used.



- The use of VC- or PC-CMV is recommended to minimize spontaneous breathing, which may divert increased blood flow and oxygen consumption to the respiratory muscles
- $V_T$  range is moderate from 6 to 8 mL/kg
- Set f from 10 or more breaths/min
- Peak flows 60 L/min or greater using either descending or constant waveforms
- TI range is 1 to 1.5 seconds



- Set a PEEP of 5 to 10 cm H<sub>2</sub>O to support the cardiac function
- Start FIO<sub>2</sub> at 1.0 and titrate quickly with SpO<sub>2</sub> to maintain SpO<sub>2</sub> greater than 90% to 92%
- Monitor SpO<sub>2</sub>, ABGs, urine output, electrolytes, and systemic hemodynamic status.

**TABLE 7-1 Initial Ventilator Settings Based on Pulmonary Disorder\***

Lung Disease	Mode	$V_T$ (mL/kg IBW)	Rate (breaths/min)	Flow (L/min)	Flow Waveform	$T_I$ (sec)	PEEP (cm H <sub>2</sub> O)	$F_{I}O_2$
Normal lungs	VC- or PC-CMV	6-8	10-15	60	Descending or constant	1	≤5	≤0.5
COPD <sup>†</sup>	VC- or PC-CMV	6-8	8-12	>60 (80-100)	Descending or constant	0.6-1.2	≥5 or 50% of intrinsic PEEP	<0.5
Neuromuscular disorder	VC-CMV	6-8	8-12	≥60	Descending or constant	1	5	0.21
Asthma	VC- or PC-CMV	6-8	10-14	60-70	Descending	≤1	Only to offset intrinsic PEEP and improve triggering	≥0.5
Closed head injury	PC- or VC-CMV	6-8	15-20	60	Descending or constant	1	0-5 with caution Only in severe hypoxemia	1.0
ARDS	PC- or VC-CMV	4-8	12-35	≥60	Descending or constant	1	5 to >15	1.0
CHF	VC- or PC-CMV	6-8	≥10	≥60	Descending or constant	1-1.5	5-10	1.0

