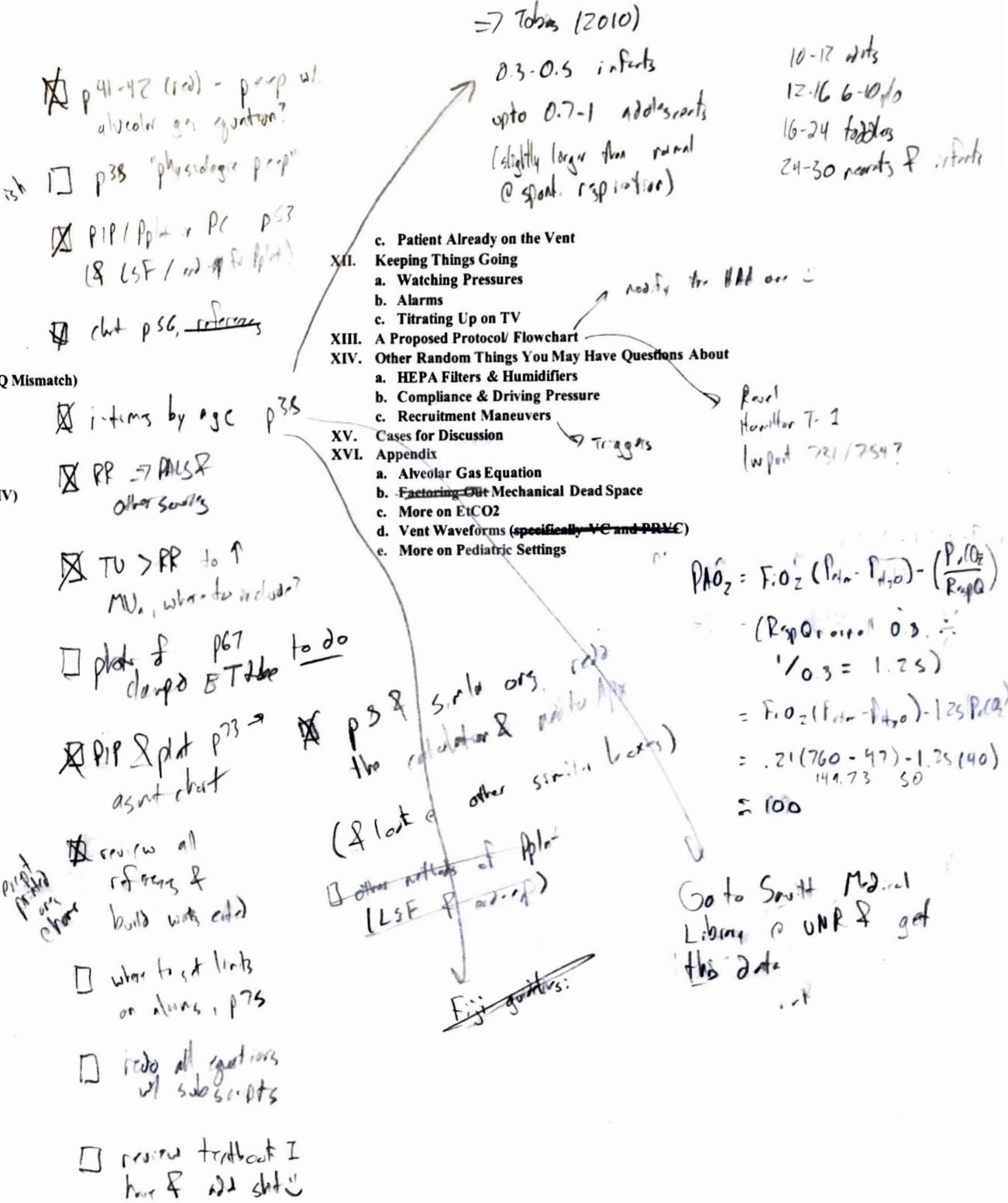


- I. Intro
- II. Some Very Basic Physiology
  - a. The Normal Breathing Process
  - b. How is Positive Pressure Ventilation Different?
- III. Other Important Concepts in Physiology
  - a. Ventilation, Oxygenation and Respiration
  - b. Dead Space
  - c. Hypoxic Vasoconstrictive Response (also Shunts and V/Q Mismatch)
  - d. Alveolar Surface Area and Recruitment
  - e. Lung Size and IBW
- IV. Modes of Ventilation
  - a. Control
  - b. Assist Control (AC)
  - c. Synchronized Intermittent Mandatory Ventilation (SIMV)
- V. Control of Ventilation
  - a. Volume
  - b. Pressure
  - c. Pressure Regulated Volume Control
- VI. Vent Parameters, Round One
  - a. Tidal Volume
  - b. Rate
  - c. Minute Volume
  - d. Fraction of Inspired Oxygen
  - e. Positive End-Expiratory Pressure
  - f. Inspiratory Time (and I:E Ratio)
- VII. Three Big Things
  - a. Oxygenation (and SpO<sub>2</sub>)
  - b. Ventilation (and EtCO<sub>2</sub>)
  - c. Comfort
- VIII. Vent Parameters, Round Two
  - a. Peak Inspiratory Pressure
  - b. Plateau Pressure
  - c. AutoPEEP
- IX. A General Vent Strategy
  - PIP & Pplat in PCP!
- X. Specific Vent Strategies
  - a. Bronchospasm
  - b. Hypotension
  - c. Acidosis
  - d. Acute Lung Injury/ ARDS
  - e. Other Potential Strategies
- XI. How to Get Started
  - a. Getting All the Numbers Ready
  - b. From Scratch



## I. Intro

There are lots of good reasons why I thought it'd be good to put together a primer of sorts on vent management, but the primary one is that my first vent experience was a near-disaster and I'd like to share what I've learned since then so that others can avoid what I had to go through. Also, I think there's some room for diversity in how we, as an industry, present material to each other and move forward with our understanding of complicated things. So my second hope is that this interactive text style of writing can be of help to some folks and maybe inspire others to do the same and build on it. *the whole idea*

But to start with the awful beginning story: I was brand new to an ambulance service in rural New Mexico, having moved from Pittsburgh about two years after I first got my medic. I was still green but felt like I had gotten a lot of experience back in the city and was (over, perhaps?) confident. Anyways, I started at this service in mid-November and this call I did was the day after Thanksgiving, so I had basically just arrived in NM and gotten settled in to the second EMS service I had ever been given medical control at. Things were different for sure. Five- and ten-minute transport times had been replaced by ones much longer in our 5,000 square mile coverage area, the ambulances were giant machines that could be rigged to carry three patients each and would never have made it in the city alleys, and protocols/ capabilities were a lot more lenient and included vents, surgical 1 crics, hiking in to patients broken in the woods - that sort of thing that this city boy just hadn't done before.

Oh, and also two-patient interfacility transfers. Our flagship hospital was in Albuquerque, one hundred and eighty miles or two and a half hours away by bus, so it was hugely advantageous to load two patients in on a single truck to avoid and extra six-ish hours of that second truck being gone from the service area. So when I was asked if I was OK with a vent patient and a psych patient going up to Albuquerque at the same time I didn't say no and we started getting things together. Part of that prep process was another guy showing this guy how to use the LTV1200, as I hadn't gotten to that part in my orientation and didn't yet have the confidence to say "no" to things I wasn't comfortable with or ready for.

My five-minute vent lesson was subpar, to say the least, and then I was off to the big city with the vent guy on the stretcher and the psych guy on the bench seat, two EMTs up front just in case I needed anything. My first action when the vent started beeping was to press that handy "silence" button - per the lesson I had received on the machine's operation. When that didn't work I figure it might be because the patient wasn't listening to the vent settings we had dialed in before leaving, so I paralyzed him with Vec - also per the lesson I had received. And that worked for a little while. Then I started getting more alarms and a low sat, so I did what all good medics do and disconnected the vent, grabbed my bag and had the EMTs up front pull over so that one of them could hop in the back and give me a hand.

Sats still stayed low, the alarms were yelling at me, the EMT was like "WTF, bro, get it together," and I didn't know what to do, so I turned the vent off, pulled the tube out and started over from the very beginning with BLS airways and a BVM. So that happened and we had the airway secured, sats came up and then I handed the bag off to the EMT and set my sights on restarting this vent machine the way I had been taught just a little while ago. It was during this process that I realized my connections from the machine to the circuit had come undone. I must have stepped on them or something during the shuffle... Nowadays I would have simply looked at which alarm I was getting and worked through a systematic process for addressing that alarm. The whole fiasco would have been avoided. But back then I didn't know a single thing about

vents, to include that the text on the screen was relevant to getting the alarm to stop. Other than what I learned in my short pre-trip lesson.

And that's just part of the story. One other part, don't forget, is that guy on the bench seat watching the whole damn thing and me hoping he stays cool enough that I don't have to try and manage two patients simultaneously. And another part is that even though I finally did get that alarm situation sorted, I still had trouble managing my vent settings. I couldn't maximize my SpO2 or keep my EtCO2 in range, my patient would get super agitated every time the Vec wore off, etc.... So I returned back to small town New Mexico late on the day after Thanksgiving, year 2012, and decided then and there that I was never, ever, going to be in that situation again.

My initial study list (after a few days of asking lots of questions and scouring the web) looked something like this:

- The Ventilator Book – William Owens (there was a kindle version at the time and I could take the kindle with me on my long transports to Albuquerque – this was in the day before I had a smartphone, so I couldn't just pull up videos on my phone like I can nowadays!)
- The LTV1200 Product Manual and DVDs (super exciting stuff... but I have since read the manuals for lots of the equipment I have worked with and it does provide some useful information)
- EMCrit Dominating the Vent Series (I had to watch these at the coffee shop down the street, as I didn't have internet where I lived – I was instead trying to grow food and tobacco in my yard back then, that and not get caught up in the "technology craze")

I later came across many other great resources and I will mention those as we get to them. And also, I got on the technology train. Which I think is a huge facilitator of learning when used in the right way and I hope that this little experiment can demonstrate that. If you have the print version of this badboy you can just scan the QR codes for any of the references to access them (if available for free) or to see where you can purchase them (if they want your monies); if you have an electronic version, just click the links. And if you have a version where the links don't work because it isn't legit, that's cool too: go here to get it all free and official.

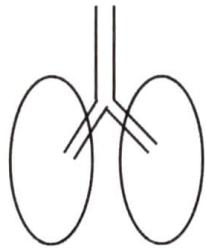
So now let's jump into the weeds and see where we end up. Keep in mind that this is to be an ongoing project and my first foray into this type of thing – so if you have feedback, just send it my way and offer either to lend a hand or a valid suggestion. I'd love to get more folks involved in this and make it both better and more accessible for all involved :)

## II. Some Very Basic Physiology

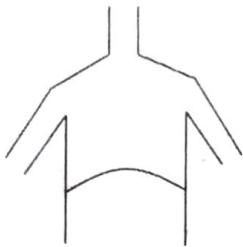
As a disclaimer: the stuff I outline here is super basic and intended to give a foundation for the fundamental concepts of vent management. My personal recommendation for looking into the details beyond this (much of which comes up later when we talk about specific conditions) is a good, solid, heavy Anatomy and Physiology textbook. Or this free one thanks to [OpenStax.org](https://openstax.org). Also note that all the images in here that don't look like they were made by a four-year-old on Microsoft Paint are taken from this source (unless otherwise noted) and the images themselves are links to the specific pages in that text; if you are working on a print version there are page numbers and QR codes at the bottom of each page; and the four-year-old equivalent in the above discussion would be yours truly...

### a. The Normal Breathing Process

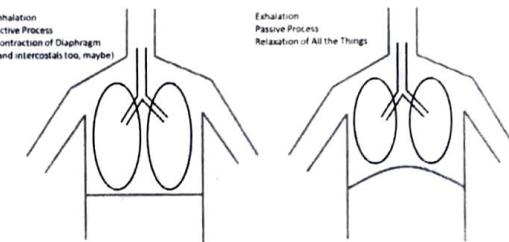
Let's start with a picture of what major components we are working with in normal inhalation and exhalation. At its most basic we have the lungs and the large airways:



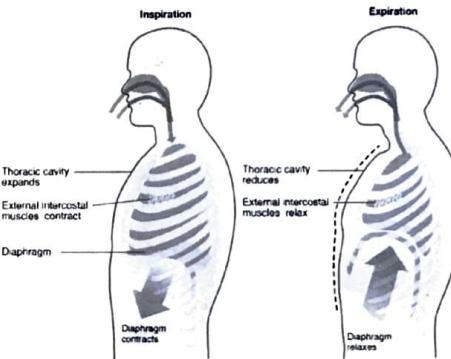
We also have the chest cavity and the diaphragm:



It's OK to consider the lungs to be "attached" to the chest cavity and diaphragm so that when the diaphragm contracts or flattens, the lungs expand – this sucks air into the plural space via a negative pressure:

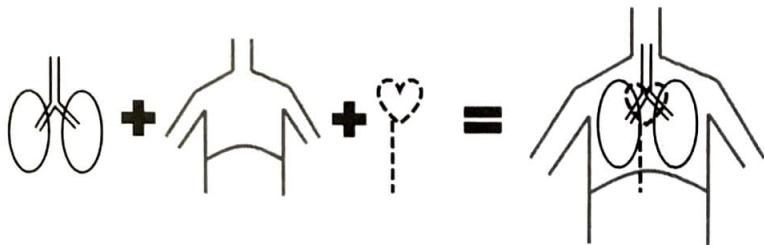


Here's another version (though less aesthetically pleasing) that shows a bit more detail:

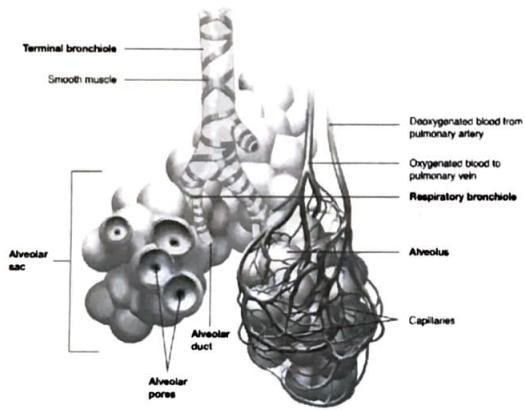


Inside this same cavity lie the heart and great vessels (primarily the inferior vena cava):

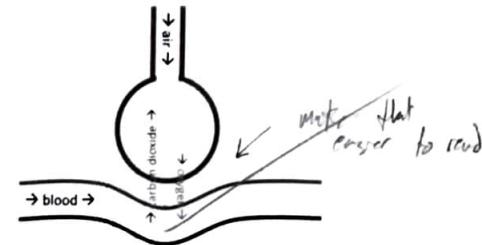
*and most input off to our digestive*



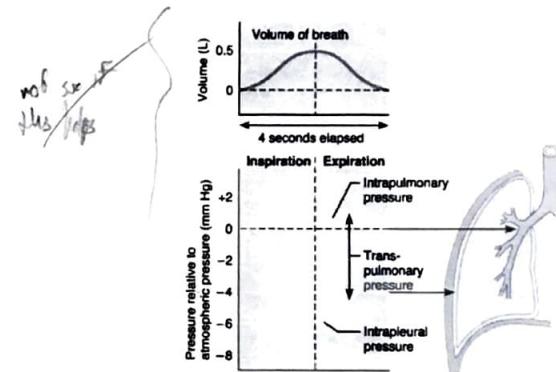
So now we have a system that normally functions by contraction of the diaphragm (with or without help from the intercostal muscles) to create a negative pressure, "sucking" of air into the lungs. Because this air movement occurs via a negative pressure, blood return via the inferior vena cava is unaffected (and maybe even enhanced, though the pressure is quite small) by normal ventilation. From there we need to zoom in and take a look inside the lung tissue. The image below shows blood vessels encircling little sacs, known as alveoli, which are the homestay of the all-famous pulmonary gas exchange where oxygen goes into the blood and carbon dioxide goes out:



A simplified version of a single alveoli with a corresponding blood supply would look like this (see below). This is a representation that we will return to later on, as it can help us understand the pathophysiology of different situations:

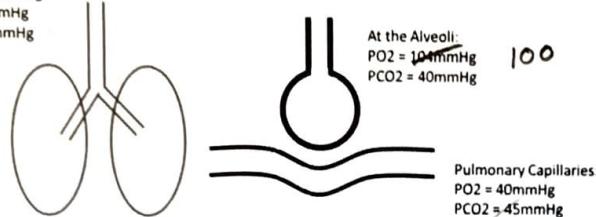


Last thing in the normal physiologic process to consider is, "How does air move from the large airways down to the individual alveoli? And what makes that happen?" Diaphragm contraction at normal resting respiration produces a "suck" of air into the lungs. To properly quantify the negative pressure produced by this movement, we'd have to delve deeper into some of the physiology, but suffice it to say that it only takes somewhere between a smidge and a few mmHg of pressure change to produce a breath by this negative pressure mechanism:



Next, let's add some numbers to that graphic of a single alveoli and its blood supply. Note that in real life blood is continually moving past the alveoli and gases are constantly moving to reach equilibrium, so that as carbon dioxide is offloaded and oxygen is onboard, there is a new supply of blood and a reset of the gradients across that membrane. It's important to know that in the normally functioning system, the body cannot "outrun" this system – diffusion of gases and movement of blood is enough to keep up with a body running or operating at full capacity.

1 ATM = 760mmHg  
 PO<sub>2</sub> = 160mmHg  
 PCO<sub>2</sub> = 0.3mmHg

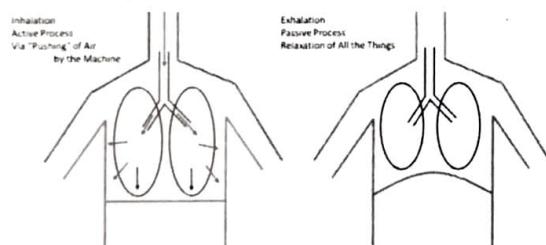


Because there is an open system between the ambient air and the alveoli, the ~~overall~~  
 pressure at the alveoli is also 760mmHg, however the components are different  
 (partial pressures)

It's also worth mentioning that the pressure gradient or difference from alveoli to capillary are drastically different when comparing oxygen to carbon dioxide: oxygen has a ~~delta~~ pressure of about 60mmHg, carbon dioxide has one of just 5mmHg. While this may seem, at first glance, to put the body at risk of some sort of imbalance, recall that carbon dioxide moves more effectively through liquids, and thus the membrane between capillary and alveoli, (roughly twenty times so) and the net result is that oxygen and carbon dioxide exchange at about the same rate.

### b. How is Positive Pressure Ventilation Different?

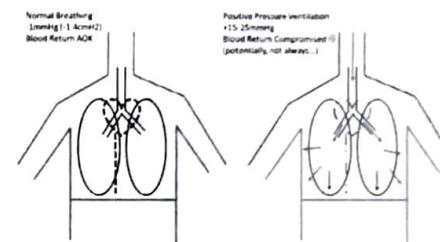
Up to now we've covered the basics of spontaneous, negative pressure ventilation as occurs in the body at baseline. Next, we need to consider what happens when we bypass the whole negative pressure mechanism for ventilation and instead go for a positive pressure approach. Let's start at the top with the basic sketch of airways + lungs superimposed on the chest wall and diaphragm. When we ventilate by positive pressure we have to physically displace the diaphragm and chest wall while simultaneously pushing air into the system – this requires a lot more pressure than we needed for that negative pressure, spontaneous mechanism:



We will get to airways pressures and limits for them later on, but a normal plateau pressure (which reflects alveolar pressure in positive pressure ventilation) is in the range of 15-

25cmH20; compare this to -1mmHg or -1.4cmH20 in the previous discussion and you start to see how drastic the difference is between negative and positive pressure ventilation.

The biggest impact of that increased intrathoracic pressure is the effect it may have on cardiac output. Increased intrathoracic pressure can decrease blood return to the heart via pressure on the vena cava, resulting in decreased preload and, therefore, less output. Let's represent it this way:



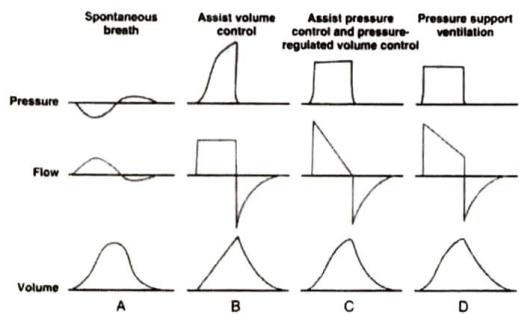
Other negative sequelae of positive pressure ventilation include discomfort to the patient (which we will cover), risk for barotrauma or over-inflation of the alveoli (which we will also cover), and muscle fatigue and weakening (more so with long-term ventilator dependence, so we won't worry about this one here; just know that not all patients can transition back from PPV to regular respiration easily and these folks may get stuck on a vent for a very long time once we do this to them). In addition, this all assumes that we have the airway secured with an endotracheal tube – don't forget that PPV via a BVM puts our patient at risk for aspiration, especially if we are delivering breaths that are more than needed to see chest rise.

We already saw how a pressure waveform might look over time with spontaneous, negative pressure breaths, so let's see how it looks with a machine delivered breath. Note that there are different types of machine delivered breaths in this diagram (and also some terms to discuss) and we haven't yet gotten there; that's totally OK, we just want to point out some general trends here. Big takeaway: the left set of patterns (the normal) looks nice and smooth, without any harsh changes or drastic swings in amplitude; all of the others have those things we don't want. Another thing worth mentioning is that the graphic representations of the modes (i.e. each column of the three towards the right) are each slightly different, meaning that sometimes one mode will be more comfortable for a certain patient in spite of trying to do all the other things you know how to do.

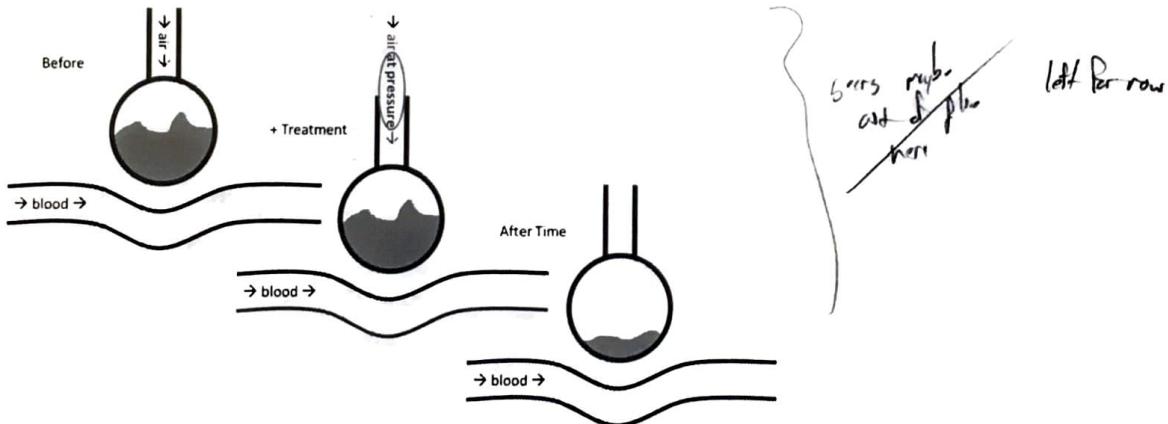
Last thing about this graphic: this assessment of what the body "wants" in terms of smooth waveforms and avoidance of harsh changes in amplitude is scientifically unfounded (as far as I know) and, rather, is a subjective concept pieced together over time. It seems to make intuitive sense, but I'm not sure how one would verify that hypothesis. If you have any leads on that, it would be greatly appreciated. And if you have evidence to the contrary, that would also be of benefit for future versions of this handbook. But for now we will roll with it.

but there may not be a good  
 way to verify the idea  
 (try to get it out of here)

you too  
 it's ok

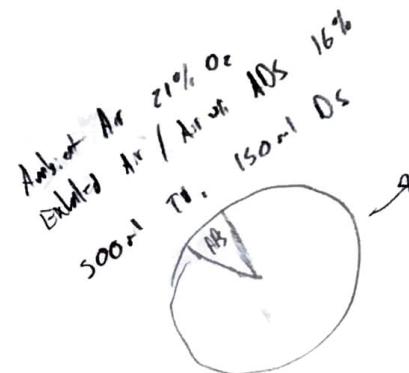


In an effort not to be a Debby Downer and discourage you from ever putting a patient on a vent, there are some advantages of positive pressure ventilation/ mechanical ventilation. Most obvious of these is that it allows us to breathe for a patient in a relatively simple way when that patient is unable to do so on his or her own. More specifically, mechanical ventilation allows us to control and direct recovery with specific pathologies (such as acidosis, asthma and ARDS, all of which we will discuss later on). And on a detailed level, the pressures involved in positive pressure ventilation allow us to more quickly correct certain disruptions in the system. One example of this is the treatment of pulmonary edema (which doesn't necessarily have to be done via a ventilator, rather it could also be accomplished via Non-Invasive PPV, but it's worth mentioning here):



Another example would be treating various forms of hypoxia, as sometimes getting oxygen to the patient's face just isn't enough. Pressure can help move that oxygen in to the bloodstream more effectively, managing ventilation (and therefore acid-base balance) can help that oxygen get delivered more effectively, manipulating time spent at different parts of the respiratory cycle can increase the amount of time that the body can participate in pulmonary respiration, etc. There are lots of good uses of the ventilator and we will get to all of them in due time, so don't worry if you lost track of it all for a moment and know that in spite of its drawbacks, mechanical ventilation and positive pressure ventilation do have their place in the cosmos.

*that got to be too much*



ISSUE  $P_{aCO_2} 40 \text{ & } P_{CO_2} 45$

$$\frac{VD}{VT} = \frac{5}{40}$$

.125

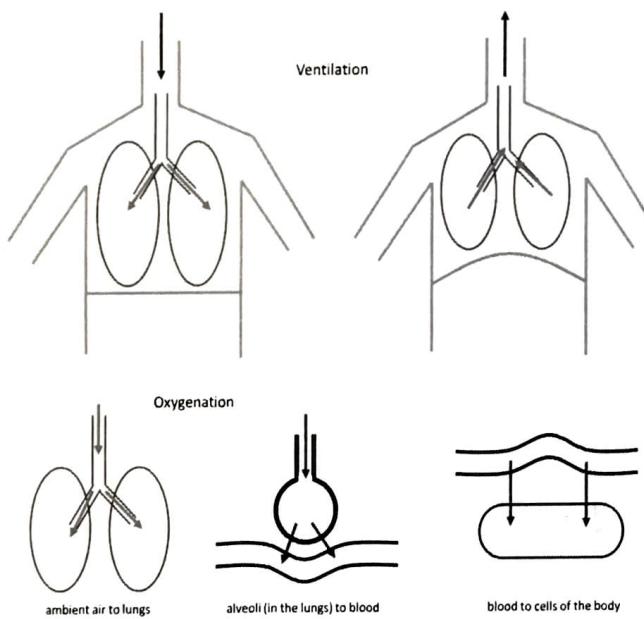
$$V_D = 6.5$$

### III. Other Important Concepts in Physiology

Before we get to the specifics of the machines and strategies for setting it all up, there are a few more components that are worth clarifying. Again, these are simple explanations of complicated concepts, so if you are looking for further info just refer to any of the resources mentioned.

#### a. Ventilation, Oxygenation and Respiration

Just to differentiate the concepts that collectively represent breathing let's chat about these three terms. Ventilation refers to the gross (like in a general sense, not disgusting or distasteful) movement of air as the body breathes in and out. Oxygenation refers to the movement of oxygen from the air outside of the body, through the respiratory and circulatory systems, and to the capillaries where it can be picked up by tissues for us. And lastly is respiration, which has two specific flavors. Pulmonary respiration refers to the exchange of carbon dioxide and oxygen in the alveoli of the lungs; cellular respiration refers to that same gas exchange at the tissues. If it helps, here are a few images to represent all of that:



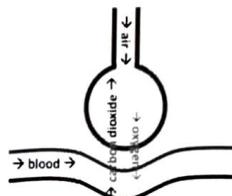
- 4 factors to describe dead space
- Anatomic
- Alveolar
- Physiologic
- Mechanical

#### - Application

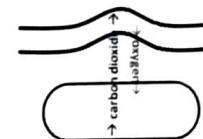
- $V_D \neq V_T$   
it "stretches"
- anatomic
- mechanical
- alveolar:  $P_{aCO_2}$   $H^+$   $HCO_3^-$ , occurs its pressure is sickles
- circuit stuff:  $V_D = P_{aCO_2} - (P_{CO_2})$
- $P_{aCO_2}$

$$\frac{VD}{VT} = \left\{ \begin{array}{l} \frac{P_{aCO_2} - P_{CO_2}}{P_{aCO_2}} \\ \frac{P_{CO_2} - P_{aCO_2}}{P_{aCO_2}} \end{array} \right\} \text{ after the } \frac{P_{aCO_2} - P_{CO_2}}{P_{aCO_2}}$$

#### Pulmonary Respiration



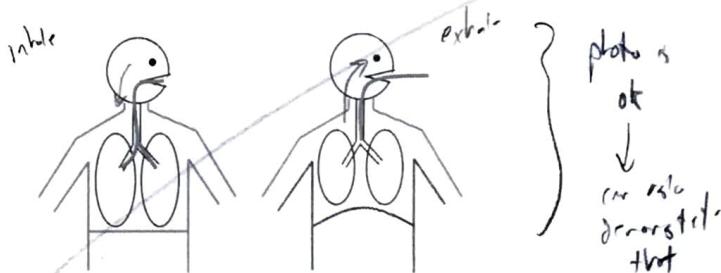
#### Cellular Respiration



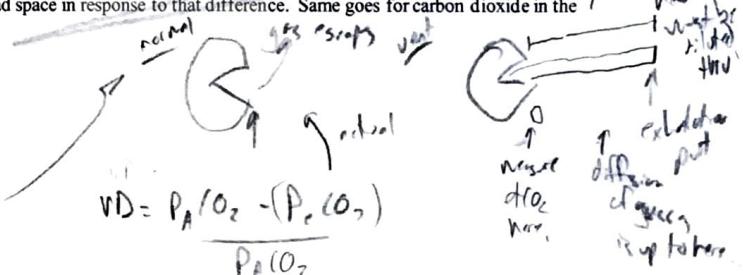
It is true that there is some overlap between oxygenation and pulmonary respiration in this context, but it often helps to differentiate these ideas out. When managing the vent, we are most focused on the processes of ventilation and oxygenation. While respiration (in both forms) is very important, our ability to manipulate these processes isn't as straightforward as it is with ventilation and oxygenation; also the part of respiration, the pulmonary part, that we can impact is covered in a roundabout way by our actions to address oxygenation.

#### b. Dead Space *do this sm over*

Dead space can be an intimidating concept for many when it comes to vent management and we are going to try to both simplify it and identify specific situations in which it matters most. Think of dead space (for now!) as the chunk of air that moves back and forth in the vent circuit/ large airways as ventilation occurs that doesn't actually make it down to the alveoli to participate directly in the gas exchange. In the image below, the blue lines indicate this conceptualization of dead space and shows how it moves with inspiration (left) and expiration (right); note how it extends beyond the mouth with exhalation into what would be the vent circuit.



Dead space as a term is a bit misleading, however, as gases are continually moving across pressure gradients within that space of air. For example, if the partial pressure of oxygen up by the mouth (and still within the dead space) is higher than it is down towards the lower airways (which it will be as oxygen at the distal end moves in to the blood in the alveoli), oxygen will move within the dead space in response to that difference. Same goes for carbon dioxide in the



opposite direction. So even though the dead space air doesn't directly participate in gas exchange and may be best conceptualized as a fixed volume of air stuck in limbo, it is actually more alive than the name would lead one to believe.

Another consideration about the above artistic masterpiece is that it doesn't accurately reflect volumes of air. While it does help to visualize this idea of dead space, in reality the volume that moves back and forth in this manner is quite small, consider this chart from when we were back in school:

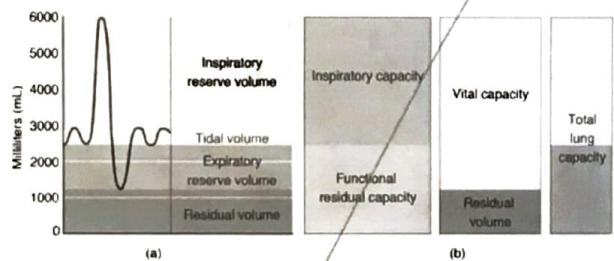


Figure 22.18 Respiratory Volumes and Capacities These two graphs show (a) respiratory volumes and (b) the combination of volumes that result in respiratory capacity

The normal anatomic dead space is just a fraction (roughly one third, see below) of that yellow (on the left) tidal volume section and represents an even smaller fraction of total volumes. Let's jump ahead for a second and assume 150ml of dead space for a given adult, male patient; the trachea of said patient holds anywhere from 10-140ml of air – this means that the dead space graphic would better represent reality if the blue lines were much shorter and maybe moved or "swung" back and forth a bit more. But we digress, this was just meant to be a graphic to demonstrate a point and not accurately describe all the intricacies of anatomy...

So when does dead space matter? It matters when we assume that the volume of air we put in to the front/mouth end of the system equals the volume of air that the alveoli receive. In the simple sketch, however, this is hard to appreciate, as it looks as if the volume in equals volume out – a net difference of zero should mean that the amount of air going in (inspiration) equals the amount of air going out (expiration) which should equal the amount of air getting to the alveoli, right? Not quite, as there is a lot of stretchy stuff between the end of that blue, dead space line on the left image and the individual alveoli where gas exchange occurs; in essence, much of this volume goes towards inflation of the lung so that some of the air can get to the terminal airways, but not all of it does.

Another component of dead space is that it is actually a blanket term for some distinct, but related ideas. First is the anatomic dead space (due to the stretch described above) that happens to all of us, vented or not. Second, however, is the mechanical dead space that we introduce with our fancy contraptions. Just like the lung tissue has stretch, so too do our vent circuits. We can also introduce extra space with humidifiers, EtCO<sub>2</sub> detectors, suction gadgets, etc. – while these are generally small and inconsequential, they can add up and have an impact

get to air

Dead space

- anatomic

- swing or - doesn't matter

- stretch it - does (VT is VT<sub>a</sub>)

- mechanical

- alveolar

"physiologic"

- anatomic

+ alveolar (ideal is zero b/c so flat physiologic = anatomic)

on how quickly gasses diffuse across the dead space (due to more space/volume of air), which becomes particularly relevant the smaller our patients are. But we'll come back to this idea later on. Lastly is alveolar dead space – when air gets down to the alveoli, but there is no corresponding blood supply to make use of it effectively. We will cover this concept a bit more in just a bit.

Normal anatomic dead space volume is .33TV (or one third of tidal volume) or 1ml/lb IBW or roughly 150ml for the adult patient – this means that alveolar tidal volume or alveolar minute volume is about two thirds of what we dial in to the machine (or that we estimate based on our settings). And that's totally OK, as long as we know that there is a difference between the two and what really matters are the alveolar volumes. We will come back to this idea when we discuss adjusting vent settings to manage ventilation or address EtCO<sub>2</sub> values. It also can make a huge difference if we are dealing with small volumes (i.e. pediatric patients), as the difference between expectations and reality has a greater influence on alveolar volumes – but again, we will get to this in detail later on.

As far as strategies to mitigate all of this nonsense, here's some suggestions for what we can do. Note that we are getting a bit ahead of ourselves, as we haven't yet discussed modes or settings, but all of these things will be re-discussed later; so if you don't quite get it now, no worries at all, just hang with us for a bit longer. Firstly, when assessing volumes, always consider exhaled volumes if available (bypasses the mechanical dead space that you introduce). Second, the smaller a patient is, the more inclined you should be to use pressure control ventilation over volume control (bypasses the underestimation of anatomic dead space with those patients). Lastly, do things like maintain the head of bed up when possible, consider recruitment, maximize oxygenation, maximize volumes without causing barotrauma, etc. (these all address alveolar dead space). Again, we are getting ahead of ourselves here and will return to each of these concepts as we move forward, so don't get caught up at this point (but feel free to refer back to this as a quick reference if needed).

### c. Hypoxic Pulmonary Vasoconstriction (also Shunts and V/Q Mismatch)

In systemic circulation, hypoxia causes vasodilation. If a part of the body isn't getting the oxygen it needs, the body opens up the blood supply to counteract the deficit and get blood (and thus oxygen) where it needs to go. The opposite occurs in the lungs: hypoxia in the pulmonary vascular bed results in vasoconstriction (thus the term, "hypoxic pulmonary vasoconstriction"). This mechanism helps the lungs to avoid wasting blood supply to part of the lung that isn't getting enough oxygen – it's a mechanism to conserve resources and maximize oxygenation. Just as in the systemic capillaries, the pulmonary capillaries are in a state of flux and respond by opening and closing to the needs of the system and the availability of resources (oxygen, in this case, being the driving force).

Two terms related to this concept are shunt and V/Q mismatch. Shunt refers to when blood supply from the right side of the heart (un oxygenated) makes it over to the left side of the heart still without oxygen – something happened where it passed through a pulmonary vascular bed and didn't get any oxygen loaded on to it. This can happen when the alveoli are filled with fluid (as in pulmonary edema, pneumonia or ARDS). If there were no hypoxic vasoconstrictive response, the body would put even more blood flow into these regions and the patient's condition would worsen. Treatment here is to fix the cause of the shunt, i.e. move the fluid, gunk,

b/c it seems that this is a small amt of air & gas diffusion occurs across it anyways. And that is right, this type (or shape) of dead space - or that swings back forth w/ it & out - though I'd be remiss to say,

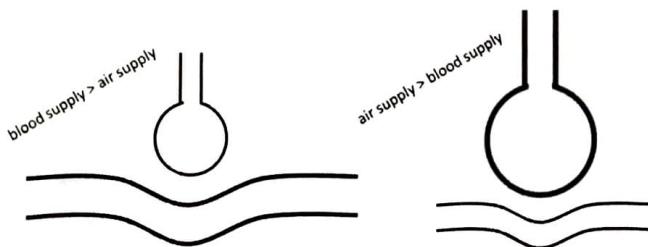
is more or less negligible for all practical purposes. That said, other types of dead space do matter!

whatever else is in that alveolar space out of there, so that air can get back in contact with the capillaries.

In reality, there can, in fact, be some exchange of gasses across fluid in the alveoli, it just happens much less efficiently. Another component here is that while oxygen diffuses in air faster than carbon dioxide, it diffuses across liquids less quickly; the result is that you may have movement out of carbon dioxide without comparable movement in of oxygen:



V/Q mismatch (or ventilation-perfusion mismatch) describes a state in which blood supply and air supply to the alveoli-capillary interface are out of balance, i.e. one or the other valuable resource is passing through the system without being utilized. This represents an inefficient use of resources and contributes to the previously mentioned idea of alveolar dead space. It can occur by either of two mechanisms: blood supply outweighs air supply or vice versa.



Going back to this hypoxic vasoconstrictive response, the V/Q mismatch represented on the left would lead to vasoconstriction – the body wants to redirect that blood flow to where it will be met with adequate air delivery to facilitate efficient oxygenation. Moving right, this V/Q mismatch is a step in the right direction and what we aim for with treatment: as we recruit alveoli (see next section) and add air in to parts of the system which have clamped down, we can reverse that vasoconstriction and improve the amount of lung participating in alveolar gas exchange. While a mismatch still exists at this point, the body will eventually respond to air supply and the vessel will dilate to meet that supply. (How fast does this occur?)

The easy way to utilize this information in your patient management is to always try to maximize pulmonary respiration. Note that I didn't just say "maximize oxygenation" – there is

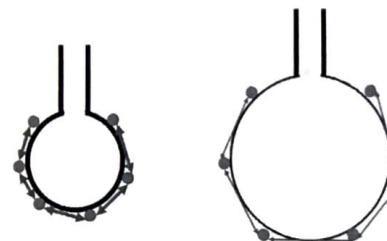
more to it than that. We can dump all the oxygen we want in to the tube going down a patient's throat, but if we don't match that with pressure needed to open up alveoli (and thus get that oxygen to previously clamped down lung regions) it won't get us the full effect we want. Plus there are downsides to too much oxygen, as you are probably already aware, but just in case we will discuss this when we get to the section on FiO<sub>2</sub>. Take away here: we always want to use as much lung as possible and mitigate this hypoxic vasoconstrictive response. The next section discusses how we make that happen.

Last thing: there are ways to do many things and calculate the extent to which a shunt/mismatch exists, but the actions to address the results of those calculations are things that we should arguably be doing anyways for our patients, so I will defer all of that nerding to the Appendix.

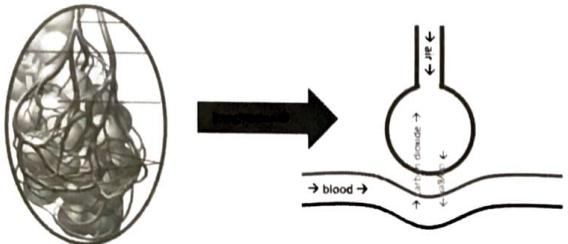
#### d. Alveolar Surface Area and Recruitment

Without getting to far gone into the laws of physics, let's consider blowing up a balloon. At first it is a bit difficult to get it started, but once we get over that initial hump, it gets easier and we have a party. The reason for that is that as things stretch they resist further stretching less, at least up to a certain point (another way to say this is that as things stretch they become weaker, which is often how we describe a dilated cardiomyopathy and discuss Frank Starling's law – same idea, just a different application). Another concept specific to the alveoli is surface tension. There is fluid around the surface of each alveoli that tends to hold hands with itself and resist expansion, but as we increase the volume of that alveoli we increase the distance between those hand-holders and make it more difficult to do so, thus an easier expansion. Look at it this way and consider the strength of the hand holding to be proportional the thickness of the arrows:

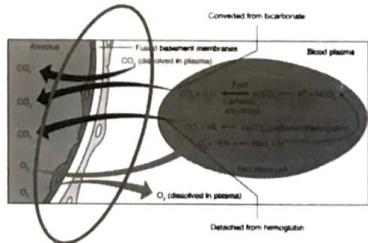
*Not w/ great  
surface tension...  
S. op. great  
analogy...*



So we have an alveoli that is difficult to open up at first, but then readily expands. Now there is a limit to this expansion, so it isn't a never-ending process – we will discuss that later on when we get in to measuring and addressing airway pressures, so let's hold off for now. Another super important thing to notice that changes from the left image to the right is that the available surface area on the inflated, right-sided alveoli has increased dramatically. This means that there is more alveolar surface area available for gas exchange. While we have been simplifying the interaction between alveoli and blood supply with a simple graphic representation, don't forget that the alveoli is actually covered by lots of vessels:



And the last important thing to take note of is that as that alveoli expanded and the surface area increased, the thickness of that alveolar membrane also stretched and got thinner. This makes it easier for gasses to diffuse across the membrane, particularly oxygen (which doesn't diffuse across liquids as readily as carbon dioxide).



Now we know that filling the alveoli up from an uninflated/underinflated state is a bit difficult, but that the advantages are increased alveolar surface area and thinning of the space that impedes gas exchange, so it's worth the difficulty to make this happen. For now, suffice it to say that we need to make this happen and that we do that by increasing pressure in the system; we also know that there is a limit to how far these alveoli will stretch, but we'll get to both the mechanism for making this all happen and how to avoid causing damage in later sections.

#### e. Lung Size and IBW

Last thing related to underlying physiology before we move on to talking about the machine: lung size is most strongly correlated with patient height; therefore, we use a patient's height to calculate an ideal body weight when doing vent things. The idea is that a six-foot dude could weight either 120lbs or 300lbs and the size of his lungs wouldn't change. There is a formula to calculate IBW for both males and females, typically presented as a hybrid of metric and standard units as either:

$$\text{IBW}_{\text{dukes}}(\text{in kg}) = 2.3(\text{height in inches} - 60) + 50$$

$$\text{IBW}_{\text{chicks}}(\text{in kg}) = 2.3(\text{height in inches} - 60) + 45.5$$

on  
too much  
padding in  
the sentence

For the metric enthusiasts, you also have it as so:

$$\text{IBW}_{\text{dukes}}(\text{in kg}) = 0.91(\text{height in cm} - 152.4) + 50$$

$$\text{IBW}_{\text{chicks}}(\text{in kg}) = 0.91(\text{height in cm} - 152.4) + 50$$

Or you can use charts like this:

HEIGHT	PBW	4 mi	5 mi	6 mi	7 mi	8 mi
4' 0" (48)	17.9	72	90	107	125	143
4' 1" (49)	20.2	81	101	121	141	162
4' 2" (50)	22.5	90	113	135	158	180
4' 3" (51)	24.8	99	124	146	174	198
4' 4" (52)	27.1	108	135	161	187	217
4' 5" (53)	29.4	118	147	176	205	235
4' 6" (54)	31.7	127	159	190	222	254
4' 7" (55)	34	136	170	204	238	272
4' 8" (56)	36.3	146	182	218	254	290
4' 9" (57)	38.9	154	193	232	270	309
4' 10" (58)	40.9	164	203	245	282	327
4' 11" (59)	43.2	173	216	259	302	346
5' 0" (60)	45.5	182	228	273	319	364
5' 1" (61)	47.8	191	239	287	335	382
5' 2" (62)	50.2	200	281	301	347	401
5' 3" (63)	52.4	210	212	314	367	419
5' 4" (64)	54.7	219	274	328	383	441
5' 5" (65)	57	228	342	399	456	
5' 6" (66)	59.3	237	297	358	415	474
5' 7" (67)	61.6	246	306	370	431	493
5' 8" (68)	63.9	255	325	386	447	511
5' 9" (69)	66.2	265	331	397	463	530
5' 10" (70)	68.5	274	343	411	480	548
5' 11" (71)	70.8	283	354	425	496	566
6' 0" (72)	73.1	292	366	439	512	585
6' 1" (73)	75.4	302	377	452	528	603
6' 2" (74)	77.7	311	388	468	543	622
6' 3" (75)	80	320	400	480	560	640
6' 4" (76)	82.3	329	412	494	578	659
6' 5" (77)	84.6	339	423	506	592	677
6' 6" (78)	86.9	348	435	518	608	695
6' 7" (79)	89.2	357	446	535	624	714
6' 8" (80)	91.5	366	457	546	643	732
6' 9" (81)	93.8	375	469	563	657	750
6' 10" (82)	96.1	384	481	577	673	769
6' 11" (83)	98.4	394	492	590	689	787
7' 0" (84)	100.7	403	504	604	708	806

HEIGHT	PBW	4 mi	5 mi	6 mi	7 mi	8 mi
4' 5" (48)	25.4	80	102	124	146	167
4' 1" (49)	24.7	99	124	146	173	198
4' 2" (50)	27	108	135	162	189	216
4' 3" (51)	29.3	117	147	176	205	234
4' 4" (52)	31.6	126	158	190	221	251
4' 5" (53)	33.9	135	169	202	233	260
4' 6" (54)	36.2	144	181	213	244	271
4' 7" (55)	38.5	154	193	231	270	308
4' 8" (56)	40.8	163	204	245	286	328
4' 9" (57)	43.1	172	215	259	302	345
4' 10" (58)	45.4	182	227	271	311	355
4' 11" (59)	47.7	191	239	286	334	372
5' 0" (60)	50	200	280	300	360	400
5' 1" (61)	52.3	209	262	314	365	418
5' 2" (62)	54.6	218	273	328	382	437
5' 3" (63)	56.9	228	281	341	398	455
5' 4" (64)	59.2	237	290	351	408	463
5' 5" (65)	61.5	246	308	369	421	482
5' 6" (66)	63.8	255	319	383	447	510
5' 7" (67)	66.1	264	331	397	463	522
5' 8" (68)	68.4	274	342	410	476	547
5' 9" (69)	70.7	283	354	424	492	566
5' 10" (70)	73	292	366	438	511	584
5' 11" (71)	75.3	301	377	452	527	603
6' 0" (72)	77.6	310	388	468	543	623
6' 1" (73)	79.9	320	400	476	559	636
6' 2" (74)	82.2	329	411	486	561	641
6' 3" (75)	84.5	339	423	507	582	676
6' 4" (76)	86.8	348	434	518	593	694
6' 5" (77)	89.1	357	446	535	624	713
6' 6" (78)	91.4	366	457	556	640	731
6' 7" (79)	93.7	375	469	562	655	750
6' 8" (80)	96.0	384	480	580	670	769
6' 9" (81)	98.3	393	492	599	688	786
6' 10" (82)	100.6	402	503	604	704	805
6' 11" (83)	102.9	412	515	617	720	823
7' 0" (84)	105.2	421	526	631	736	842

#### IBW and Tidal Volume for Females

ARDENet Studies

Or you can use apps like this:



#### IBW and Tidal Volume for Males

ARDENet Studies

As an aside, some people remember this formula for IBW as "inches over five feet" as shown below. Only problem with this is that it gets tricky if you have someone under five feet. But either way works:

$$\text{IBW}_{\text{dukes}} (\text{in kg}) = 2.3(\text{every inch over } 5') + 50$$

$$\text{IBW}_{\text{chicks}} (\text{in kg}) = 2.3(\text{every inch over } 5') + 45.5$$

When dealing with pediatric patients, your go-to reference ought to be the Broselow Tape. If that isn't available, you do have some formulas you can refer to:

$$\text{Infant Weight (in kg)} = \frac{(\text{age in months} + 9)}{2}$$

$$\text{Kiddo Weight (in kg)} = \frac{(\text{ages in years} + 4)}{4}$$

Or you can use apps like this:



And ~~not~~ that the Broselow overlaps with the equation/ chart above, so if you have a really small grownup or a big kiddo, you should still be able to get an IBW just fine. So no excuses!

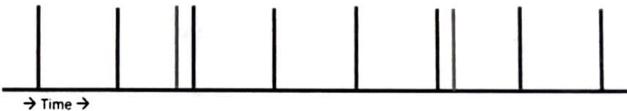
#### IV. Modes of Ventilation

##### a. Control

Plain old control ventilation or controlled mandatory ventilation (CMV) isn't utilized much these days and doesn't exist as an option on most transport vents, but it helps as a starting point to understand the other modes. In this mode we dictate how often we want to give breaths and how much of a breath to give on each of those instances and we ignore whatever the patient does in response to that. Seems OK for patients with no inherent respiratory effort, but it can pose problems with those who do have some respiratory effort that doesn't quite mesh up with what the machine wants to do. Let's assume a hypothetical timeline running left to right over an arbitrary amount of time with black hashes to represent machine delivered breaths:



Now let's discuss what happens when the patient tries to breathe during this underlying delivery scheme, both just before (red) and just after (blue) machine delivered breaths:



In the red situation the machine would give the subsequent breath right in the middle of the patient's breath and in the blue situation the patient would be trying to take a breath in the middle of a machine-given breath. Both situations lead to some bad stuff: firstly, that the patient-initiated breaths, both red and blue, don't get actualized, as we have increased pressure in the system significantly and the patient's effort will not be enough to overcome this hurdle and actually draw in air. Other factors are patient discomfort and a vent strategy that doesn't respond to the changing needs of the patient. The idea moving forward is that we need a strategy that works alongside the patient and helps meet their expressed needs. Syncing the machine with the patient improves comfort, conserves resources, facilitates recovery and gives us more control over the management of the patient.

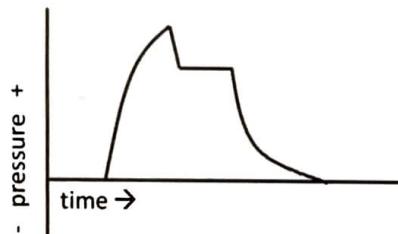
##### b. Assist Control (AC)

Assist Control ventilation is a mode that supports a patient's spontaneous respiratory effort by delivering a preset amount of air (either by volume or pressure, but we'll cover that soon) regardless of the underlying rate. So in this case (with the red and blue patient triggered breaths), the machine would sense inspiratory effort by the patient (a small negative pressure or "pull") and then respond by giving a breath as programmed. The result would be ten full breaths delivered in the timeline, rather than the underlying eight breaths noted as black lines. The

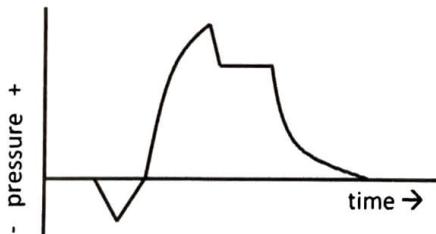
obvious advantage here is that the patient's expressed need for more breaths per unit time (or more minute volume) would be met.

On the flipside, however, we have the proximity of breaths to consider. If a patient initiates the red breath just before a machine-programmed one, we run the risk that the first breath may not have time to cycle through before the next is delivered, we might get a breath on top of another, or "breath stacking." This can increase pressure in the system and cause a complication known as AutoPEEP in which the pressure in the system doesn't get back to baseline before we add on another breath. Again, we will discuss this further on down the line, but note that this is the primary drawback to the assist control mode.

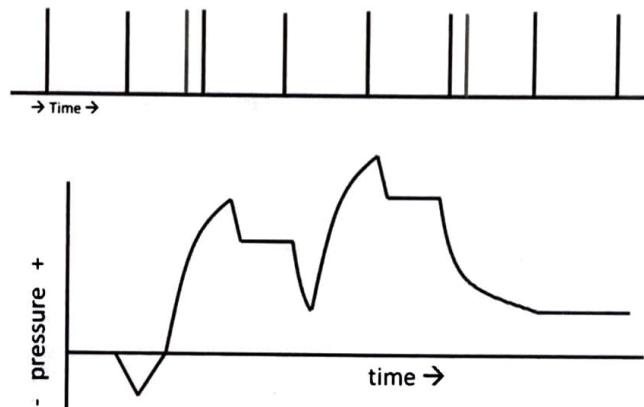
In the case of the blue patient triggered effort, the machine breath occurs just prior and, if airway pressures haven't had time to settle back to baseline, the breath may get missed or ignored. Now this depends on how the machine is set up to sense a patient trigger and we can generalize it by saying that the further along the breath is or the closer the pressure has returned to baseline makes it more likely that the breath will "catch" and result in that full delivery. To represent these ideas graphically, let's start with a sketch of what alveolar pressures look like over time as a machine-delivered breath is delivered. We are going to ignore PEEP (since we haven't discussed that yet) and assume that baseline is "zero" or atmospheric pressure and that changes above and below the horizontal line are relative to that set point. We also don't have to worry about the specific components of the waveform at this point, but those things will be discussed later on:



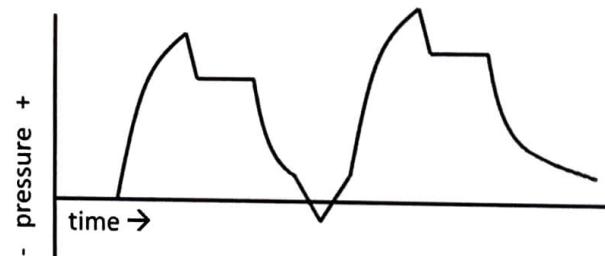
Now the next step is to see what a patient triggered breath looks like. Note the dip in pressure at the start of the waveform as the patient breathes in and creates a negative pressure, this effort is sensed by the machine and then a full positive pressure breath is then given:

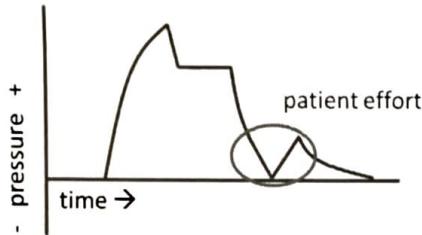


*(A)* Let's go back to that initial sketch with red and blue lines representing the patient's attempt to breath and see what it would look like in the red line situation where the patient takes a breath and then the machine delivers a breath before that patient triggered one has a chance to return to baseline. Note that the end result is a higher pressure (greater overall amplitude) and a baseline above where we initially started.



*(B)* In the blue line situation, where a machine delivered breath precedes a patient trigger, there are two possible outcomes: one in which the trigger results in a breath (shown first and with similar consequences of the above example) and one in which the trigger does not result in a breath and the efficacy of the machine triggered breath is simply altered somewhat:



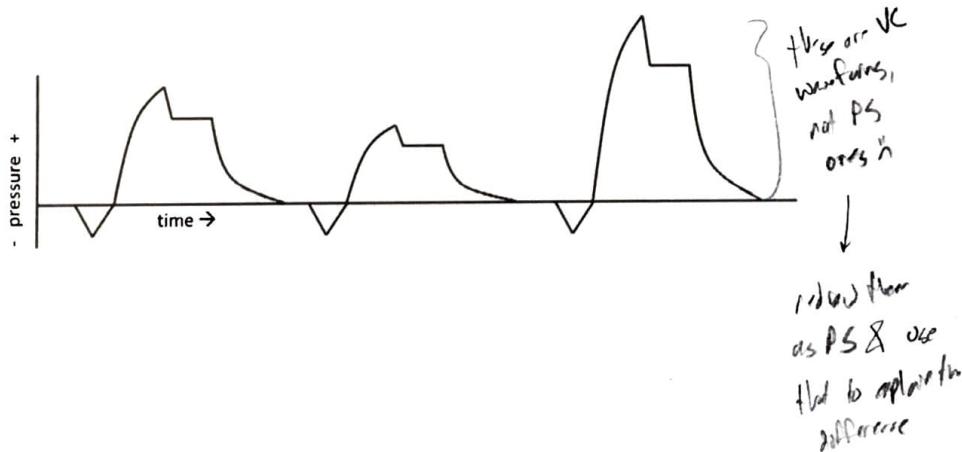


To summarize, AC mode machine-delivers breaths at a set rate and will supplement that with full breaths whenever a patient effort meets the trigger threshold. Upsides to this are that the increased needs of the patient are readily met, downsides are the risk for increased pressures and a move away from baseline (AutoPEEP, which we will return to later). As a general rule: anytime you have someone in AC mode you need to be vigilant and monitor both airway pressures and AutoPEEP.

#### c. Synchronized Intermittent Mandatory Ventilation (SIMV)

SIMV is another mode of ventilation that also seeks to mitigate the shortcomings of CMV. While SIMV has often been cited as a mode for weaning patients from the vent, it does have utility and is commonly used in the transport setting. SIMV assists patient effort by a similar trigger mechanism as is seen in AC mode; the difference is that rather than giving a full breath it provides a "pressure support breath" to augment patient effort. We haven't yet made it to the point of fully discussing the difference between pressure-delivered and volume-delivered breaths, but know that a pressure-delivered breath gives a variable amount of air (at a set pressure) and the resultant volume of air is dependent on how much the lung tissue expands in response to that set pressure.

One really important thing to consider here is that the volume that results from a given pressure can vary from breath to breath and is the function of many different variables. Let's assume three consecutive patient triggered, pressure support breaths. The area of the space under the waveform represents volume delivered, so in each breath we see a different amount of air resulting from the same pressure support parameter dialed in on the machine.



This concept isn't, in and of itself, a bad thing, it is just something that we need to be aware of. If we dial in a pressure support of 15cmH<sub>2</sub>O and get a few breaths of 400ml (measured by exhaled tidal volume, again a concept we will get to later on), we can't assume that this will hold true with time and, therefore, we need to keep an eye on it as we move forward.

One other aspect of SIMV that sets it apart from AC is that it has a mechanism built in to prevent breath stacking or one breath being given on top of another. If you recall from our discussion of AC, one of the pitfalls was that you can stack breaths on top of one another and end up with both increased pressures and AutoPEEP. SIMV avoids this by delaying machine delivered breaths after it facilitates a patient-triggered breath. Our initial dilemma with CMV was that we wanted to mitigate the negative consequences of breaths times in close proximity to one another:



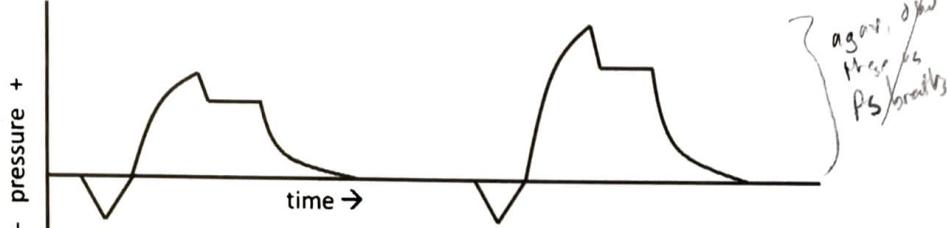
SIMV mode would respond to this as shown below. Note how the breath initially "planned" to get delivered just after the red line (which indicates a patient triggered breath) got pushed back in time to allow that red breath to cycle all the way through:



The downside to this, however, is that if the patient is triggering lots of breaths (because of inadequate sedation, increased need, or false triggering due to vibrations or a bumpy road), we could end up with something like this:



"Well," you might argue, "that doesn't seem too bad, the patient is breathing when he wants and we are simply supporting him with that." True story, but what if each of those breaths looks like this (left side) instead of that (right side)?



a goal of breath PS breaths

The one exception to this would be an acidotic patient who needs a high minute volume and the hypothetical machine that defaults to SIMV mode (i.e. we would prefer this patient in AC mode), but I don't know if that's even a thing and I also think an SIMV strategy with pressure support to match a goal tidal volume (i.e. ignore that 75% rule we discussed earlier) would be just fine... So there we have it: just match the mode already in place or start with what our machine defaults to. And then as we get more comfortable with the ins and outs we can always switch up our approach – there is nothing wrong with trying a different mode on a patient to see if we get better results, even mid-transport.

If we get all left-sided breaths (with less area under the waveform, representing lower tidal volume), we may actually be ventilating the patient with less air per unit time (decreased minute volume). And that can be a bad thing, as we need to ensure adequate minute volume with all of our ventilated patients (another one of these concepts that we'll get to later...).

Ideally SIMV would include a mix of machine-delivered and patient-triggered breaths and the resultant minute volume would be close to our therapeutic goal, but that doesn't always happen and we need to watch out for it. Last thing to mention about SIMV: while we program the machine-delivered breaths to give us a certain volume (whether in volume control or pressure control mode), it is standard practice that patient triggered breaths do not exceed 75% of that goal for machine-delivered breaths. So what you typically see is tidal volumes at goal for machine initiated breaths and slightly lower tidal volumes for patient triggered breaths. While that is the status quo, I am not convinced that such a strategy makes sense in the transport setting and have been known to titrate my pressure support up so that pressure support breaths are comparable to machine-initiated breaths. (And if you have any insight on that, let's for sure chat about it, I'm still not 100% sure on it).

To summarize, SIMV delivers patient-triggered breaths via pressure support and not a guaranteed volume; in addition, there is a delay mechanism built in that attempts to prevent breath stacking. Upsides to this are the avoidance of overinflation and AutoPEEP, downsides are that minute volume can suffer if there are too many triggered breaths being delivered. As a general rule: any time you have someone in SIMV mode you need to be vigilant and monitor exhaled tidal volumes (to compare machine-initiated and patient-triggered breaths) and minute volumes.

1 minute to work  
1st & 2nd person

#### d. And Beyond...

Now that we know about both AC and SIMV modes, the decision becomes which mode to use for a given patient. While many folks have their preference and we could argue one over the other all day long until we are both blue in the face, the bottom line is that either mode could work for just about any patient type. Here's the general strategy we'll recommend (and we will revisit this idea again at the very end when we talk about building out a protocol/ guideline and putting it all together): if we have a patient already on the vent and all is well, just stick with whichever mode they are working with; if we are starting from scratch or reworking the settings altogether, try what our machine defaults to and then change modes if we need to down the line. That's about as simple as you can make it.

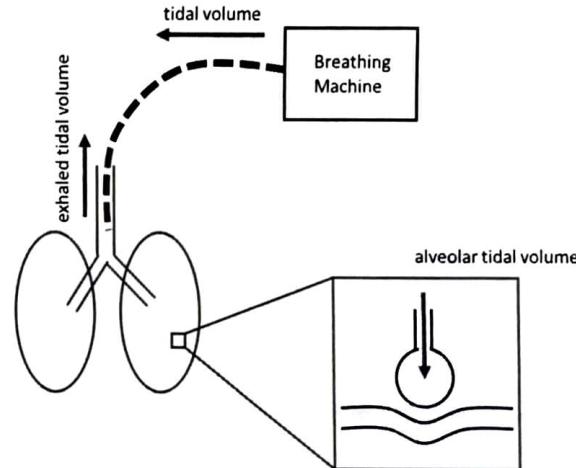
#### IV. Control of Ventilation

We already discussed the first big choice in vent management: which mode (AC vs SIMV in the transport setting) to utilize for our patient. The next decision is to choose whether we want to control tidal volume or airway pressure. If we choose to control volume, airway pressures will function as the dependent variable (i.e. we won't be able to directly control them); if we choose to control pressure, tidal volume will function as the dependent variable. There is no right or wrong answer to this conundrum, but the general trend is that folks will use volume control in most cases and pressure control with pediatrics or when they are especially concerned about airway pressures. Not saying this is the best decision, just saying that's how it's been done.

The reason for this is twofold. First (and arguably most relevant), the machines tend to default to volume control mode unless you do something to intentionally get out of it (such as choose "infant" on the patient type category). Second, volume control is a bit easier for some folks to wrap their heads around – it's a little more intuitive to think about set volumes and resultant pressures than it is the other way around. But as we said above, there is no right or wrong; we can just as effectively and safely ventilate a baby in volume control as we can an adult in pressure control (even though this is contrary to what we normally do), as long as we know the underlying concepts and keep an eye on all the important things along the way!

##### a. Volume

In volume control ventilation we choose how much tidal volume we want to push down the circuit with each breath delivered. Now, this tidal volume that we put in goes into the lungs, does its thing at the alveolar level, and then gets exhaled out of the circuit. When we say "tidal volume" we are referring to the air going into the system from the machine; those other two concepts (alveolar tidal volume and exhaled tidal volume) vary from that value due to a number of different factors. Let's see how this looks in a graphic and then we'll hash out a few details of all these terms:



"Hey there, mister," you might say, "my big fat A&P book that you recommended me to spend my last paycheck on says that 'tidal volume' is the amount of air exhaled during a respiratory cycle. What's up with that!?" That is true. But! We have a specific term, in this context, for exhaled tidal volume and we need another term for the value we dial in to the machine, so it helps us to ignore the literal definition and break those two concepts up as I have shown above.

And to review what we discussed previously about dead space, the alveolar tidal volume is normally exhaled tidal volume minus anatomic dead space (which is .33TV, 1mL/lb, or 150ml-ish), so about two thirds of what we push into the system. Now what about those other kinds of dead space; mechanical and alveolar? The first one is easy: we factor out mechanical dead space by assessing volume by looking at exhaled tidal volume. To say it another way, when we want to know how much air we are giving to our patient, we look at the air leaving the lungs (that actual, textbook definition of tidal volume) and not at the air we push in from the machine, as there can be a significant (in the sense of it actually matters, not necessarily super large) difference between the two.

Alveolar dead space is a little bit more difficult to measure. While there is a way to do this (which we have deferred to the [Appendix](#)) the volumes in the system don't change and we always take action to address alveolar dead space anyhow. But just to hash this idea out, let's do a thought experiment: assume a tidal volume of 350ml, an exhaled tidal volume of 300ml and an alveolar tidal volume (estimated) of 200ml. If 100ml or half of that alveolar tidal volume is dead space (i.e. that air goes to portions of the lung with no corresponding blood supply and doesn't participate in gas exchange), the volumes we see remain unchanged and the patient still exhales 300ml (200ml of which went to the alveoli, 100ml of which actually did work to help our patient).

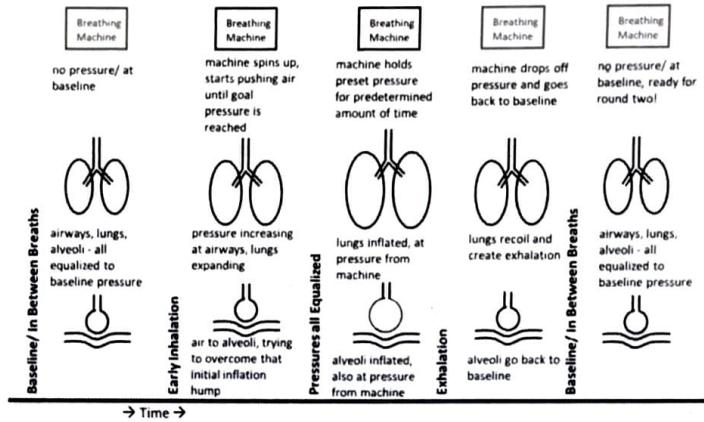
To summarize all of this: volume control ventilation allows us to control the amount of air we put into the vent circuit. While we mostly care about exhaled tidal volume and alveolar tidal volume, dialing in a tidal volume on the machine is the closest we can get to controlling those values. Tidal volume, as we program it into the machine, is a precursor to both exhaled tidal volume and alveolar tidal volume and we should always make adjustments to the system using exhaled tidal volume to eliminate the effect of mechanical dead space. In addition, we need to remember that alveolar tidal volume is about two thirds of exhaled tidal volume (factoring out anatomic dead space) and that there may be some of that alveolar volume that doesn't get to play gas exchange (alveolar dead space). While this may have seemed like a bit of tangent, I promise this is important!

Next bit: when we dial in a tidal volume and move that air through the circuit to the lungs and alveoli, the result is an increase in pressure that is dependent on the amount of air going in and how that air moves. For now, we will defer a discussion of how we describe this air movement (i.e. its speed or flow and all that), just know that pushing a preset volume in means that pressure changes happen as a result of that air movement and that certain pressure changes (i.e. too much air too fast) can cause damage to the alveoli. Remember that balloon example and how we said that the easier-stretch superpower was self-limiting? At a certain point we can overinflate alveoli and we for sure want to avoid that.

So the way to do this with volume control ventilation is to monitor your airway pressures and adjust the volume input to avoid causing damage. We will get to the specifics as to how we do that eventually, for now it's ok to leave it as so: in volume control ventilation we control the amount of air going in to the circuit at the expense of control over resultant pressures; that said, we always need to monitor airway pressures during volume control ventilation in order to avoid causing damage to the alveoli. In addition, volume control ventilation lends itself to an overestimation of alveolar tidal volume if we forget to factor in dead space.

### b. Pressure

In the other corner of the arena we have pressure control ventilation. In this mode, a breath happens as so: we have a dialed-in pressure, the machine spins up to maintain that pressure, the air all the way from machine to alveoli equalize to this pressure for a set time, then the breath cycles off and we go back to baseline. Because our input here is only pressure, however, volume becomes our dependent variable (exhaled tidal volume, to be exact; or textbook-defined tidal volume for the OCDers out there). Let's draw it out and see if we can make it a little more clear:



In the fourth column, we see that recoil of the lungs (a passive exhalation) occurs when the pressure that had been keeping those lungs inflated drops off. This volume of air that gets pushed out of the circuit as the lungs "fall" back to normal is our exhaled tidal volume, which we then have to actively observe to make sure it meets the goal we have in mind for what volume this patient ought to be getting with each pressure breath we deliver. If this exhaled tidal volume is not what we want it to be, then we adjust the pressure in the system to get closer to our goal (more pressure means more volume, less pressure means less volume).

One thing worth pointing out here is that in pressure control ventilation we don't have to bother with considering mechanical dead space (i.e. the compliance of the vent circuit, all those gadgets we add in line by the ET tube), as the only way we have to measure volume is via exhaled tidal volume or what the patient breathes out (which is downstream of all that mechanical dead space stuff). We still need to consider anatomic and alveolar dead space, just as we did with volume control, but the components we introduce in our machine/ circuit are eliminated. This is a big advantage of pressure control ventilation with small patients: forgetting to factor in 10ml (arbitrary number) in an adult is no big deal, forgetting to do so in a neonate with tidal volumes of 25ml is huge. We'll discuss more later, but just know that this is one advantage of pressure control.

Another advantage of this pressure control is that we avoid the risk of over-inflation or high pressures at the alveolar level. The highest pressure those alveoli will see is whatever value we preprogrammed into the machine. So as long as we follow some basic guidelines as to what a safe pressure is, there's no risk of harm or barotrauma. The downside is that we don't have as good of control (compared to volume control) over the amount or volume of air that we are putting into the system; instead we have to continually monitor exhaled tidal volumes and adjust to our goals.

To summarize: in pressure control ventilation we control the pressure put in to the system at the expense of control over resultant volumes; that said, we always need to monitor those volumes when we have a patient in pressure control mode in order to avoid hyper or

f  
Mid-m2.13  
Capra  
Sky.  
W  
color

hypoventilation. In addition, pressure control ventilation makes it a little more difficult to control ventilation (as opposed to oxygenation, more or less referring to keeping the EtCO<sub>2</sub> within range – again, one of those things we will get to later on), due to the breath to breath variability in volumes.

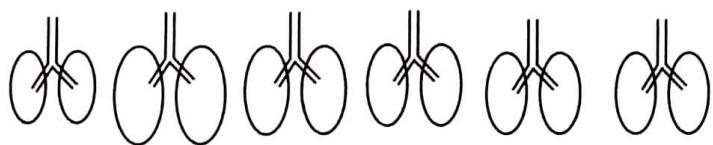
### c. Pressure Regulated Volume Control

Pressure regulated volume control (PRVC) is one attempt to get at the best of both worlds when it comes to this volume vs. pressure conundrum. In this mode we dial in a goal for tidal volume and put a cap on pressure, then the machine tries to give breaths to the goal volume without exceeding the max pressure. The machine makes adjustments to how it delivers each breath by looking at previous breaths and then adjusts flow to add or take away volume working towards the preset TV goal. In the event that it can't reach the goal volume without exceeding the upper pressure limit, volume is sacrificed - think of the "pressure regulated" part as a hard stop.

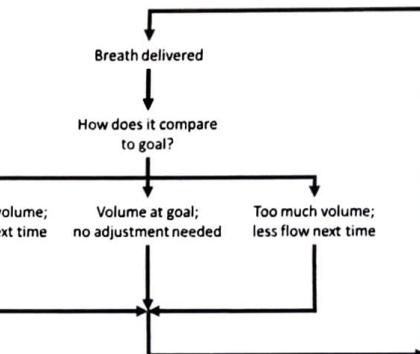
Let's visualize this over a few breaths to see what it would look like:

Goal TV: 400ml  
Pressure Cap: 30mmHg

Breath 1	Breath 2	Breath 3	Breath 4	Breath 5	Breath 6
Initial breath	More flow	A little less flow	Same flow	A little more flow	Same flow
25mmHg	30mmHg	28mmHg	400ml	29mmHg	29mmHg
300ml	450ml			400ml	400ml



If it helps, we can also think of this in an algorithm-style fashion where we decide where each breath end up in relation to our goal and then adjust the subsequent breath in a cyclical manner:



This flow of decision-making one breath at a time doesn't quite describe the process accurately, but it gives the right idea. In reality the machine looks back at the last few breaths (varies by machine) and builds a small data set from which it decides how to deliver the next breath. So the system is actually a little more refined than our crude representation, which is a good thing!

To flush out a few more details on this PRVC concept, let's look at another example of a few consecutive breaths. In this example something is causing an increase in pressure to the system, therefore breaths basically get cut short. The result of this would be a drop in MV. It's important to keep this in mind with PRVC, as we can inadvertently drop MV pretty significantly in an effort to avoid high pressures.

Goal TV: 400ml  
Pressure Cap: 30mmHg

Breath 1	Breath 2	Breath 3	Breath 4
Initial breath	More flow	Can't give more	Same flow
25mmHg	30mmHg	30mmHg	30mmHg
300ml	325ml	325ml	325ml

→  
And on and with the result  
that MV goes down  
(compared to our goal)

A few more things about PRVC: "pressure cap" is a make-believe term – the machine most often uses 5cmH<sub>2</sub>O less than the set PIP for this value. There are also limits on how much variation occurs from one breath to the next; to say it another way, the machine won't make

crazy, drastic changes in response to one or two funky breaths. Another thing: the machine has a system to get this whole process started by giving "test breaths" via different methods when it first gets set up – no need to worry about that here, that's homework for us depending on the system and machine we use in the field. Along that same idea, the machine doesn't actually know how much air (i.e. TV) it gives with each breath until after the fact when it sees the exhaled tidal volume, that's why it can overshoot the goal. Last thing: PRVC is good when we are worried about barotrauma or giving too much pressure, but it is important to make sure we keep an eye on MV and match it to our calculated goal.

## XVII. Vent Parameters, Round One

Next step in our journey is to explain fully the ins and outs of some of the terms we use to describe different aspects of ventilation. Some of these have been mentioned already (and few explained in detail), but most of the complete explanations have been left out up until this point in an effort to better organize thoughts in a linear, stepwise fashion. If it helps to go back to previous sections after this discussion, go for it. Also, keep in mind that this is not an exhaustive list of all the terms, these are just the basics (with which you may have already been familiar with prior to getting into the manual), and more will come later.

### a. Tidal Volume

Tidal volume per the textbooks is the amount or volume of air exhaled in a given breath. As previously discussed, it sometimes helps to break this concept up into two distinct terms: tidal volume and exhaled tidal volume. Tidal volume, in this way of thinking, would be the volume of air we put into the system, while exhaled tidal volume would be the volume of air that comes out of the system. Tidal volume may be notated as TV or VT, exhaled tidal volume is notated at Vte. In this manual, however, we have tried to abbreviate things with initial letters of words if the term would be spelled out, but this is just so you know what things mean if you see it abbreviated elsewhere (and in the protocols at the very end of this manual where space is of the essence).  
*Vtr & Vte*

Tidal volume varies by the size of the patient and the normal range is 6-8ml/kg IBW. Recall the discussion we already had about ideal body weight (IBW) and the idea that lung size is best correlated to height. Also recognize that 6-8ml/kg IBW is just a framework from which we start when determining our initial settings and that tidal volume can range from 4-10ml/kg IBW or more, depending on the specific situation that we are up against. Enough on that for now though, we will talk further on that when we get into ventilator strategies.

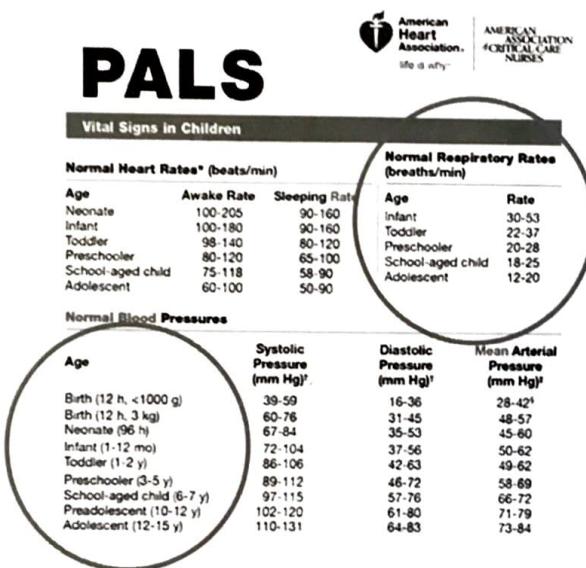
We also previously mentioned the concept of alveolar tidal volume, but let's hold off on that one for now, as we will discuss it in a later section in more detail. For now we will focus on tidal volume as two distinct ideas (tidal volume and exhaled tidal volume) with a normal range of 6-8ml/kg IBW.

### b. Rate

Rate is equivalent to the idea of respiratory rate and describes how many breaths are delivered or taken in one minute of time. It is also known as frequency and may be abbreviated by "f." You also may see rate abbreviated as "RR" to stand for respiratory rate. Normal parameters vary by age, but the typical adult rate is 12-20 and pediatric rates are as outlined on your Broselow Tape or by this chart from the PALS Manual:

\* discuss how pali rates are basically just guesses &  
that we decided to use pali's bc it's a commonly  
used reference already

# PALS



There are times that we set rate above or below what might be considered normal for the patient's age, but we'll get to those specifics when we discuss vent strategy for different situations later on.

## c. Minute Volume

Minute volume, also known as minute ventilation, is the amount of air moved in one full minute. It is the product of tidal volume and rate:

$$MV = TV \times RR$$

Minute volume/ minute ventilation can be abbreviated as "MV" or "VE" and is the primary mechanism by which we control ventilation (per our previous discussion of Ventilation, Oxygenation and Respiration). We will discuss soon how to manipulate both tidal volume and rate to address ventilation in just a bit, so don't worry about that for the moment. A normal minute volume for the adult patient is often cited at 4-8 liter per minute, but we prefer to use weight-based calculation so that it applies to all patient sizes:

$$MV = 100\text{ml/kg (IBW)}/\text{min}$$

As with rate or frequency, there are times that we use a different MV goal with specific patient types, but we will get to that later on. Last thing: just as with tidal volume, there can be different types of minute volume. "Minute volume" or "minute ventilation" typically describes what we dial in to the machine, then we tag "exhaled" on to either term to describe the feedback the machine gives us about what the patient breathes out, and lastly there is alveolar minute ventilation which takes out that anatomic dead space from the equation. While alveolar minute volume is an important concept and we'll return to it later, we typically base goals and calculations on MV or exhaled MV and not on alveolar ventilation.

## d. Fraction of Inspired Oxygen

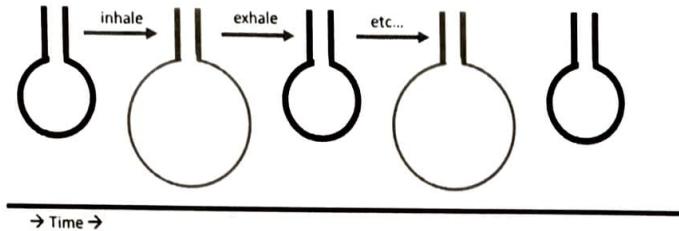
Fraction of inspired oxygen, or FiO<sub>2</sub>, describes the amount of oxygen in the mix of gasses that we push into the patient's vent circuit when we give a breath. 100% oxygen would be an FiO<sub>2</sub> of 1.0, 21% oxygen or ambient air would be an FiO<sub>2</sub> of 0.21. ~~We've already~~ <sup>will</sup> soon establish the importance of oxygenation in the management of ventilated patients (Ventilation, Oxygenation and Respiration) and adjusting FiO<sub>2</sub> is often times the easiest way we can fix an oxygenation issue. But again, we'll discuss fixing things in just a little while.

One thing worth mentioning at this point, however, is the idea that too much oxygen can be a bad thing. While it may be tempting to dial the FiO<sub>2</sub> up to 100% on all patients, this isn't always warranted and can cause harm to our patients if they don't need it. At the same time, however, don't be skimpy and titrate FiO<sub>2</sub> to maintain an SpO<sub>2</sub> in the mid-to-high-90s unless you have good reason to suspect that SpO<sub>2</sub> isn't an appropriate measurement (such as hemorrhage, CO exposure, etc.) or you have another greater worry (baby in the belly of mommy, traumatic brain injury, etc.). And if you are ever in doubt, just give oxygen: most of the bad things take a longer time to cause damage and the risk of giving a little bit extra in transport outweighs the risk.

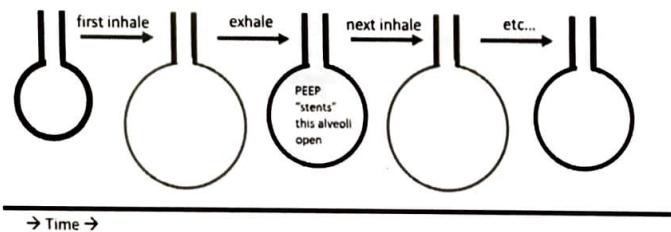
## e. Positive End-Expiratory Pressure

Positive end-expiratory pressure (PEEP) describes the positive pressure that remains in the alveoli at the end of expiration. And let's recognize that we basically explained a term using the words it's made up of, so we'll try it another way via a few steps. During mechanical ventilation we push air into the alveoli on inspiration, then that air moves out of the alveoli on expiration. We tend to conceptualize this (and have done so in all the sketches so far) as a net zero movement of air where the alveoli go from deflated to inflated and then back to deflated, as so:

\* reason for this? tough to measure / know, we always fix it. If there was alveoli and open to outside any ways



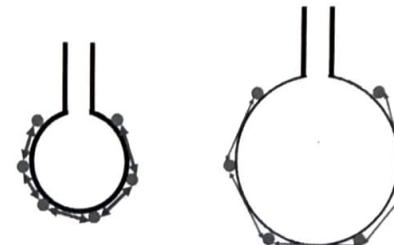
Now the truth is that we can put pressure into the alveoli and then leave some of that pressure there to hang out throughout exhalation. So rather than the alveolar air sac deflating all the way back to its original size, it deflates only part way:



Recall our previous discussion of alveolar surface area (i.e. the more inflated an alveoli is, the more it can participate in gas exchange) and add to that the idea that blood flow through the pulmonary capillary bed is continuous, it doesn't stop when inhalation stops; pulmonary respiration or gas exchange across the alveolar membrane occurs throughout the respiratory cycle, both on inhale and exhale, and PEEP maximizes alveolar surface area during exhalation to make the exhalation-side of pulmonary respiration much more efficient.

Another idea particularly relevant to this discussion of PEEP is that the “stenting” or opening-up of alveoli doesn’t always happen in one breath as it’s been depicted in the above drawing. Sometimes it takes a very long time to get from a that left-most, deflated stage to a “recruited” or opened-up stage that provides some benefit to patient outcome. The reason for this is that initial “hump” that we must overcome when starting the inflation process. Remember that picture with the hand-holding surface tension molecules?

*Alveoli recruitment  
expansion of the left VT &  
etc*



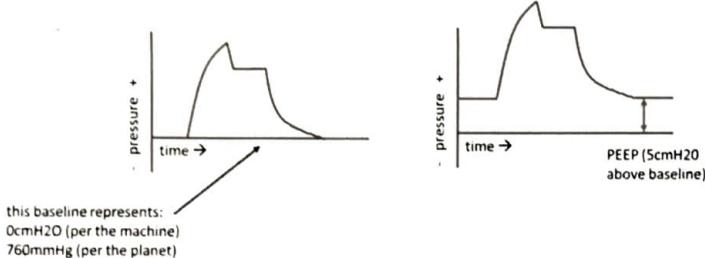
To summarize so far: PEEP is a residual pressure that we leave in the alveoli during exhalation to both maximize pulmonary respiration during exhalation and recruit alveoli. That's the basics of it, but there are two more things worth hashing out just to make sure we have it all solidified. First is a discussion of how we measure PEEP and what it looks like in relation to all the other numbers we've been discussing up to now. Second is the concept of physiologic PEEP – it's worth clarifying that now before we get too far gone. And then we will end this section on PEEP with a short thought experiment about why we even need to cycle breaths in the first place.

During mechanical ventilation we measure pressures in centimeters of water (cmH<sub>2</sub>O). You may occasionally hear this pronounced as “sonnimeters of water” and know that a “sonnimeter” and a centimeter, in this context, are the same thing. So we have cmH<sub>2</sub>O with mechanical ventilation, but we generally talk about ambient air pressures in other terms, such as mmHg, kPa, PSI, etc. We skinned right on past this concept in a previous section when we said that 1mmHg is about 1.4cmH<sub>2</sub>O (this was when we talking about the fact that a normal negative pressure, spontaneous breath only talks -1mmHg of “suck” while a typical positive pressure breath via machine takes 15-25cmH<sub>2</sub>O to move an equivalent amount of air), but let's now put it all down in a quick chart just to clear the water (or air):

	ATM	PSI	kPa	mmHg	cmH <sub>2</sub> O
ATM	1	14.7	101.3	760	1033
PSI	0.068	1	6.89	51.7	70.3
kPa	0.0098	0.145	1	7.5	10.2
mmHg (Torr)	0.0013	0.019	0.133	1	1.36
cmH <sub>2</sub> O	0.00097	0.014	0.098	0.736	1

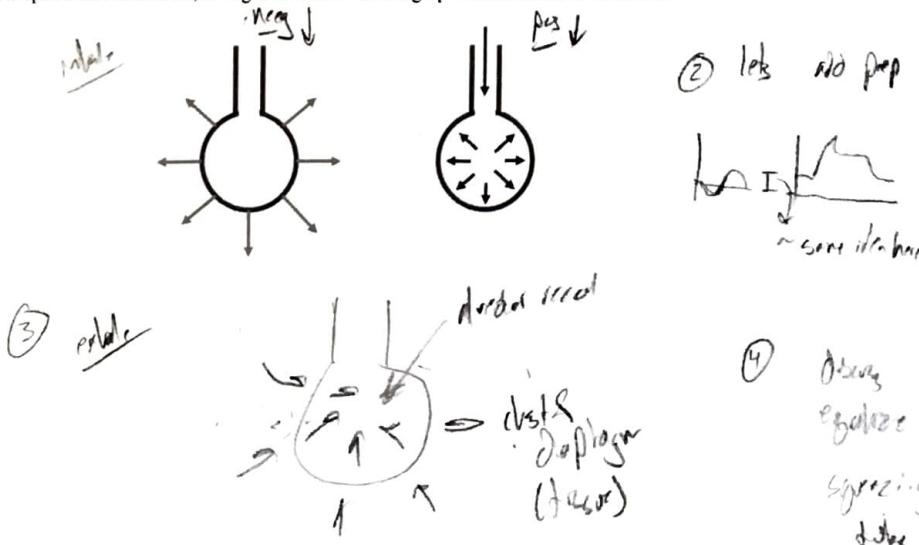
So now that we have that clarified, let's look a waveform representing alveolar pressures as we deliver a breath. We've seen this image previously, but now we are going to add some numbers to it. The first breath is with no PEEP or zero PEEP, the second one (right) is with 5cmH<sub>2</sub>O worth of PEEP added in:

*of ZEEP*

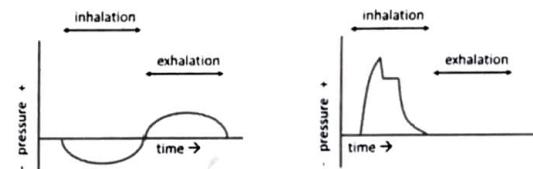


Two more things to note about this sketch. First, the 760mmHg atmospheric pressure is included there just to demonstrate that "0cmH2O" is a construct that makes it easier to conceptualize changes on the machine and in the airways, the actual pressures would be difficult to work with, so we assume a zero baseline at whatever atmospheric pressure happens to be for our setting. Second thing to note is that the area under the right-sided waveform in this example breath is much larger than the area on the left. Recall from our discussion of SIMV when we said that the area under the curve represents tidal volume – while that was more or less true in that SIMV example with no PEEP, the area under the curve actually represents the volume of air that participates in alveolar gas exchange. PEEP not only increases functional tidal volume, it also extends effective gas exchange into the expiratory phase of the respiratory cycle.

We are getting closer to the end of our PEEP chat, but a few more tidbits before we move on. You may be wondering about this idea of "physiologic PEEP" and the idea oft-cited concept that all of us, at baseline, live with 3-5ish cmH20 worth of PEEP in our alveoli. "But how does this work," you may wonder, "when PEEP is a positive pressure and we normally breathe by a negative pressure mechanism and with very small pressure changes!?" Let's start at the beginning with two alveoli: one on the left representing negative pressure, spontaneous respiration and one on the right representing positive pressure ventilation. Note two very different mechanisms for opening each alveoli. The left shows a mechanical force pulling the alveoli open from the outside, the right shows air "blowing up" the alveoli from the inside:



Now let's compare the change in pressure within each alveoli example over time through the respiratory cycle. And I've taken PEEP out of the right handed, mechanically ventilated one to demonstrate something - we'll add it back in real soon:



On the left we have the spontaneous, negative pressure waveform of alveolar pressure through the breath cycle. Not

#### f. Inspiratory Time (and I:E Ratio)

The next (and final, for now!) term to consider is inspiratory time, often referred to as "I-time." I-time is the amount of time over which we deliver a breath. A normal I-time for the adult patient is about one second (which we would write out as 1.0s) and that norm varies by age as so:

Adult	Pediatric	Infant
0.8-1.2s	0.5-0.8	0.3-0.5s

(Age  $\geq 1.5$ )

We've already mentioned that during positive pressure ventilation the more time we spend pushing air into system, the more oxygen gets moved into the bloodstream. This means that more time spent on the inspiration side of the breath cycle (vs. exhalation) equals better oxygenation. With that in mind, the most intuitive way to increase time spent at inspiration would be to lengthen the I-time. If we do that, however, we have to accommodate by decreasing time spent at expiration or by decreasing rate. Consider seventeen breaths over one minute of time:

$$60 \text{ seconds} \div 17 \text{ breaths} = 3.52941176 \text{ seconds per breath}$$

$$\approx 3.5 \text{ seconds per breath}$$

$$\approx 3.5 \text{ seconds per each in/out cycle}$$

If "in" or inspiration = 1.0 seconds, then "out" or exhalation = 3.5 seconds – 1.0 seconds  
Therefore "out" or exhalation = 2.5 seconds

If we lengthen inspiratory time to 1.5 seconds:  
Exhalation time = 3.5 seconds – 1.5 seconds  
= 2.0 seconds



Using time to equalize pressure, i.e.  
Squeezing at the narrow  
site

We often represent this ratio between I-time and expiration time as an "I:E Ratio" to represent the amount of time spent at inspiration in comparison to the amount of time spent at exhalation. A normal I:E ratio is anywhere from 1:2 – 1:3. Let's build an I:E ratio for the above examples:

In the first example, we have 1.0s : 2.5s, so our I:E Ratio is 1:2.5

In the second example, we lengthened out inspiratory time to 1.5s;

So we now have 1.5s : 2.0s

We always write out I:E ratios with "1" as the first number, so we need to simplify the ratio:<sup>4</sup>

Simply divide both sides by the first number as so,  $\frac{1.5}{1.5} : \frac{2.0}{1.5}$

And solve for our new I:E ratio of 1:1.33

So to bring it back home: we had a rate of 17 and an I-time of 1.0 with a resultant I:E ratio of 1:2.5. We wanted to increase time spent at inspiration, so we changed our I-time to 1.5 and ended up with an I:E of 1:1.33. For now we don't have to worry about the significance of these numbers, we just need to understand the math, how we get to these numbers, and the terminology associated with them. Let's try another example, but this time we will adjust rate instead of I-time:

Per above: rate of 17, inspiratory time 1.0s = I:E of 1:2.5

Now let's increase our rate to 20 and recalculate the I:E ratio

60 seconds ÷ 20 breaths = 3 seconds per breath

If "in" or inspiration = 1.0 seconds, then "out" or exhalation = 3.0 seconds – 1.0 seconds

Therefore "out" or exhalation = 2.0 seconds

In the this example, we have 1.0s : 2.0s, so our I:E Ratio is 1:2.0

Now let's shorten our inspiratory time to 0.8s and see what happens:

If "in" or inspiration = 0.8 seconds, then "out" or exhalation = 3.0 seconds – 0.8 seconds

Therefore "out" or exhalation = 2.2 seconds

Now we have 0.8s : 2.2s,

but we need to make this in to an I:E ratio with "1" as the first number:

$$\frac{0.8}{0.8} : \frac{2.2}{0.8} = 1: 2.75$$

And let's summarize this all one more time and make a few generalizations: we can shorten our I:E ratio by either increasing I-time or increasing rate; we can lengthen our I:E ratio by decreasing I-time or decreasing rate. A shorter I:E ratio means less time (in relation to the whole in/out cycle) spent on exhalation, a longer or lengthened I:E ratio means more time for exhalation. We will return to this concept later when we get to ventilator strategies, but know

↳ changing I:E ratio, until we do well  
inspired ratios.

that some patients can benefit from a shorter I:E ratio and other can benefit from a longer I:E ratio, so it is important to know which changes affect the I:E ratio in which direction.

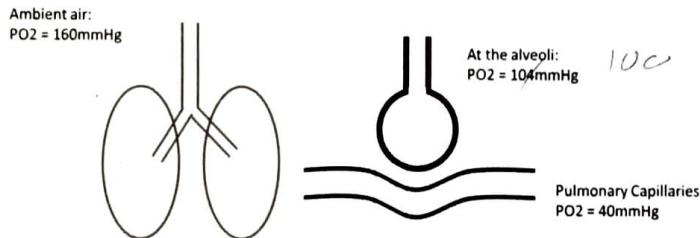
# The Big Things

## I. Monitor and Fix The Big Ones

There are three super duper important things that need to be monitored and addressed for all ventilated patients, hands down and no matter what. The order we discuss them here is totally arbitrary, they all hold equal weight and are interrelated. The discussions that follow are in general terms and not specific to certain pathologies or patient types, that sort of stuff will come soon.

### a. Oxygenation (and SpO<sub>2</sub>)

*If my heart can't*  
You may have heard once or twice before, but oxygen is pretty important stuff. Oxygen gets to tissues via a few steps, some of those we can affect directly with the ventilator. There are also more complicated ways to manipulate oxygenation, but let's focus on the simple stuff for now, starting with a review of how oxygen gets from the ambient air to the tissues. The following is a version of a graphic we used earlier that shows partial pressures at a few steps along the way. These pressures are for the spontaneously breathing patient, just FYI:



We also mentioned that gasses will diffuse from areas of high concentration (represented by higher partial pressures in this graphic) to area of lower concentration. So in this baseline example, we can conclude that oxygen will move from the ambient air, to the alveoli and then in to the pulmonary capillaries. The first way that we can speed this process up is by changing the partial pressure of oxygen at the start of the system. Instead of 21% of the gas mix or 160mmHg of oxygen, we can titrate that all the way up to 100% (FiO<sub>2</sub> 1.0) or 760mmHg. This will increase the rate at which oxygen diffuses to the alveoli, resulting in a higher partial pressure of oxygen downstream and, subsequently, faster diffusion into the blood stream:

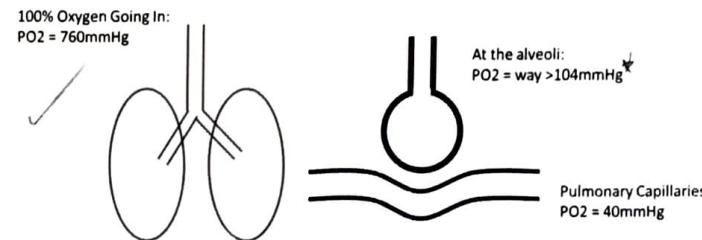
$$PAO_2 = F.O_2 (P_{atm} - P_{H_2O}) - 1.25 (P_a(O_2))$$

$$.21 (760 - 47) - 1.25 (40)$$

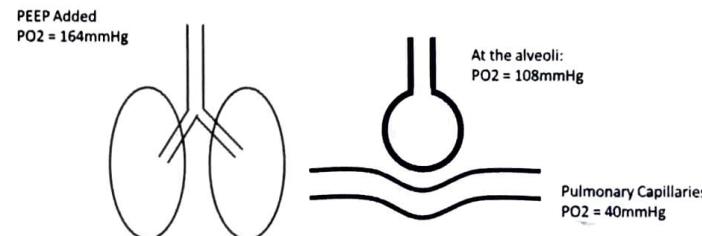
150.57

100.57

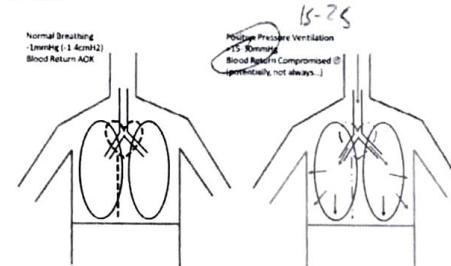
101



Another way we could have done this is by adding PEEP into the system. So going back to the 21% FiO<sub>2</sub> of ambient air, let's add 5cmH2O of PEEP (roughly 4mmHg) on to our partial pressure of oxygen:



PEEP is really good at increasing oxygenation, but at the potential cost of decreasing blood return to the heart. It does its oxygenation thing by increasing alveolar partial pressure of oxygen, increasing alveolar surface area and by helping "push" fluid out of the alveoli. Recall from a previous discussion that any increase in intrathoracic pressure can impede blood flow back to the heart (and see image reproduced below). Because of this, normal PEEPs are less than 10cmH2O. That said, we sometimes use PEEPs up to 20cmH2O in specific cases and we will talk about those later.



↑ & get a good value here

PAO<sub>2</sub> calculation in various situations / settings

760-15

21 (7.75 - 47) - 1.2 (40)

725

153

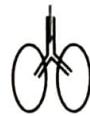
102

105

And now to quantify these two strategies, let's do a side by side comparison of two hypothetical situations. The math part of this is left to the **Appendix**, but it is a good exercise to demonstrate why we typically titrate FiO<sub>2</sub> first and then PEEP when dealing with oxygenation:

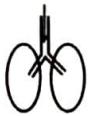
**Situation 1**  
FiO<sub>2</sub> 0.21 (room air)  
PEEP 10cmH<sub>2</sub>O

PO<sub>2</sub> in: 160mmHg  
PO<sub>2</sub> at alveoli: 120mmHg



**Situation 2**  
FiO<sub>2</sub> 0.40 (40%)  
PEEP 0cmH<sub>2</sub>O (no PEEP)

PO<sub>2</sub> in: 304mmHg  
PO<sub>2</sub> at alveoli: 240mmHg



With this ↑ PO<sub>2</sub> is  
only good if O<sub>2</sub>  
is crossing the alveolar  
membrane, so maybe  
not so hot?

The partial pressure of oxygen at the alveoli (PAO<sub>2</sub>) in Situation 2 is twice that of Situation 1! And Situation 2 doesn't carry the negative consequences of increased PEEP that Situation 1 has. Moral of the story: with oxygenation issues, start with FiO<sub>2</sub> first – more bang for your buck and less negative consequences. That said, there are ways to titrate FiO<sub>2</sub> and PEEP together in an effort to maximize oxygenation. We won't spend time talking about it too much here, but there are some strategies from the ARDSNet that line this out as so:

**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>

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

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

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

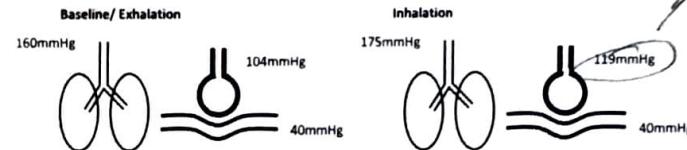
FiO <sub>2</sub>	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5
PEEP	5	8	10	12	14	14	16	16

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

Just a quick recap before pressing on: assuming ventilation and comfort are adequate (see next sections), initial steps to fix oxygenation are increasing FiO<sub>2</sub> and then adding PEEP. While it is totally OK to use a stepwise approach that titrates both FiO<sub>2</sub> and PEEP in line with one

another, recognize that FiO<sub>2</sub> is your most direct fix for improving partial pressure of oxygen at the alveoli and has very few consequences in the acute setting. FiO<sub>2</sub> is especially helpful in increasing alveolar surface area and driving fluid out of the lungs, but may decrease CO by way of a drop in preload to the heart. And lastly, both of these techniques (FiO<sub>2</sub> and PEEP) improve oxygenation throughout the respiratory cycle

The next logical step in this discussion is to consider what happens during inhalation. Now changes to both FiO<sub>2</sub> and PEEP affect oxygenation throughout the respiratory cycle, that is both on inhalation and exhalation, but lots of oxygenation happens during inspiration. Here's a comparison of what pressures would look like with an FiO<sub>2</sub> of .21 (ambient air) and no PEEP, both at baseline/ on exhalation (left) and on inspiration (right). We'll use an arbitrary added pressure of 20cmH<sub>2</sub>O or 15ish mmHg:



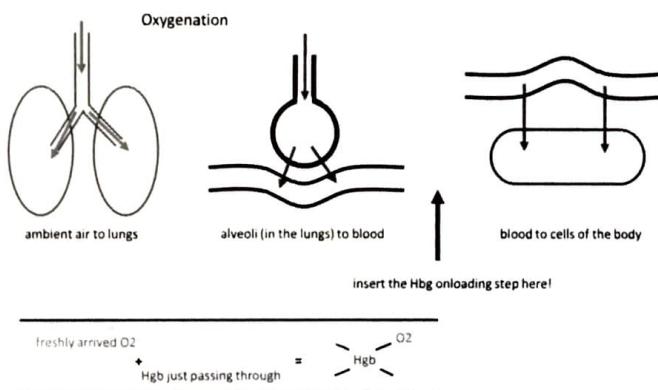
Note the higher pressure difference between alveoli and capillary during inspiration. This leads us to conclude that more time spent at inspiration further maximizes oxygenation, therefore strategy number three to maximize oxygenation is to increase the I-time to make use of this piece of knowledge. If we extend I-time long enough, it will eventually become longer than exhalation and we end up with an "inverted I:E ratio" that might be written as 2:1. I know that I previously stated before that we "always" express an I:E ratio with a "1" as the first number, but I lied – the exception to that rule is when we have an inverted I:E ratio. Let's amend that previous rule to say that one of numbers in the ratio needs to be "1" and that it is always the first (inspiratory) number except in cases where we have an inverted I:E ratio.

The primary drawback of a really long I-time (and therefore of an inverted I:E ratio) is that it is extra uncomfortable for our patients and we will need to get super aggressive to maintain patient synchrony with the machine. Comfort is one of the three super duper important concepts in this section, so enough said about that until we get there. Summary up to this point is that there are three ways to improve oxygenation by spinning dials on the vent: increase FiO<sub>2</sub>, add PEEP and lengthen the I-time.

"Now why," might you ask, "do we not just fill the lungs up with 100% oxygen and keep them inflated – we'd have a forever-long maximum diffusion of oxygenation into the blood stream, right?" There are two reasons for this. One is that we don't want to drop preload or blood return to the heart indefinitely (as discussed above). Two is that it isn't all about oxygen – we also have to consider its partner in crime, carbon dioxide. Carbon dioxide doesn't diffuse so well in gas (as compared to oxygen) because it is a bigger, heavier molecule. The movement of carbon dioxide, therefore, is partially dependent on movement of the body of air in which it hangs out. And that leads us into our next section on ventilation, but a few more things to cover before we get there.

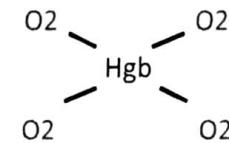
Recall back to our previous discussions of both the hypoxic vasoconstrictive response and alveolar dead space. There are times where we are getting oxygen into the system just right, but components inside the system are out of whack and that oxygen is not being put to good use. One thing we, as clinicians, sometimes do to exacerbate this "things out of whack" concept is lay our patients flat. Unless you have good reason to do so, all vented patients should have their head of bed elevated somewhat. And backboards (if you are still using those archaic torture devices!) are no excuse, just prop the whole head end up with something to get a comparable effect. The reason why we elevate the head of bed to improve oxygenation is multifaceted, but it has a fair amount to do with gravity and is beyond the scope of this discussion.

One more thing to consider is how we measure oxygenation. Our standard tool in the field is pulse oximetry or SpO<sub>2</sub>. SpO<sub>2</sub> uses infrared to "see" to what extent our hemoglobin is saturated with oxygen (or oxygen-like thing, but we won't worry about the tricky parts here). The process here goes like so: oxygen gets to the alveoli, it crosses into the blood stream via diffusion gradients of gas, then once in the bloodstream it gets picked up by hemoglobin (Hgb) for a ride down the blood vessel. This is the onloading process and the focus of our discussion for now, we will talk about how that oxygen gets off or unloaded from the Hgb later on. But let's draw those onloading bits out for now:



So we have a Hgb with four seats free for the blood vessel train, one of which is occupied by an O<sub>2</sub> molecule and the resultant hypothetical SpO<sub>2</sub> here is 25% (1 of 4 seats filled). Fill all four seats up and we are "100% saturated" as so:

*red. they don't*



*wl, it can  
cross freely.  
ie P.O<sub>2</sub>*

Do note that Hgb doesn't cruise freely through the vessels, it comes attached to red blood cells (lots and lots of Hgb per each RBC), but the four seats per Hgb is a fair description. Also consider that we measure this saturation peripherally (hence the "P" in SpO<sub>2</sub> versus an SaO<sub>2</sub> for "arterial" or an SvO<sub>2</sub> for "venous"). This means that if blood is getting to the periphery where we have our little probe attached, numbers may not be accurate (and one way around this is to always confirm a good qualitative waveform before believing a quantitative value the machine gives you).

One last summary before moving on from oxygenation. Oxygenation is one of these three super duper important things. We measure it via SpO<sub>2</sub>, which tells us how filled up with oxygen the Hgb (attached to RBCs) in the blood are as they move past wherever we have attached the SpO<sub>2</sub> probe. To get a better number (or improve oxygenation) by moving numbers on the vent interface, we have three options (and we typically do them in this order): increase FiO<sub>2</sub>, add PEEP, lengthen the I-time. All that said, let's not forget the basics: position your patient appropriately and make sure ventilation (i.e. adequate MV) and comfort are addressed simultaneously (see below below).

#### b. Ventilation (and EtCO<sub>2</sub>)

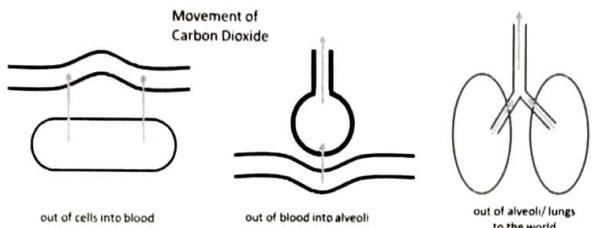
Next super duper important thing is ventilation. Ventilation refers to the movement of air in and out of the system as we deliver breaths and allow exhalation. As discussed before, this is vitally important for the movement out of carbon dioxide. Too much carbon dioxide hanging out in the lungs with no escape is bad news, so we can't just focus on getting oxygen in. So how do we know if we are moving enough air for a given patient? There are two strategies here and we will discuss them both in turn: calculated minute volume and end-tidal carbon dioxide (EtCO<sub>2</sub>).

If we math it out, our minute volume goal for the typical patient should be:

$$MV = 100 \text{ ml/kg (IBW)}/\text{min}$$

This number varies a bit for patients with an increased need (i.e. acidosis), but it's a good place to start as written and is appropriate as a minimum for most patients. Having a goal minute ventilation in mind and then assessing actual minute ventilation (typically calculated by the vent and readily available) is great way to ensure that the patient's minimum needs are met.

Concurrently, we can also use EtCO<sub>2</sub> to monitor ventilation. When the body uses up oxygen at the tissue level it kicks back CO<sub>2</sub> into the blood stream, that carbon dioxide then makes its way up to the lungs where it passes into the alveoli and then is exhaled out. It looks about opposite to our previous sketch showing how oxygen moves through the system:



So the value we get on our quantitative EtCO<sub>2</sub> reading is a function of all of these factors. It gets a bit complicated and has been deferred to the **Appendix**, but the standard approach to managing ventilation with EtCO<sub>2</sub> is to use a base range and then adjust minute volume (which is a function of both RR and TV) to get the quantitative value within that acceptable range. Normal range for EtCO<sub>2</sub> is 35–45 mmHg; values above range require an increase in MV to “blow off” more carbon dioxide, values below range need you to read the next paragraph carefully.

A low EtCO<sub>2</sub> can be caused by a few different things, one of which is hyperventilation or too much ventilation. This can be detrimental to a patient, as an alkalotic state (due to this respiratory alkalosis) can throw off the patient’s homeostasis and lead to some bad stuff. In this case, it’d make sense to decrease MV (by lowering either RR or TV) to get the EtCO<sub>2</sub> (and therefore ventilation) back to normal. All that said, a low EtCO<sub>2</sub> could also be due to a breakdown somewhere else in the system (i.e. at any of those yellow lines in the above drawing). For example, if perfusion is no good we may see a low EtCO<sub>2</sub> even though the issue is not necessarily a ventilation problem. In this case we could kill the patient by “chasing” their EtCO<sub>2</sub> or dropping MV to an unsustainable level.

We can navigate this whole situation by managing ventilation by looking at both minute volume and EtCO<sub>2</sub> instead of just EtCO<sub>2</sub> by itself, that’s why they are both mentioned here.

There are times when we will be a bit off with MV and others when our goal range for EtCO<sub>2</sub> varies, but this system of dual parameters to evaluate ventilation ~~makes~~ is a safety check to remind us of all the factors that go into ventilation. So to summarize: we measure ventilation using both a calculated MV goal and EtCO<sub>2</sub>. *(MV is ... Nari d' O<sub>2</sub> is ... %)*

### c. Comfort

The third super duper important parameter that we need to consider with vent management is patient comfort. If your patient is not comfortable, he or she will be “fighting the vent” or “out of sync” and the therapeutic effects that we want to achieve will be more difficult to attain. Also, it’s kind of rude to shove a big plastic tube down someone’s throat, take over their respiratory function in a way that goes opposite to normal physiology and then load them

up inside a small flying box with people crowded all around and lots of noise, vibration, weird lights, etc. So be a nice person and keep your patients’ feelings in mind.

We won’t spend too much time on this subject of pharmacology, as the main focus here is on manipulating the vent itself, but recognize that analgesia and sedation are two different things and that we need to treat them both. Also recognize that paralysis should be a last resort for nearly all ventilated patients, as it prevents us from actually assessing and evaluating our patients. And one more recognition: there are no set rules on how to achieve this state of happy dreams and a calm face in a patient and you should for sure ignore folks who subscribe to a “this is what I do for all my vented patients” attitude because it just means that they aren’t as nice, observant and/or aware of clinical course as you strive to be. ‘Nuff said about that.

When we manage comfort it is important to have a strategy for quantifying comfort so that we can gauge the efficacy of our interventions. Many agencies recommend scales or tools to use and here are just a few examples:

**TABLE 1.**  
**Adult Nonverbal Pain Scale (NVPs)**

Category	0	1	2
Face	No particular expression or smile.	Occasional grimace, tearing, frowning, wrinkled forehead.	Frequent grimace, tearing, eyes wrinkled forehead.
Activity (movement)	Lying quietly, normal position.	Seeking attention through movement or slow, cautious movement.	Restless, excessive activity and/or withdrawal reflexes.
Guarding	Lying quietly, no positioning of hands over areas of body.	Splinting areas of the body, tense.	Rigid, stiff.
Physiology (vital signs)	Baseline vital signs unchanged.	Change in any of the following: <ul style="list-style-type: none"> <li>• SBP &gt; 20 mm Hg</li> <li>• HR &gt; 20/min</li> </ul>	Change in any of the following: <ul style="list-style-type: none"> <li>• SBP &gt; 30 mm Hg</li> <li>• HR &gt; 25/min</li> </ul>
Respiratory	Baseline RR/SpO <sub>2</sub> synchronous with ventilator	RR > 10 above baseline, or 5% decrease SpO <sub>2</sub> , or mild asynchrony with ventilator	RR > 20 above baseline, or 10% decrease SpO <sub>2</sub> , or severe asynchrony with ventilator

From Dohner, M., Wegner, D., Freeland, N., Steinmetz, A., & Ingraham, G. (2003). Assessing pain control in nonverbal critically ill adults. *Dimensions in Critical Care Nursing*, 22(6), 263.

### Richmond Agitation-Sedation Scale (RASS)

Score	Term	Description
+4	Combative	Overly combative, violent, immediate danger to staff
+3	Very agitated	Pulls or removes tubes or catheter(s), aggressive
+2	Agitated	Frequent nonpurposeful movement, fights ventilator
+1	Restless	Anxious but movements not aggressively vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert but has sustained awakening (eye opening eye contact) to voice (>10 seconds)
-2	Light sedation	Briefly awakens to voice with eye contact (<10 seconds)
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)
-4	Deep sedation	No response to voice but movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

Verbal Stimulation

Physical Stimulation

*for Sedation Round 1*

Relevant story to put this in context: when I was first taught GCS, I remember it being put more or less like so, "GCS is one of those things that nurses like to hear on radio reports and that supervisors like to see on charts, so even though we generally don't calculate a GCS in the field, it is important to sort out before you get to the hospital and before you submit your chart." Sedation scales are not those types of things, they actually help in real time are not simply another box to check to avoid a nit-picky peer review from a colleague. With that said, it's also OK to recognize that putting someone on the vent involves a lot of steps and other important things and so it is alright (opinion alert!) to have an initial, preplanned strategy for first round of sedation and analgesia, and then pull out a sedation scale reference card once you are sailing smoothly and work through it checklist-style with your partner.

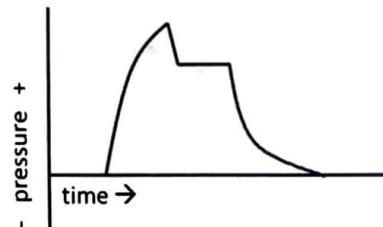
Let's imagine a hypothetical scenario to get in to the details on this: we pick up a vented guy from a hospital, he's obviously uncomfortable and out of sync with the vent, we address ventilation and oxygenation (per above discussions) and then give our preplanned analgesia/sedation combo and are on our way. Now we are cruising along, referring back to our chosen sedation scale reference card to find that our patient is becoming more uncomfortable - what do we do? Most obvious is pharmacologic intervention, that's often what we reach to first and is a totally acceptable move. But there are other things we can do on the machine that may not have the negative consequences/ adverse effects that the drugs do.

One parameter that we've discussed previously is I-time – occasionally a minor adjustment here can make a patient feel more comfortable. Not sure there's any evidence on this beyond the anecdotal, but as long as we aren't making large adjustments that impact other values, we should be good to experiment here. Switching modes may also help in this situation. We'll talk about this more later, but breaths are delivered differently in different modes (depending on the specific machine) and sometimes one may feel better to the patient for whatever reason. And lastly we can consider adjusting our triggers to make it easier for the patient to trigger a breath when he or she wants. Again, more on that to come.

So last summary here and we'll include all three of these super duper important parameters that we need to address on all of our patients, hands down and no matter what. Comfort should be assessed using an actual scoring tool and can be fixed with both drugs and vent manipulations. Oxygenation is measured by SpO<sub>2</sub> and gets fixed by increasing FiO<sub>2</sub>, adding PEEP and lengthening the I-time. Ventilation is evaluated by a comparison to expected MV and then EtCO<sub>2</sub>, we make adjustments to RR and TV to manage ventilation; increase TV and then RR to increase MV, decrease RR and then TV to decrease MV.

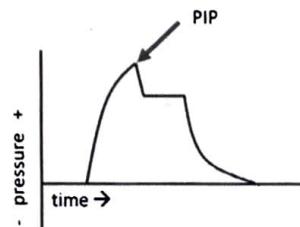
## VIII. Vent Parameters, Round Two

This next section discusses a few more vent parameters that we measure after the initial setup or taking over of a vented patient. They are considered separately than the other values previously discussed, because they are dependent on other things – we can't typically dial them into the machine, but rather we measure them to assess how things are coming along with the values we were able to control. To help clarify these ideas, which are all interrelated, let's refer back to an image we previously discussed. It shows pressure in the alveoli over time as a breath is delivered in volume control ventilation:



We previously used this graphic to demonstrate a few concepts in general, but it is now worth mentioning that this waveform and the two subsequent concepts (peak inspiratory pressure and plateau pressure) apply only to volume control ventilation. For a further discussion of this and the nitty gritty on how a comparable waveform would look in pressure control (or PRVC, for that matter), refer to the **Appendix**. And just know that in PC ventilation the machine won't deliver pressures higher than we tell it to, therefore PIP and Pplat are obsolete concepts – we only need them when pressures are a function of other settings, such as volume control ventilation. ✓

### a. Peak Inspiratory Pressure



Peak Inspiratory Pressure (PIP) is the highest point on this waveform. It represents the maximum pressure present in the airways as we deliver a breath into the system. PIP is a

*Hold so, we can consider Pplat to be the end of flow  
like falling pressure ...*

function of both how we deliver a breath via the machine and how easily that breath can get from the machine down to the alveoli. A normal PIP is <35mmH2O. A PIP that is too high generally won't cause significant damage to the patient, but it likely indicates something gone wrong in the system. This is particularly relevant when we have a normal PIP that then become elevated – in these cases it is important to seek out the cause and fix the underlying issue.

But let's get back, real quick, to what goes in to giving us this value of PIP. On the machine end, it is the result of flow ~~everytime~~. Flow is a term we haven't touched on, but it essentially describes how fast we push air to achieve a breath. In many transport ventilators, flow is calculated internally by the machine and we don't manipulate it directly. In these cases, the closest we have to adjusting this parameter is via I-time or what we call "rise profile." That said, let's hold off on discussing how to decrease PIP by adjusting vent settings, as it is more often the result of airway stuff ~~we can adjust more directly~~.

This airway stuff would be the passageway from the vent circuit to the alveoli. If it inhibits adequate movement of air (such as with a small or kinked ETT), we will see a higher PIP. Another factor here is patient comfort and the idea of laminar flow. Without getting too far into the weeds on this, recognize that air can flow freely and efficiently through a uniform pipe or tube, but if we cause movement or disruptions to that tube airflow will be less uniform and more chaotic and will result in higher pressures. Morale here: make sure your vented patient is comfortable.

Other causes of an elevated PIP would be secretions in the airway and/or ETT, tension pneumothorax, migration of the ETT to one of the mainstem bronchi, bronchospasm and decreased compliance (i.e. the lungs don't expand like we want them to). Any time we see a high PIP we ought to try and identify a cause. Once that cause is identified, then we can decide whether or not an action is needed. For example, a high PIP due to secretions should get suction and a high PIP due to a pneumo should lead to decompression; on the other hand, a high PIP due to a small ETT may be acceptable. The PIP in this case represents pressure at the ETT and not the patient's anatomy, so we may decide to leave it alone (especially if there is good reason for that small ETT, such as airway swelling).

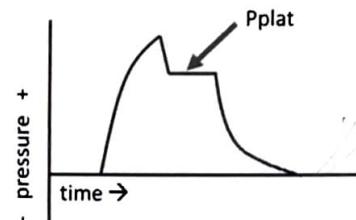
To measure PIP we simply need to look at the vent display. Most machines will either give you the value of PIP or show a little barometer of sorts that fluctuates with each breath – PIP is always the highest value that comes up during a breath. Another way to keep an eye on PIP is by setting an alarm so that machine yells at you when a certain pressure is reached. This is similar to the idea of setting your SpO<sub>2</sub> alarm during an RSI so that the monitor ~~yells~~ when your patient desats and you know to stop the attempt and reoxygenate the patient. That said, there is one critical difference with a high pressure alarm on the vent: yes it will tell you that the pressure has gotten too high, but it ~~may~~ (depending on model) also cycle off the breath it is giving in response to that high pressure alarm. This can potentially kill your patient and we will get in to that a bit more later on.

So in summary, PIP represents the maximum pressure present in the airways as a breath is delivered by the machine. A normal value is <35mmH2O and we measure it by looking at the feedback on the vent interface. Potential causes include too much air, too much flow, small ETT, kinked ETT, patient discomfort, secretions, pneumothorax, mainstem ETT placement,

*just matter sbr I'm  
not overly repetitive  
when I talk about  
this stuff again  
later :)*

bronchospasm and decreased compliance. While there are subtle ways to address PIP on the vent, interventions should focus instead on airway issues.

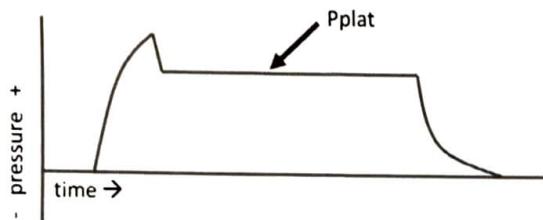
### b. Plateau Pressure



Plateau pressure (Pplat) is the pressure in the system once the lungs fill with air and essentially holds its breath until the breath cycles off. It represents the pressure at the alveoli during gas exchange or pulmonary respiration. A normal Pplat is less than 30cm H2O. Values higher than that can lead to direct damage to the alveoli which can subsequently cause issues with the whole respiratory process. There is no "too low" for Pplat but recognize that lungs that aren't being filled all the way (i.e. a low Pplat) may not be maximizing the surface area of alveoli and therefore oxygenation may not be at its best. And we'll discuss this concept here in just a moment.

The primary cause of a high Pplat is too much tidal volume. That said, it can also be due to decreased compliance, pneumo, mainstem intubation and inhibition of chest wall expansion (such as in burns). If we get a high Pplat, it is worth considering these other causes (and addressing them appropriately!) before dialing down TV, as we don't want to give up lung unnecessarily. We do, however, want to avoid a sustained high Pplat over many breaths, as that will likely lead to damage at the alveolar level.

Measuring a Pplat is little less direct than measuring a PIP and involves what we term a "maneuver." There are ~~two~~ maneuvers that we will discuss and this is the first of them. While we could theoretically watch the barometer on the machine and wait for that point during inspiration where pressure stays constant for a short spell, that amount of time is quite short and ~~this is~~ logically difficult to accomplish. The workaround is to prolong inspiration via a maneuver called an "inspiratory hold" and allow the machine to measure that pressure accurately. It would look something like this:

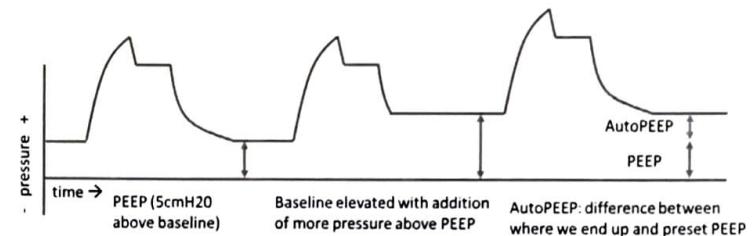


Basically we just perform the inspiratory hold maneuver (in whatever way is appropriate for our particular machine) and the Pplat either pops up on the screen for us or we have enough time to read the value from the barometer. Easy enough, but when and how often do we do this thing? There isn't a universally accepted frequency for measuring this (or any of the other pressures discussed in this section), but it seems to make sense that we just add them on to our reassessment of vital signs (so every 5-15 minutes, depending on the program/ patient acuity). While that may be overkill, it's better to measure too much than to miss things due to not checking often enough. At a minimum, Pplat should be measured after any increase in TV to make sure that we don't cause alveolar damage (and this includes after first putting the patient on the vent).

In summary, Pplat is the pressure seen by the alveoli when we deliver a breath in volume control ventilation. A normal value is <30cmH<sub>2</sub>O and we measure it by performing an inspiratory hold maneuver. While there is no bottom limit to Pplat, it is important to recognize that we want to fill the lung and alveoli up with each breath delivered, so be wary of a super low Pplat and consider inadequate TV (and subsequently MV). High Pplat can be caused by too much TV, pneumo, decreased compliance, restriction to chest wall expansion and mainstem intubation.

### c. AutoPEEP

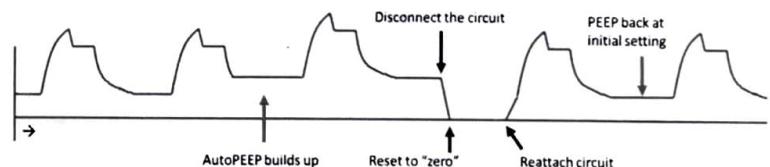
AutoPEEP is the idea of PEEP being cumulatively added into the system inadvertently. Remember how we said before that we assume atmospheric pressure to be 0cmH<sub>2</sub>O as the starting point for our vent discussions and that PEEP is the addition of pressure on top of that (i.e. "adding 5cm of PEEP" to reset that baseline to 5cmH<sub>2</sub>O)? Well, AutoPEEP is when that baseline starts to creep up from whatever we have set as PEEP to higher values because the patient isn't able to exhale all the way back to baseline before the next breath comes around. This idea is commonly referred to as "breath stacking" and might be represented like this:



Normal AutoPEEP is zero, i.e. we shouldn't have any AutoPEEP in the system at all. Presence of AutoPEEP in volume control can lead to an increase in other airway pressures, most importantly of which is Pplat; AutoPEEP in pressure control can result in decreased VTe and MV. To measure AutoPEEP or to check its presence, we have to perform another maneuver called an "expiratory hold." Just as with the inspiratory hold for plateau pressure, doing an expiratory hold allows us to accurately see what the real time pressure is when we expect the breath to have returned to baseline. Normally the machine will calculate an AutoPEEP for us by subtracting PEEP from whatever pressure it measured during the hold.

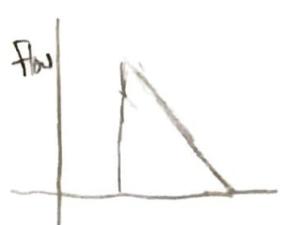
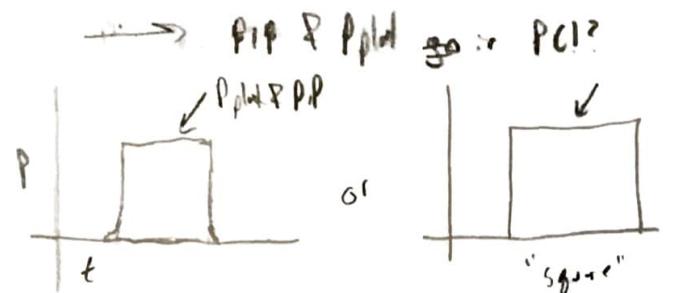
If we do have AutoPEEP this means that something is getting in the way of the patient exhaling all the way back to baseline before a subsequent breath is delivered. This could be due to patient discomfort or need for more MV, but it can also be due to obstructive processes that get in the way of effective exhalation (i.e. asthma and COPD) or even inadvertent triggering of breaths. The fix on the vent interface would be to shorten our I-time or decrease RR to increase my I:E ratio and allow more exhalation; otherwise we could consider more sedation/pain control and make sure we aren't accidentally triggering.

One other thing we can do to eliminate AutoPEEP and reestablish our baseline at actual PEEP is disconnect the patient from the vent circuit to allow a full and complete exhalation. This is one of those rare cases in which it is OK to disconnect the vent circuit from the patient during transport for therapeutic reasons. Simply allow the patient to exhale and then reattach the circuit (and most likely cancelling out a bunch of alarms in the meantime!). Just to make sure we understand how this works, let's draw it out as a waveform over time and label things along the way:



To bring it all home, AutoPEEP is a movement or the pressure baseline above whatever we have dialed in for PEEP. Issues with this are increased pressures (volume control) or

decreased volumes (pressure control). Causes include inability to exhale fully, agitation and inadvertent triggering. Fixes include extending amount of time spent in exhalation (shorter I-time, lower RR), treating discomfort and avoiding accidental triggers. In addition, we can reset AutoPEEP back to zero (and then actual PEEP) by disconnecting the vent circuit.



h/c correlate A b/t  
input & alveoli



$$p = 20 \text{ cmH}_2\text{O}$$

$$10 \text{ cmH}_2\text{O}$$

$$\begin{matrix} \text{cm} \\ 20 \text{ cmH}_2\text{O} \end{matrix} \rightarrow$$

## IX. A General Vent Strategy

In this section we are going to summarize some general parameters that we work with in each type of ventilation (i.e. each combination of mode and control). The idea here is to demonstrate what parameters and goals are shared among all methods and what parameters are specific to certain types of ventilation. We will also hash out a few of the differences in determining general settings for adult versus pediatric population. We will start with a discussion of things that apply to all ventilated patients, regardless of mode or control:

$$\begin{aligned} \text{TV} &= 6 - 8 \text{ ml/kg IBW} \\ \text{MV} &= 100 \text{ ml/kg (IBW) / min} \end{aligned}$$

If we choose a TV of 6ml/kg and our goal is 100ml/kg/min, then our rate ought to be 17:

$$\begin{aligned} 6 \text{ ml/kg} &= 100 \text{ ml/kg/min} \\ 6 \text{ ml/kg} &= 100 \text{ ml/kg/min} \\ \frac{6}{100} &= \text{ /min} \\ \frac{6}{17} &= \text{ /min} \end{aligned} \quad \begin{aligned} \text{MV} &= \text{ RR} \times \text{TV} \\ 100 \text{ ml/kg/min} &= \text{ RR} \times 6 \text{ ml/kg} \\ \frac{100 \text{ ml/kg/min}}{6 \text{ ml/kg}} &= \text{ RR} \\ \frac{100 \text{ ml/kg/min}}{6 \text{ ml/kg}} &= \text{ RR} \\ \text{RR} &= 17 \text{ /min} \end{aligned}$$

Likewise, if we go with 8ml/kg our initial rate (to match that MV goal) comes to 13/min. Although it's not uncommon to see recommendations for an initial rate of 10 or 12 with adults, for the sake of using reason and math and not pulling things out of thin air, calculating a RR based on a MV is a solid strategy. There are good reasons to use a lower RR, but we'll get to those later.

To expand on this idea, if we have a range of TVs to choose from, sometimes it just makes life easier to pick a nice, even number. For example, in an 80kg patient we end up with a TV goal of 480-640ml and it's a totally legit move to choose 500 or 600 or any value in that range. Just recognize that if we pick a higher value for TV, we may want a lower value for RR just to keep our MV approximately the same. This does not have to be exact, as we will adjust these settings as we go and work towards our goals moving forward. So we may choose a TV of 500 and a RR of 16. Or a TV of 600 and a RR of 14. Either is cool for now and we'll dial in our settings once we see how the patient responds to it all.

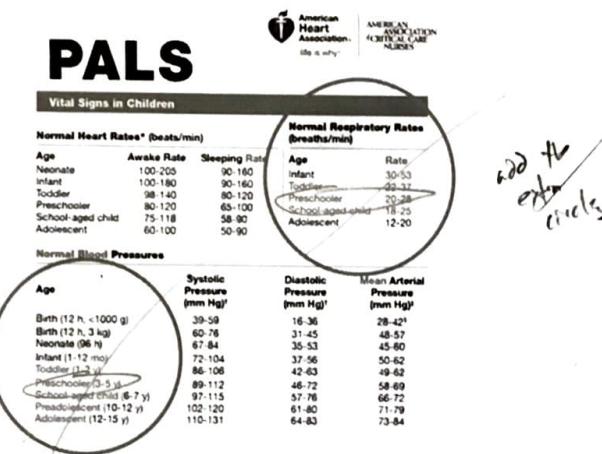
As for kiddos, the preferred strategy is to choose a rate in line with a reference card and disregard the above suggestion of 13-17/min. While this will result in an overestimation of MV, we can titrate values to address that later on. For example, let's assume a 4-year-old kid of 12kg. Based on this chart (again, from PALS) we want a RR in the 20-28/min range:

$$\begin{matrix} 16 \text{ kg} \\ 12 \text{ kg} \end{matrix}$$

& if strg happens (ifr, a, brap or vle)  
we can still see a PIP > PC

$$\begin{aligned} * & (weight + 1)/2 = kg \\ 2(12 \text{ kg} + 1) & = kg \Rightarrow \text{APLS} \quad 3(\text{age}) + 7 ? \end{aligned}$$

# PALS



And let's take these values and do a few calculations as so:

$$TV = 6 - 8 \text{ ml/kg IBW}$$

$$TV = 6 - 8 \text{ ml/kg} \times 18 \text{ kg} \quad 16 \text{ kg}$$

$$TV = 78 - 104 \text{ ml}$$

$$16 - 128$$

$$MV (\text{goal}) = 100 \text{ ml/kg (IBW)}/\text{min}$$

$$MV (\text{goal}) = 1300 \text{ ml/min} \quad 1600$$

$$MV (\text{goal}) = 1.2 \text{ L/min} \quad 1.6 \text{ L/min}$$

$$MV (\text{calculated}) = RR \times TV \quad 16 - 128$$

$$MV (\text{calculated}) = (20 - 28)/\text{min} \times (78 - 104) \text{ ml}$$

$$MV (\text{calculated}) = (2106 - 2912) \text{ ml/min} \quad 1,120 - 3,534$$

$$MV (\text{calculated}) \approx 2 - 3 \text{ L/min} \quad 2 - 3.5$$

The result here is a MV goal that differs pretty significantly from a calculated MV, but what to do with this information? We will eventually want a MV (measured as "exhaled" preferably) that matches our quantitative goal of 100ml/kg/min and also gives us an EtCO<sub>2</sub> in the normal 35-45 range, but let's start with 6-8ml/kg anyways and work towards that goal in the first little while after starting ventilation. This overestimation is particularly important and maybe even lifesaving if you decide to ventilate a kiddo in a volume control mode. There is always some mechanical dead space that we introduce into the system that sneaks its way in to

our calculated MV number and this overestimation will mitigate that. (To see this all spelled and drawn out in detail, refer to Appendix)

So we have TV, MV and RR all sorted, both for big people and small people, next we need to consider the other parameters that are constant between modes and control methods, then we will talk specifically about those things. Let's put them in to a chart just to make it easier to visualize. And this chart is basically a summary of **Section VI. Vent Parameters, Round One** with number recommendations added in – if you need to review the specifics of any of them, just refer back to that bit:

Parameter	Value	Origin(s) of the Suggestion
TV	6-8ml/kg	ARDSNet
MV	100ml/kg/min	EMCrit, Deranged Physiology
RR	Adult: 13-17/min Kiddos: use a chart	Adult: Comes from math, see above Kiddos: we made an assumption that normal ranges per PALS apply to this setting
FiO <sub>2</sub>	1.0, then titrate down	It just makes sense... Also, consider the strategy recommended by Scott Weingart of EMCrit – start at 1.0 and if all is well, drop to 0.4 and see how the patient responds (you can always go back up!)
PEEP	5cmH <sub>2</sub> O	Typical default on vents, also improves oxygenation without much negative impact on preload
I-time	Adult: 0.8-1.2s Pediatric: 0.5-0.8s Infant: 0.3-0.5s	Comes from ??? science? Put together a chart / line of best fit / regression with all sorts of data for PALS

Next step is to look at what extra parameters need dialed in on the machine depending on which mode and which method of control we choose for our patient. As we said before, we can ventilate any patient in any mode and via any method of control, so long as we know what to monitor for depending on what we choose. Let's draw it all out in a quick chart:

	Additional Parameters
AC Volume	None
SIMV Volume	<b>Pressure Support</b> – start at 10-15mmH <sub>2</sub> O and titrate to 75-100% of TV goal
AC Pressure	<b>Pressure Control</b> – start at 15-20cmH <sub>2</sub> O and titrate to TV goal
SIMV Pressure	<b>Pressure Control</b> – start at 15-20cmH <sub>2</sub> O and titrate to TV goal
	<b>Pressure Support</b> – start at 10-15mmH <sub>2</sub> O and titrate to 75-100% of TV goal
AC PRVC	" <b>Pressure Cap</b> " set to 25-30cmH <sub>2</sub> O (often by setting PIP to 5cmH <sub>2</sub> O above what we want this to be)

\* real life "pressure cap" is a mid option

SIMV PRVC	<b>"Pressure Cap"</b> – set to 25-30cmH2O (often by setting PIP to 5cmH2O above what we want this to be) <b>Pressure Support</b> – start at 10-15mmH2O and titrate to 75-100% of TV goal
-----------	---

At the expense of being overly redundant, let's combine the last two charts into a decision tree of sorts to describe how we determine vent settings, in general and for the "normal" patient:

Step One: Set These Guys		Step Two: Make a Choice and Dial in Extra Stuff	
TV	6-8ml/kg	AC Volume	None
MV	100ml/kg/min	SIMV Volume	<b>Pressure Support</b> – 10-15mmH2O (eventually titrate to 75-100% of TV goal)
RR	Adults: 13-17/min Kiddos: use a chart	AC Pressure	<b>Pressure Control</b> – start at 15-20cmH2O and titrate to TV goal
FiO2	1.0, then titrate down	SIMV Pressure	<b>Pressure Control</b> – 15-20cmH2O (eventually titrate to TV goal) <b>Pressure Support</b> – 10-15mmH2O (eventually titrate to 75-100% of TV goal)
PEEP	5cmH2O	AC PRVC	<b>"Pressure Cap"</b> – set to 25-30cmH20 (normally: set PIP to 5cmH2O above what we want this to be)
I-time	Adult: 0.8-1.2s Pediatric: 0.5-0.8s Infant: 0.3-0.5s	SIMV PRVC	<b>"Pressure Cap"</b> – set to 25-30cmH20 (normally: set PIP to 5cmH2O above what we want this to be) <b>Pressure Support</b> – 10-15mmH2O (eventually titrate to 75-100% of TV goal)

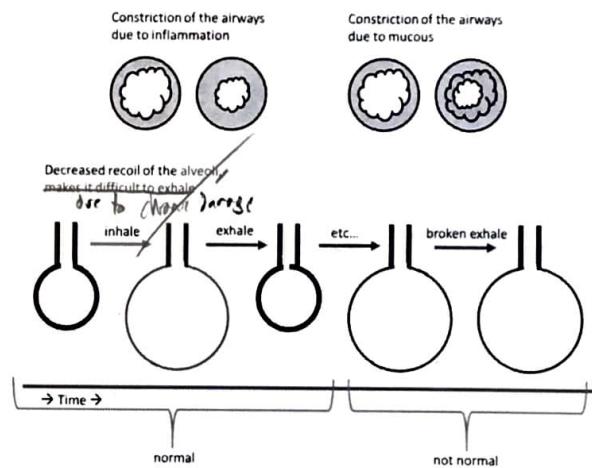
In the ideal world, that's how we get vent settings for a specific patient. In the actual world we have a few things to consider (and we'll frame them as questions): What pathophysiological changes affect the way this patient should be ventilated? What do we do with a patient already being ventilated if settings don't match what we come up with? How does this individual's body respond to all my theoretical stuff? The next few sections will answer these questions in turn. We will first look at specific situations that warrant alterations to this settings framework, then we will talk about setting up them vent in any scenario, and then we will discuss how to evaluate an individual's response to what we are doing with the machine and how we might adjust things to make him or her as happy as possible.

## X. Specific Vent Strategies

Now we have a chart that basically summarizes the initial calculations and choices we need to make for the average patient and depending on which type of breaths we want to deliver. Next step is to look at exceptions to the norm. To say it another way: sometimes a patient needs their breaths delivered in a specific way (different to what we might call "normal") due to a specific pathology. We sometimes take those normal parameters and alter them to meet specific needs and issues. It's totally OK to break the rules we've established so far, as long as we know when and how to do it and can justify a good reason. Let's look at a few situations/ etiologies in turn to see how it all looks.

### a. Bronchospasm

In patients with asthma, COPD and/or allergic reaction, we tend to run in to a problem of breath stacking or AutoPEEP because the patient is unable to exhale fully in a normal amount of time. The pathophysiology is multifaceted and varies a bit depending on unlaying cause, but they can be summarized as some combination of the following:



Our fix to this is to adjust vent parameters to allow for more time at exhalation. We do this by extending or lengthening the I:E ratio. As we said before, a normal I:E ratio is 1:2-3 and we can adjust that by dialing either the I-time or RR. In this patient population a good starting point is an I:E ratio of 1:5-6. The typical way to get here is to decrease RR (and also I-time, to a lesser extent) until we see an I:E ratio in that range that we want. The machine normally does this calculation for us, but just an example we'll show it all here:

With I-time 1.0s and RR 17:  
 $60\text{s} \div 17 \text{ breaths} \approx 3.53\text{s/breath}$   
 $3.53\text{s} - 1.0\text{s (I-time)} = 2.53\text{s}$   
 $\therefore \text{I:E ratio} = 1:2.53$

With I-time 1.0s and RR 13:  
 $60\text{s} \div 13 \text{ breaths} \approx 4.62\text{s/breath}$   
 $4.62\text{s} - 1.0\text{s (I-time)} = 3.62\text{s}$   
 $\therefore \text{I:E ratio} = 1:3.62$

With I-time 0.8s and RR 13:  
 $60\text{s} \div 13 \text{ breaths} \approx 4.62\text{s/breath}$   
 $4.62\text{s} - 1.0\text{s (I-time)} = 3.64\text{s}$   
 $\therefore \text{I:E ratio} = 1:3.64$

So even if we drop both RR and I-time to the lower ends of our "normal" parameters, we end up with an I:E shy of what we need for these bronchoconstricted patients. Let's keep up with some of these calculations and put them in to a small chart:

I-time 1.0s		I-time 0.8s		I-time 0.5s	
RR	I:E	RR	I:E	RR	I:E
17	1:2.5	17	1:2.7	17	1:3
13	1:3.6	13	1:3.8	13	1:4.1
10	1:5	10	1:5.2	10	1:5.5
8	1:6.5	8	1:6.7	8	1:7

While an I-time of 0.5s may be uncomfortable for some patients, we've included it here just as a point of reference. We typically leave I-time alone at "normal" range, but it's worth keeping in mind and giving it a shot to see how the patient does. Shorter I-time may lead to increased PIPs with volume control ventilation, but so long as our Pplat is within range we are AOK with that.

Now assume we choose an I-time of 0.8s and a RR of 8 (for a calculated I:E of 1:6.7), what does that do to our other parameters? Biggest thing that will be affected is MV. We'll do some calculations to demonstrate this impact on a 65kg IBW patient with TV of 8ml/kg:

$$\begin{aligned} \text{MV (goal)} &= 100\text{ml/kg/min} \\ \text{MV (goal)} &= 100\text{ml/kg/min} \times 65\text{kg} \\ \text{MV (goal)} &= 6500\text{ml/min} \\ \text{MV (goal)} &= 6.5\text{l/min} \end{aligned}$$

$$\begin{aligned} \text{TV} &= 8\text{ml/kg} \times 65\text{kg} \\ \text{TV} &= 520\text{ml} \end{aligned}$$

$$\begin{aligned} \text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 520\text{ml} \times 8/\text{min} \\ \text{MV (calculated)} &= 4160\text{ml/min} \\ \text{MV (calculated)} &\approx 4.1\text{L/min} \end{aligned}$$

In fact, we'd have to go all the way up to a TV of 12ml/kg to get close to our MV goal:

$$\begin{aligned} \text{TV} &= 12\text{ml/kg} \times 65\text{kg} \\ \text{TV} &= 780\text{ml} \end{aligned}$$

$$\begin{aligned} \text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 780\text{ml} \times 8/\text{min} \\ \text{MV (calculated)} &= 6240\text{ml/min} \\ \text{MV (calculated)} &\approx 6.2\text{L/min} \end{aligned}$$

And at this point we run the risk of barotrauma or over-inflation injury (assuming a volume control mode). That said, start at a TV of 10ml/kg and then titrate up if the patient's lungs allow for it (i.e. Pplat still below 30cmH<sub>2</sub>O). If we can't reach our MV goal exactly, that's OK in the short term – we just want to try and get as close to it as possible while still allowing for full exhalation and avoiding the AutoPEEP issue. We will simultaneously be doing pharmacological interventions (Albuterol, Ipratropium, MagSulfate, Ketamine, Epi – whatever your agency endorses) and hopefully the reason for this alternative strategy can get reversed to some degree and then we can go up on RR and work our way back to normal parameters.

In pressure control, we still drop the rate (and maybe I-time) to lengthen I:E, but we also want as much volume per breath to try and get as close to our MV goal as possible. Instead of a PC at 15–20cmH<sub>2</sub>O, consider going straight to the top and starting at 30cmH<sub>2</sub>O (the upper limit for a safe Pplat) to see what our VTe values look like. If we happen to overshoot our TV goal of 12ml/kg, we can always titrate back down. In addition, recognize that 30cmH<sub>2</sub>O is a generalization and that there are ways to determine if we can go higher than that.

Last thing to mention: it may be worth dropping PEEP to zero in these cases to better allow the patient exhale. If they are breathing out while we are pushing air in, this has the potential to be problematic. Just know that we'd prefer to maintain PEEP at our minimum of 5cmH<sub>2</sub>O to maximize oxygenation and help recruit more alveoli, but sometimes we let that go in order to avoid AutoPEEP. There may be a happy middle ground with a PEEP somewhere between zero and 5, but there isn't much content on that and we'll leave it as a "maybe" in the overall scheme of things.

To summarize our bronchospasm strategy: utilize a lower rate (and consider a lower I-time also) to a goal I:E of 1:5-6. Consequently, we need to titrate TV (or PC) up as far as the patient's lungs will allow. Know that we will likely be short on our MV goal and that's OK – as our pharmacological interventions start to work we can hopefully migrate back towards "normal" parameters to meet the MV goal. Maybe considering dropping PEEP if no oxygenation issues are noted. Also, be sure to check for AutoPEEP periodically and consider disconnecting the vent circuit to reset it back to zero if need be.

Also include some notes:  
 over AutoPEEP is constantly  
 if over, we can  
 start to I:E (1:8)  
 work back up to MV goal)

### b. Hypotension

In patients with hypotension (or the potential for hypotension) the primary concern is that mechanical ventilation can decrease preload to the heart and further contribute to the problem. We discussed this already in reference to both negative pressure vs. positive pressure ventilation and PEEP, so first strategy here (since we are committed to PPV) is to restrict PEEP to whatever minimum value we need to maintain adequate oxygenation. Beyond that, however, we can limit the time spent in inspiration during the overall respiratory cycle. Think of it this way: preload drops when we increase intrathoracic pressure, so if we decrease the amount of time spent pushing air into the system (i.e. increasing intrathoracic pressure), we can limit this effect.

To quantify the idea, consider two patients: one at a RR of 17 and one at a RR of 10. If we assume an I-time of 1.0s (norm for the adult patient), let's calculate how much time the patient experiences a state of decreased preload (i.e. inspiration):

$$\% \text{ time at decreased preload} = (\text{RR} \times 1 - \text{I-time}) / 60 \text{ seconds}$$

$$\% \text{TaDP} = (17 \times 1.0) / 60s$$

$$\% \text{TaDP} = 17s / 60s$$

$$\% \text{TaDP} \approx 28\%$$

$$\% \text{TaDP} = (10 \times 1.0) / 60s$$

$$\% \text{TaDP} = 10s / 60s$$

$$\% \text{TaDP} \approx 17\%$$

We can further drop this percentage by decreasing I-time:

$$\% \text{TaDP} = (10 \times 0.8) / 60s$$

$$\% \text{TaDP} = 8s / 60s$$

$$\% \text{TaDP} \approx 13\%$$

By dropping our rate to 10 (from 17) and dropping I-time to 0.8s (in the adult patient), we can cut the amount of time spent at decreased preload by over half. While we could keep dropping RR, we stop at 10 because we need to maintain adequate MV in these patients. Let's look at what happens to MV if we drop RR to 10 and then come up with a strategy to address it. As before, we'll assume a patient with an IBW of 65kg and a TV of 8ml/kg:

$$\text{MV (goal)} = 100 \text{ml/kg/min}$$

$$\text{MV (goal)} = 100 \text{ml/kg/min} \times 65 \text{kg}$$

$$\text{MV (goal)} = 6500 \text{ml/min}$$

$$\text{MV (goal)} = 6.5 \text{L/min}$$

$$\text{TV} = 8 \text{ml/kg} \times 65 \text{kg}$$

$$\text{TV} = 520 \text{ml}$$

\* notice more up term, but useful!

$$\begin{aligned}\text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 520 \text{ml} \times 10/\text{min} \\ \text{MV (calculated)} &= 5200 \text{ml/min} \\ \text{MV (calculated)} &= 5.2 \text{L/min}\end{aligned}$$

Now 5.2L/min isn't super far off from 6.5L/min, but we need to remember that a hypotensive patient is likely at risk of shock and, therefore, we need to make sure we are matching blood flow to the lungs by delivering at least what our calculated MV goal is. This idea is in stark contrast to the bronchospasm strategy in which we decided it was OK to let MV fall below goal; in hypotension we need to maintain (or even exceed, especially with acidosis or trauma – discussion on that to follow) our MV goal. So let's titrate TV up to 10ml/kg and see where we end up:

$$\begin{aligned}\text{TV} &= 10 \text{ml/kg} \times 65 \text{kg} \\ \text{TV} &= 650 \text{ml}\end{aligned}$$

$$\begin{aligned}\text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 650 \text{ml} \times 10/\text{min} \\ \text{MV (calculated)} &= 6500 \text{ml/min} \\ \text{MV (calculated)} &= 6.5 \text{L/min}\end{aligned}$$

If we drop RR to 10 (and I-time to low of normal by age) to minimize the percentage of time spent at decreased preload (i.e. inspiration) and increase TV to 10ml/kg, then we maintain our MV goal of 100ml/kg/min. Now let's see how that would turn out in the 4-year-old kiddo of 16kg just to make sure this strategy applies across the board:

$$\begin{aligned}\text{MV (goal)} &= 100 \text{ml/kg/min} \\ \text{MV (goal)} &= 100 \text{ml/kg/min} \times 16 \text{kg} \quad 16 \\ \text{MV (goal)} &= 1600 \text{ml/min} \quad 1600 \\ \text{MV (goal)} &= 16 \text{L/min} \quad 1.6\end{aligned}$$

$$\begin{aligned}\text{TV} &= 10 \text{ml/kg} \times 16 \text{kg} \quad 16 \\ \text{TV} &= 160 \text{ml} \quad 160\end{aligned}$$

$$\begin{aligned}\text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 130 \text{ml} \times 10/\text{min} \\ \text{MV (calculated)} &= 1300 \text{ml/min} \quad 1600 \\ \text{MV (calculated)} &= 1.3 \text{L/min} \quad 1.6\end{aligned}$$

So that appears to be right on, but recall that we want to ensure adequate ventilation and that this calculation is an overestimate if we have a pediatric patient in volume control. It's also worth noting that the change from a RR of 17/min to 10/min for an adult is reasonable, but a

change from 20-28/min for a four-year-old to 10/min is pretty significant. So if we want to be able to drop the percentage of time spent at decreased preload (i.e. inspiratory time) by a factor of two as we did for adults, what RR should we aim for instead? We'll calculate this percentage at an I-time and RR on the high end, then do it again for both parameters on the low end of normal. After that we will decide how much to drop the rate to get our percentage of time down by half:

$$\begin{aligned}\% \text{ time at decreased preload} &= (\text{RR} \times \text{I-time}) / 60 \text{ seconds} \\ \% \text{TaDP} &= (28 \times 0.8) / 60 \text{ s} \\ \% \text{TaDP} &= 22.4\% / 60 \text{ s} \\ \% \text{TaDP} &\approx 37\%\end{aligned}$$

$$\begin{aligned}\% \text{ time at decreased preload} &= (\text{RR} \times \text{I-time}) / 60 \text{ seconds} \\ \% \text{TaDP} &= (20 \times 0.5) / 60 \text{ s} \\ \% \text{TaDP} &= 10\% / 60 \text{ s} \\ \% \text{TaDP} &\approx 17\%\end{aligned}$$

As you can see, simply by using a RR and I-time sat the low end of normal for a pediatric patient, we can drop this %TaDP in half. At this rate, we'd still meet and exceed our MV goal with enough of a margin of error (in the off-chance that we happen to be in volume control):

$$\begin{aligned}\text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 130 \text{ ml} \times 20/\text{min} \quad 160 \\ \text{MV (calculated)} &= 2600 \text{ ml/min} \quad 3.200 \\ \text{MV (calculated)} &= 2.6 \text{ L/min} \quad 3.2\end{aligned}$$

*also do a  
lrcal  
regression  
for RR by  
nge w/ PALS  
data*

While we could possibly go even lower on RR with continued concern for hypotension, this is more than adequate as a starting point for the hypotensive pediatric patient. And just to reiterate: these suggestions are merely starting points from which we will later fine tune our settings. For now let's assume that with pediatric patients and hypotension, it's safe to use an I-time and RR at low end of normal and a TV of 10ml/kg. For further discussion and a quantitative analysis of all of this, refer to **Appendix**.

To summarize: go with a RR of 10 (adults) or low end of normal per PALS (pediatrics), decrease I-time to low end of normal, then use a TV goal of 10ml/kg. In pressure control, this might translate to an initial PC of 20-25cmH<sub>2</sub>O. As for PEEP, we don't really want to drop it to zero in this case (as we thought about for bronchospasm), as oxygenation is critical in a low perfusion state. That said, we also should be cautious of going high on PEEP, as it can impede blood return to the heart. The short and sweet of ventilating a hypotensive patient: drop RR and I-time, increase TV and leave PEEP alone.

### c. Acidosis

With acidosis one of our primary vent goals is to facilitate the respiratory compensation against the underlying acidosis. The classic example here is a DKA patient breathing at 30/min. Flight crew comes along, RSIs the patient and then sets the vent up at a "normal" rate of 12. The patient had been compensating with an increased RR (and thus MV), but that compensation got taken away suddenly. As a result, the patient crashes and dies. So let's not do that. And just to quantify the extent to which our doing so changes the game for this hypothetical patient, let's quantify the MV difference between a rate of 12 and 30 with an assumed TV of 500ml:

$$\begin{aligned}\text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 500 \text{ ml} \times 30/\text{min} \\ \text{MV (calculated)} &= 15000 \text{ ml/min} \\ \text{MV (calculated)} &= 15 \text{ L/min}\end{aligned}$$

$$\begin{aligned}\text{MV (calculated)} &= \text{TV} \times \text{RR} \\ \text{MV (calculated)} &= 500 \text{ ml} \times 12/\text{min} \\ \text{MV (calculated)} &= 6000 \text{ ml/min} \\ \text{MV (calculated)} &= 6 \text{ L/min}\end{aligned}$$

In an acidotic state our MV goal increases a lot. While a bit tricky to pinpoint exactly what that goal ought to be, let's aim for a goal double that of the normal patient: 200ml/kg/min. To achieve that goal, we may need to increase both RR and TV. We said before that to increase MV (i.e. in an effort to get our EtCO<sub>2</sub> within a normal range) we typically start by changing TV first and then RR. The reason for this way that we get more bang for our buck, as adding a breath also adds in dead space to the equation. In the acidosis situation, however, the patient is likely already ~~breathing fast~~, so let's just use a high of normal TV (i.e. 8ml/kg) and see what kind of RR we'd need to get to this increased MV goal of 200ml/kg:

$$\begin{aligned}\text{MV (goal)} &= 200 \text{ ml/kg/min} \\ \text{MV (goal)} &= 200 \text{ ml/kg/min} \times 65 \text{ kg} \\ \text{MV (goal)} &= 13000 \text{ ml/min} \\ \text{MV (goal)} &= 13 \text{ L/min}\end{aligned}$$

$$\begin{aligned}\text{TV} &= 8 \text{ ml/kg} \times 65 \text{ kg} \\ \text{TV} &= 520 \text{ ml}\end{aligned}$$

$$\begin{aligned}\text{MV (goal)} &= \text{TV} \times \text{RR} \\ 13 \text{ L} &= 520 \text{ ml} \times \text{RR} \\ 13 \text{ L}/520 \text{ ml} &= \text{RR} \\ 25 &= \text{RR}\end{aligned}$$

This means that a TV at 8ml/kg and a RR of 25 will get us the theoretical MV of 200ml/kg/min. But what is the consequence of a MV that high? In the normal patient, this would drive our EtCO<sub>2</sub> down significantly and create a state of respiratory alkalosis, but we said

*where to  
plan/  
open  
or the?*

already that this compensatory respiratory rate is what we want – now we just need to figure out how to measure or quantify to what extent we are helping the patient. There are a few strategies here and we'll talk about them stepwise in order of least exact to more exact.

First thing we can do is to match our set RR on the vent to the rate at which the patient was breathing before we took the airway away. This assumes that the patient was compensating adequately. And while this doesn't give us a quantitative goal to work towards, it is better than nothing. We can match the patient's effort on our machine, complete a transport and then have the receiving facility check ABGs when we arrive to see how things have improved (or gotten worse, for that matter). Or if we can do gasses en route we can start this strategy and then evaluate progress along the way.

Another strategy is to measure the patient's EtCO<sub>2</sub> (perhaps via a nasal canula device or by cutting the ETT connector off a regular in-line attachment and sticking in the patient's mouth) prior to taking the airway. We can then match the patient's RR (as above) or set RR to 25 (as calculated) and then adjust to this EtCO<sub>2</sub> that the patient was at prior to us messing with things. Again, this strategy is similar to the above strategy in that it requires that the patient was compensating adequately on his or her own before we intervened.

A third approach is to utilize Winter's Formula to establish an EtCO<sub>2</sub> goal. The formula looks like so:

$$P_{CO_2} = (1.5 \times HCO_3^-) + 8 \pm 2$$

The formula is designed to measure the respiratory component with a known acidosis (i.e. measured PCO<sub>2</sub> is compared to a calculated PCO<sub>2</sub> to determine if a mixed disorder is present), but we can modify its use to the transport setting to guide our titration of EtCO<sub>2</sub> (via MV):

$$EtCO_2 \text{ should} = (1.5 \times HCO_3^-) + 8 \pm 2$$

Assuming compensation was adequate when HCO<sub>3</sub><sup>-</sup> measured  
(and HCO<sub>3</sub><sup>-</sup> from either BMP or ABG)

And in fact we can do all of these strategies together: try to match the patient's RR and EtCO<sub>2</sub> as measured before we intervene, then compare MV to our calculated goal of 200ml/kg/min and compare EtCO<sub>2</sub> (both the patient's pre-intervention one and our subsequently-measured one) to EtCO<sub>2</sub> goal from Winter's Formula. The only next best thing here would be to remeasure gasses en route to see how the patient is responding to treatment, but most of us don't have that capability in the field and we'll withhold a discussion of it here.

We went on a bit of a tangent here, but let's get back to our vent strategy for the acidotic patient: use a TV goal high of normal (8ml/kg) and a RR of at least 25 (or more to match patient's rate), then aim for a goal MV of 200ml/kg/min and an EtCO<sub>2</sub> of patient's baseline prior to intervention or as determined by Winter's Formula. Because we are shooting for high MVs in the acidotic patient, AC mode may be the best for these patients if they are triggering breaths spontaneously. If we do go SIMV and the patient has spontaneous effort to breathe, we may consider increasing PS so that patient-triggered breaths match machine-delivered ones (and this

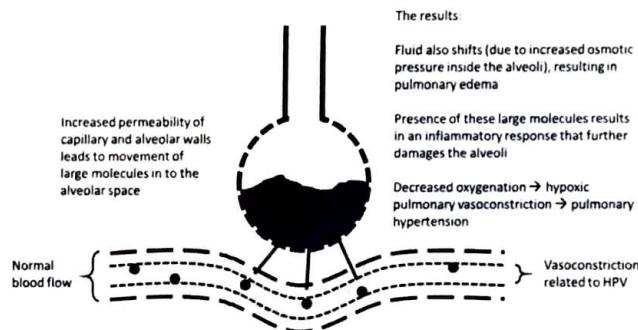
would avoid a drop in MV if we were following the normal SIMV strategy of PS breaths at no more than 75% of TV goal).

#### d. Acute Lung Injury/ ARDS

Another well-known and established strategy in vent management is the "injured" or "sick" lung strategy. These patients have lungs that are particularly susceptible to further injury and barotrauma and, as a result, we use less volume per breath in an effort to avoid over-inflation. We then have to increase rate to maintain MV or be OK with a higher EtCO<sub>2</sub>.

Another component of this strategy is higher than normal PEEPs to improve oxygenation, recruit alveoli and physically displace stuff that has accumulated in the alveoli. We'll start by reviewing the concept of "acute lung injury" and discussing the pathophysiology of ARDS, then we'll get into specifics about vent strategy.

Acute lung injury (ALI) refers to a number of pathologies that inhibit normal pulmonary gas exchange. Specific causes include sepsis, pneumonia, bleeding from a traumatic injury, inhalation of toxins or smoke and aspiration. ALI is a concept that lives on a spectrum with acute respiratory distress syndrome (ARDS) being the end result if left alone to progress to the bitter end. While ALI, as a term, may also be described as mild or moderate ARDS, the underlying pathology is the same. The main component of the pathophysiology is that the alveolar and capillary walls becomes permeable to stuff that normal is normally sequestered in the blood:



There are quantitative criteria for ALI and/or ARDS (depending on how we choose to define it), but that isn't necessary to our field treatment. We can identify a patient who needs this vent strategy from a report per sending facility, suspicion based on clinical progression of the illness or the simple fact that we can't get to a point of adequate oxygenation by other methods. The strategy includes low volumes, PEEP, maintaining recruitment and permissive hypercapnia. Let's discuss each of these in turn and give some specific guidance.

Starting TV for these patients should be 4ml/kg IBW. This recommendation is from the ARDSNet studies which compared TVs of 4ml/kg against 12ml/kg and determined that lower TVs resulted in significantly better outcomes for these patients. While it may seem that 4ml/kg and 12ml/kg represent two extremes and it could be tempting to rationalize that 6ml/kg (to stay within norms) probably isn't all that bad, we do know that 4ml/kg is OK and we don't know much about 6ml/kg for these patients, so let's just stick with the data and ventilate at 4ml/kg until the science people tell us otherwise.

In addition to low TV, we go up on PEEP to improve oxygenation. Recall this chart from an earlier discussion about titrating FiO<sub>2</sub> and PEEP in a stepwise fashion to achieve our oxygenation goals. We included in our discussion of FiO<sub>2</sub> and deferred a chat about it then, but it actually is specific to this ALI/ARDS vent strategy:

**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>**

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

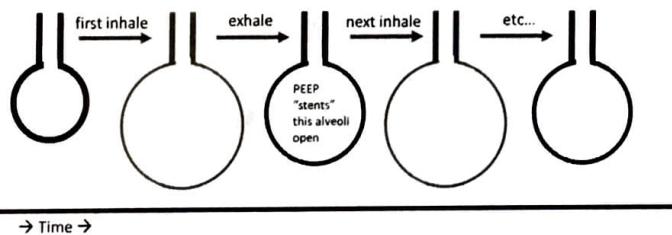
FiO <sub>2</sub>	0.7	0.8	0.9	0.9	0.9	1.0
PEEP	14	14	14	16	18	18-24

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

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

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

Another really important component of our ALI/ARDS strategy is alveolar recruitment. This is a concept that we haven't talked about much, but we'll get into it here. Recruitment is the idea that we can actively re-inflate collapsed or underinflated alveoli as we depicted in our previous discussion of PEEP:



*seconds to mins*

In all lungs we lose recruitment more or less immediately. Which means that if we have a partially inflated alveoli stented open with PEEP and then disconnect the vent circuit, that alveoli goes back to where it was before we started. In a normal lung we can re-recruit that alveoli on the order of minutes, so it isn't a huge deal for us to be worried about losing recruitment – we just get them back on the vent, add a bit of PEEP and we are back where we want to be with no real negative outcome. With the ALI/ARDS patient, however, it takes hours to recruit alveoli. This means that if we lose recruitment, we lose all of that progress towards better oxygenation and our patient can deteriorate very quickly.

With that in mind, it is important to keep the system that extends from the vent to the patient's alveoli intact at all times. When we do have to break the system, such as when we transfer the patient from our machine to the hospital's machine or vice versa, we can maintain recruitment by clamping off the ETT. The main point is to prevent pressure at the alveoli from dropping below PEEP, so it theoretically doesn't matter at which point in the respiratory cycle we clamp the tube and perform the swap. That said, just to be safe let's always do this clamping of the ETT during inspiration – that way if we leak some air out in the process, we have a cushion of safety. And here what the technique looks like:

Get a photo and label it in ppt

Last thing to mention with this ALI/ARDS strategy is MV. We mentioned already that dropping our TV to 4ml/kg will reduce MV and increase EtCO<sub>2</sub>, but let's quantify that difference in MV:

$$MV(\text{goal}) = 6.5L$$

$$\begin{aligned} TV &= 4\text{ml/kg} \times 65\text{kg} \\ TV &= 250\text{ml} \end{aligned}$$

$$\begin{aligned} MV(\text{calculated}) &= TV \times RR \\ MV(\text{calculated}) &= 250\text{ml} \times 17/\text{min} \\ MV(\text{calculated}) &= 4250\text{ml} \\ MV(\text{calculated}) &\approx 4.3L \end{aligned}$$

And to maintain our MV goal, let's see what kind of RR we would need:

$$\begin{aligned} MV(\text{goal}) &= TV \times RR \\ 6.5L &= 250\text{ml} \times RR \\ 6.5L/250\text{ml} &= RR \\ 26 &= RR \end{aligned}$$

So to maintain our MV goal with a TV of 4ml/kg we need a RR of 26. Which is OK if we can comfortably get the patient there. If not, that's also OK. In fact, there is some evidence that hypercapnia (i.e. a high EtCO<sub>2</sub> related to a lower MV) is of benefit to these ALI/ARDS

patients. The data isn't super clear at this point, but rest easy knowing that if we can't attain our MV goal there may be a silver lining in this case. With pediatrics, that rate of 26 ought to be more or less adequate (unless we have a very young patient), so we should aim to meet (or exceed if in volume control) our MV goal.

To put it all together: ALI/ARDS represents a spectrum of disease that primarily impacts the integrity of the alveolar walls and results in increased permeability, movement of large molecules and fluids into the alveolar space and further damage from an inflammatory response. Vent strategy is focused on low TVs at 4ml/kg to avoid barotrauma, high PEEPs to both recruit alveoli and displace fluid, maintenance of recruitment at all times in order to avoid rapid deterioration, and either an increase in RR to maintain MV or a strategy of permissive hypercapnia (often times somewhere in the middle of those last two).

#### e. Other Potential Strategies

The above list of vent strategies addresses four markedly different situations that we often come across in the transport setting, but there are other potential injuries or pathophysiologies that might also warrant specific adjustments to the normal list of settings that we previously came up with. While we could theoretically compile a list of all the possible things and work out an algorithm to address each one in turn, that gets a little cumbersome and would result in a hefty protocol of sorts that might be difficult to work through when time is of the essence. As we said before, the idea is to work towards an understanding of how the body responds and how the vent does its thing so that we can make changes on the fly and expect the results that will come of any adjustment away from normal. But just to mention a few examples without going into the same level of detail as we did above, consider the following situations.

In the patient with a head injury/ traumatic brain injury (TBI), we may choose to aim for an EtCO<sub>2</sub> below what we'd typically use for a standard patient. While we don't necessarily "hyperventilate" these patients anymore, we could adjust MV to a goal EtCO<sub>2</sub> of 30-35mmHg by going up on either TV (preferred) or RR. We also want to maximize oxygenation and, therefore, may be OK with an SpO<sub>2</sub> of 100% for a little while (whereas we would normally titrate FiO<sub>2</sub> down in response). We may also make small adjustments to our settings in an effort to maximize patient comfort, whereas we might not pay as close attention with other patients and simply use drugs to make them happy.

In the pregnant patient we might similarly utilize an FiO<sub>2</sub> of 100% to ensure ~~maximize~~ oxygen delivery to the fetus. Since many services don't have the capability of fetal monitoring during transport, this is a way to ensure that we don't have a hypoxic injury or put any undue stress on the baby. We also need to consider an increased MV goal for the patient, as we have baby to consider as well. Another consideration is patient positioning – in the vented pregnant patient we not only have decreased preload due to PPV, we could see that drop in CO compounded by pressure of the fetus on the inferior vena cava.

Significant chest trauma is another one. We'd like to treat these patients via the acute lung injury strategy, but we also are concerned with hypotension and may want to use the hypotensive strategy. Those two are at odds with one another (low TV and high RR for ALI/ARDS, high TV and low RR for hypotension). In this case we have to get creative. Maybe

we forgo the hypotensive strategy and choose the ALI/ARDS one, but get aggressive early on with vasopressors and fluids/ blood products in anticipation that a hypotensive state may be precipitated by our strategy. Or maybe we go with a strategy more in line with the hypotensive strategy, but start out with higher PEEP and leave FiO<sub>2</sub> at 100%. There is no right or wrong here and it depends a lot on how the patient presents in that particular situation.

On a tangent to this chest trauma idea: if a patient develops a tension pneumothorax en route, best thing we can do is to take the patient off the vent. Not take them off the vent and bag them, but take them off the vent and don't breath at all for them until we fix that problem. PPV can tension a pneumothorax very quickly and we want to avoid making things worse. So disconnect the vent, decompress, and then get the patient back on the vent. Because of this, we may consider keeping all patients with the potential for pneumothorax on an FiO<sub>2</sub> of 100% - that allows us more time to perform the procedure in the event that a pneumothorax develops before the patient desaturates.

A patient with CHF may warrant more PEEP and increased pressure (either via PC or TVs to a maximum acceptable Pplat). This would facilitate the movement of fluid out of the alveoli. (And if the CHF is particularly bad, we may also have a concurrent concern for hypotension.) In this case we could increase PEEP, then increase PC (or TV to the max before Pplat reaches its limit), then titrate rate down to maintain our MV goal. On the other hand, if the patient is ~~already~~ hypertensive, aggressively maximizing oxygenation to alleviate any pulmonary vasoconstriction (which leads to pulmonary hypertension) may be the best approach.

It quickly becomes evident that there are a number of situations that don't quite fit the cookie cutter mold by which we try to simplify vent strategies. And that's totally OK. The templates are there as a framework from which we then consider the specifics of each patient, one at a time. The important thing is to know what impact any vent change will have on the patient depending on how he or she presents in a given situation. There are lots of cases in which there isn't a straightforward answer, but as long we don't make things worse by dialing the buttons the wrong way, we are still facilitating transfer to a higher level of care where these things can be sorted out.

# 18m. get more specific w/  
the approach

## IX. How to Get Started

This next section covers how we go about setting the patient up on the ventilator. In particular, it looks at how the process differs whether its us initiating ventilation versus if we are taking over a patient in which ventilation has already been initiated. This may not seem like a big deal, but the taking over of a vented patient is a bit tricky. Even though we have these predetermined strategies for various different patient types, the truth is that there is a lot of variation in how patients respond to the vent: sometimes an asthmatic patient is happy with an I:E of 1:2, other times a hypotensive patient has a high RR and low TVs for good reason, etc.

### a. Getting All the Numbers Ready

First thing we do for any patient who needs or is already ventilated is listen. We listen to a report from whoever was hanging out with the patient before we got there. This is very important for all patients, as it can tell us how the patients has responded to or will respond to strategies we might have in mind. We then decide on a strategy based on how we think that patient ought to be ventilated (i.e. hypotensive strategy, bronchospasm strategy, or some hybrid situation). Next we get an accurate patient height (either from a reliable healthcare provider or by measuring it ourselves) and perform three calculations: IBW, TV, MV.

Another component here is the patient exam. We'll discuss a few of the specifics when we talk about a patient already on the vent, but we for sure want to get an exam done before we start manipulating things or playing with our vent. The idea here is that our mental construct of a strategy based on the report we received should match what we see in the exam. If not, we need to clarify that amongst ourselves before moving forward. No need to elaborate on that here, we all know the importance of a good assessment. So once we have a report, have done an assessment and are decided on a strategy, we move forward.

### b. From Scratch

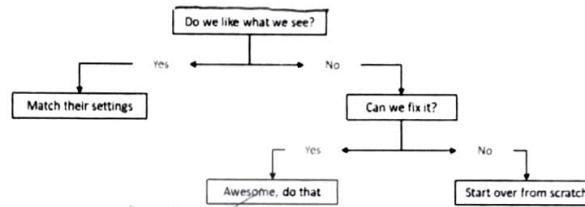
When we are the ones initiating the vent, it's a bit more straightforward: we just take the settings we've come up with based on presentation/ pathophysiology and plug them in to whatever mode and method of control we decide to use. We've already talked about the different strategies and why we may choose to use one mod/control over another (and that a lot of this has to do with provider preference), so we won't spend any more time on that here. Once the patient is on the ventilator, we just need to confirm that everything is going as planned, beginning with the three Big Things: oxygenation, ventilation, and comfort. Once we get those things sorted, we can then move on to some of the finer subjects (which will be discussed in the next section, **Keeping Things Going**).

It is worth reiterating at this point that the settings we conceptualize prior to initiating ventilation (and as discussed in the previous section) are starting points from which we then make adjustments. It may very well turn out that we end up with settings, based on patient need, that vary significantly from what we initially had in mind and that's totally OK. But the starting point ought to be based on both on calculated goals and settings founded in physiology. And if

you have no idea which strategy or the patient fits too many categories all at once, just start with those basic ~~sends~~ we discussed in **A General Vent Strategy** and go from there.

### c. Patient Already on the Vent

Now with someone already on the vent, it gets a little more complicated. We'll draw it out in a short, simple algorithm first and then we will expand on it and discuss the specifics:

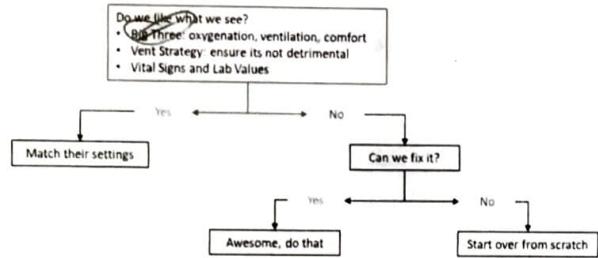


The first step in this little algorithm, "Do we like what we see?" refers to a few different things: First of all is the Big Three: oxygenation, ventilation, and comfort – those for sure need to be addressed. Second is strategy: are the chosen settings at odds with the strategy we had in mind? In the case of a hypovolemic patient with a high RR, for example, we may say, "yes, this strategy may be detrimental to the patient." In the case of an asthmatic patient with an I:E of 1:3 we may decide, "this isn't what I would've set up from scratch, but let's see if it is working for the patient or not before deciding to change things." The idea here is to see what puts your patient at risk and what doesn't: a high %TaDP and hypotension does put a patient at risk, an I:E of 1:3 in an asthmatic with no AutoPEEP doesn't.

So we addressed the Big Three, we made sure the existing strategy isn't counterproductive based on what is going on with the patient, then we look at vitals and labs. Again, no need to get into specifics here (that will come later in case reviews), but if all is well in each of those general three subject areas, then there is no reason for us to go messing with settings and we should match what they are using. The only exception here is if your machine can't do the settings they have. For example, the patient is on PRVC and you don't have that choice – then match as best you can in either volume or pressure control and go from there.

"But wait," we may hear from the audience, "what about checking a Pplat and AutoPEEP and all of that!?" If your patient is alive and well and passes an assessment in all three categories we just discussed (the Big Three, vent strategy, vitals and labs), then those things can wait until we get them on to our vent. Some reasons for this: the delay here is only a few minutes at most, the measurements will likely vary by machine (i.e. how individual breaths are delivered), and we've already determined that the patient is stable via a number of different assessment parameters.

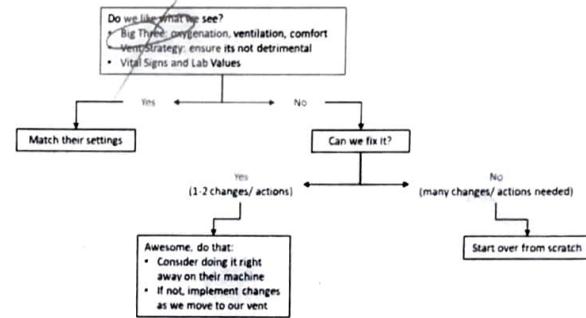
Let's redraw that simple algorithm we started with and add in just a little bit of detail to include all of these ideas and then we'll move on to the next question and talk about it in detail:



Next question to discuss further is, "Can we fix it?" The idea here is that we'd like to fix whatever issues we have (as determined by our assessment in the first box of the algorithm) by way of one or two interventions and keeping the majority of settings as they are. For examples: if the patient is uncomfortable and we can provide analgesia on top of the sedation they are already getting, that may be all that is needed; if we can fix a high EtCO<sub>2</sub> by increasing TV (or RR) a bit, no need to change mode or control; if we can address a potential for hypotension by decreasing RR and then increasing TV, all is good; etc. If, however, we are getting into a situation where it will take lots of changes to set things right, it may make most sense to start from scratch with a whole new set of parameters. And in that case we may as well change a bunch of things and go with our preferred strategy.

One thing worth mentioning here is that sometimes it's cool for us to make these changes as the patient lies and on the sending facility's (or crew's) machine, other times we just make the changes as we transition to our machine. We for sure want to avoid alienating the transferring staff by messing with their machine if that relationship doesn't exist, so just be cognizant that are two sub-options in the "Awesome, do that" course of action: do it right now and on their machine or do it as we transition on to our machine. And last thing and probably already obvious, there is some middle ground here: we may make some changes/ do some things right away and then defer other things until transfer, all part of the same strategy. Example: give sedation now, adjust TV or RR during the transition.

And one more time, let's see how the algorithm would look with these additional details added in:



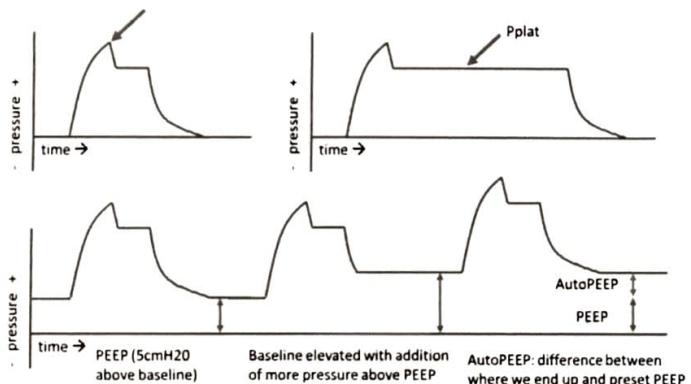
If at any time during this whole process things get too complicated, we can always skip ahead to the "Start over from scratch" end of things, but just recognize that the more changes we make, the less able we are to evaluate the efficacy of a single intervention. Just like a science experiment, it helps to isolate variables and know that the observed result can be attributed to a specific change we made. And even though we mentioned it already, interpersonal dynamics also come in to play here: make changes based on necessity, not on personal preference – that will help you maintain positive relationships with referring staff and crews.

## I. Keeping Things Going

This next section goes over what we do once we have the patient on our machine and the ~~big~~ three (oxygenation, ventilation, comfort) have all been addressed. We talked already about how we sometimes vary from the settings we start out at and this section explains how that happens. The general idea is that we want to both avoid injury and optimize ventilation, so we slowly make adjustments to work towards those goals and ensure that things stay safe for our patients.

### a. Watching Pressures

We talked about these three things already in the sections title **Vent Parameters, Round Two**, but here they are again: peak inspiratory pressure (PIP), plateau pressure (Pplat), and AutoPEEP. And for visualization, in case we forgot, here's what they look like on a pressure waveform in volume control ventilation:



High for PIP is 35mmH<sub>2</sub>O, although we may go beyond that in certain situations (such as a small small ETT). Pplat max is normally 30mmHg and we do try to stick by that one whenever possible. AutoPEEP normal is zero and we always take actions to address AutoPEEP when we see evidence of it. All of these parameters should be checked (when possible, depending on control and patient's respiratory effort) within the first few minutes after placing someone on our machine and then again periodically through transport. As we said before, if it may help to simply add these pressures on to a mental list of vital signs to reassess as we go.

As far as guiding treatment based on these parameters, let's summarize the basics in a quick chart:

Normal	Corrective Actions
--------	--------------------

PIP	<35mmH <sub>2</sub> O	<ul style="list-style-type: none"> <li>Suction, check for kinks in circuit/ ETT, reposition patient's head</li> <li>Decrease TV, decrease flow/ rise profile</li> <li>Consider bronchodilators</li> </ul>
Pplat	<30mmH <sub>2</sub> O	<ul style="list-style-type: none"> <li>Decrease TV</li> </ul>
AutoPEEP	zero	<ul style="list-style-type: none"> <li>Increase I:E ratio</li> <li>Consider disconnecting vent circuit to allow for exhalation</li> </ul>

The solutions represented in this chart for both PIP and Pplat refer, in general, to actions to be taken if abnormal values are noticed in conjunction with initiation of ventilation or new changes to settings. There are other times when abnormal PIPs and Pplats develop during the course of ventilation due to pathophysiologic changes. For example, if PIP goes up and Pplat stays the same, this is likely due to some flavor of airway obstruction (aspiration, secretions, biting of the ETT, bronchospasm, etc.). If PIP goes up and Pplat also goes up, this generally indicates decreased compliance. We haven't talked much about compliance, but the idea here is that the lungs expand less per unit of air (volume or pressure) that we put in. Causes of decreased compliance (evidenced by increased PIP and Pplat) would be pneumothorax, pulmonary edema, mainstem migration, asynchrony, abdominal distention, and even AutoPEEP.

In pressure control ventilation when we don't have access to PIP or Pplat to identify these trends, there are other parameters we can look at. Most obvious is VTe – as compliance decreases, VTe will drop (and vice versa). In the case of airway obstruction, often times we won't notice initially because the machine essentially accommodates for this increased airway resistance by using less flow. Since we don't typically monitor waveforms with transport ventilators, an airway obstruction may not get noticed in PC ventilation until it is severe enough to impact VTe. We can also (again, this is in PC) look at flow as calculated and delivered automatically by the vent. Higher flows mean less resistance, so even if we don't know ranges or normal values we can still use this concept to trend changes.

### b. Alarms

Next on our list of things to discuss are alarms. We won't talk about all the alarms that our machines might have, but we will talk about a few of the important ones. We can break alarms down into two general categories: ones that we set and ones that are default on the machine. Those default ones may be different between machines, but deliver similar messages like, "hey man, your circuit got disconnected" and "oh snap, we ran out of oxygen." Those ones can be referenced and learned about in the manual for whatever machine you happen to be using. The other ones, the ones that we set, are the ones we'll focus on here.

Most important alarm we have on the machine is the high pressure alarm (which goes off when our high pressure limit is reached). The reason this alarm is so important is because if it gets triggered, the inspiration cycles off! That means that if we have a situation where we repeatedly trigger a high pressure alarm, we may end up with a MV that bottoms out and a patient that quickly deteriorates. Imagine we place a patient on the vent who has either an

\* is not a verb

untreated airway obstruction or poor compliance – if we try to ventilate this patient in volume control and at normal settings, every breath that goes might trigger the high pressure alarm and get terminated early with a net result of almost no MV. The reason this safeguard exists, in spite of this risk, is because we could for sure cause a lot of damage if we accidentally give too much pressure.

Moral of the story here: if we are in volume control ventilation and have a concern for increased airway pressures, we should consider going up on the high pressure limit before putting the patient on the machine in order to avoid bottoming out our MV. On the flip side, in pressure control we need to vigilantly monitor MVe (and also VTe, but to a lesser extent) to avoid the same issue. Which leads us the next most important alarm we can set: low minute volume. We set this limit at a reasonable value below our MV goal so that if things get weird and MV starts to drop, we get notified right away before our patient suffers. In this way we utilize the high pressure and low MV alarms to ensure that we maintain an adequate ventilation for our patients.

As far as setting the high pressure and low MV alarms, that is a bit dependent on our margin of safety and when we want to be notified of changes in the system. As a general rule of thumb, the high pressure limit should be about 10cmH<sub>2</sub>O above your PIP. If, however, your PIPs are already high of normal, consider setting the high pressure alarm 5cmH<sub>2</sub>O over that value. In the event of one of those situations which may lead to repeated triggering of the high pressure alarm and sudden drop in MV, go up more on PIP (even beyond 35cmH<sub>2</sub>O if need be) to maintain MV. Note that this would be a short term fix and we should start to consider other strategies right away: trial pressure control mode, consider pharmacological and procedural interventions, etc.

As for the low MV alarm: set that within 10-20% of the MV goal that we calculated when we first started into this process of getting the patient on the vent. If we have a patient breathing in excess of that goal and we want to know if that changes, we just set the low MV goal 10-20% below what they are currently at. In any case, the low MV alarm is just a catch to alert us when we've missed a change – typically we will be on top of these trends and notice things before the alarm even gets sounded, but sometimes we get distracted by other interventions and this backup system can keep us notified.

Other alarms that we can typically set to help us better keep track of what's going on with the vent and our patient are low peak pressure, low frequency, and low PEEP. Low peak pressure alerts us when the expected peak pressure is lower than we would expect; this could indicate a cuff leak or a loose connection (an actual disconnection would probably trigger a disconnect alarm, one of those non-adjustable alarms consistent across machines, as the pressure would drop much more significantly). Low frequency can let you know if the patient's RR starts to decrease – this is good if the patient is consistently breathing above a set RR and we want to be aware if that intrinsic effort changes. Lastly, low PEEP lets us know if the end expiratory pressure drops below our set PEEP. This could indicate a slow leak or cuff deflation.

That's just a quick, short overview of alarms; recognize that the most important ones are high pressure and low MV, but that there are a number that can help us be aware of changes in the system as we work through a transport. Because there is so much variation between machines, the best way to get familiar with the alarms you will be working with is to read the

manual that comes with the machine. Super fun reading, but it's good information and can help you fine tune the feedback from the vent so that you can better monitor what's going with the patient.

### c. Titrating Up on VTe

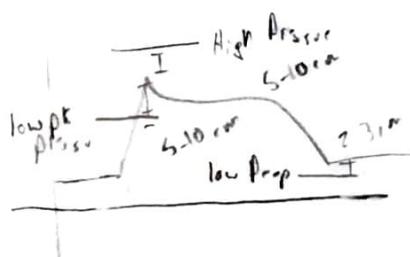
As a general rule, we always try to get VTe as high as possible (without causing damage) unless we have a good reason not to. The reason is that by recruiting as much lung as possible, we improve the patient's capacity to compensate for challenges and we can also titrate RR down while maintaining MV (which decreases that %TaDP concept). In addition, this will allow the patient to more easily maintain ventilation after extubation and can improve recovery times. So even though it may not seem like a necessary strategy in the acute settings, if all is well and we can make changes towards this end of higher VTe, we ought to do so for the sake of the patient.

As we work towards higher VTe, either by increasing TV in volume control or by increasing PC in pressure, we need to ensure that we don't cause barotrauma. The simplest way would be to limit Pplat (or PC) to 30cmH<sub>2</sub>O – the value which we identified earlier as the upper limit to safe ventilation. That strategy, however, ignores the fact that there is a significant amount of variation among individuals. Instead we can titrate up towards (and maybe even beyond) that limit and see how the patient's lungs do in response. If they seem to accommodate that change in pressure without problem, all is well; if they don't, we can dial back.

Before we get into the details on how to make that determination as to whether or not an increase in pressure is safe or not, it is worth mentioning that this strategy doesn't apply to patients with ALI/ARDS (i.e. this is one of those "good reasons not to"). There is some evidence now that we want to limit the pressure difference between PEEP and Pplat (termed "driving pressure") in these patients. While we still want to maximize use of the lung in those patients, the approach is different and involves higher PEEP and smaller TVs to accomplish the same thing. There may eventually be comparable recommendations for patients other than those with ALI/ARDS, but for now the data is scarce and only focuses on this particular patient group.

Back to how we go about making sure our increased pressure doesn't get taken too far.

VC: ↑TV until swap to Pplat or ↓compliance  
PC: ↑PC until ↓compliance or no diff in VTs



↓ safety pressure

VC  
TV 400ml Pplat 22cm Cough  
factor