

Approved by: MEDICAL DIR TRAUMA - RALEIGH

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No: 9147



HEIGHT	INCHES	PBW	8 mL/KG	6 mL/KG	4 mL/KG	
4'6"	54	36.2	290	220	150	
4'7"	55	38.5	310	230	160	
4'8"	56	40.8	330	250	170	
4'9"	57	43.1	350	260	170	
4'10"	58	45.4	370	270	180	
4'11"	59	47.7	380	290	190	
5'0"	60	50.0	400	300	200	
5'1"	61	52.3	420	320	210	
5'2"	62	54.6	.6 440 330		220	
5'3"	63	56.9	460 340		230	
5'4"	64	59.2	480	360	240	
5'5"	65	61.5	1.5 490		250	
5'6"	66	63.8	.8 510		260	
5'7"	67	66.1	530 400		270	
5'8"	68	68.4	550 410		280	
5'9"	69	70.7	570 430		290	
5'10"	70	73.0	3.0 590 440		290	
5'11"	71	75.3	3 600 450		300	
6'0"	72	77.6	620 470		310	
6'1"	73	79.9	.9 640 4		320	
6'2"	74	82.2	.2 660 500		330	
6'3"	75	84.5	680	510	340	
6'4"	76	86.8	700	520	350	

HEIGHT	INCHES	PBW	8 mL/KG	6 mL/KG	4 mL/KG	
4'6"	54	31.7	260	190	130	
4'7"	55	34.0	270	210	140	
4'8"	56	36.3	290	220	150	
4'9"	57	38.6	310	230	160	
4'10"	58	40.9	330	250	170	
4'11"	59	43.2	350	260	180	
5'0"	60	45.5	370	280	180	
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5'4"	64	54.7	440	330	220	
5'5"	65	57.0	460	340	230	
5'6"	66	59.3	59.3 480 360		240	
5'7"	67	61.6	500 370		250	
5'8"	68	63.9	510 390		260	
5'9"	69	66.2	66.2 530 400		270	
5'10"	70	68.5	68.5 550 410		280	
5'11"	71	70.8	70.8 570 430		290	
6'0"	72	73.1	73.1 590 4		290	
6'1"	73	75.4	75.4 610 450		300	
6'2"	74	77.7	77.7 620 470		310	
6'3"	75	80.0	640	480	320	
6'4"	76	82.3	660	500	330	

FEMALE OUICK REFERENCE FOR TIDAL VOLUME

KG = kilogram; mL = milliliter; PBW = predicted body weight

Lower PEEP/Higher FIO2															
F _{IO2}	0.3	0.4	0.4	0.5	0.5	0.6	0.7	0.7	0.7	0.8	0.9 (0.9 0	.9 1	.0	
PEEP	5	5	8	8	10	10	10	12	14	14	14 ·	16 1	8 1	8–24	
Higher PEEP/Lower FIO2															
F _{IO2}	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	0.5	0.5-0	8 0.8	0.9	0.9	1.0	1.0
PEEP	5	8	10	12	14	14	16	16	18	20	22	22	22	22	24

APRV tips

- APRV is an inverse ratio pressure control type setting
- Set P_{High} (use desired plateau pressure, typically 25-30 cm H2O)
- Set P_{Low} (default = 3 cm H2O)
- Set T_{Low} to create desired auto-PEEP and V_{T}
 - Auto-PEEP is created by cutting expiration short 0
 - T_{Low} typically 0.2-0.8 sec (0.8 sec is good starting point) 0
 - Observe expiratory flow graphic to target an expiratory flow cutoff of 50-75% of peak 0 expiratory flow
 - Assess auto-PEEP (via an expiratory hold) and adjust T_{Low}/expiratory flow cutoff to 0 achieve desired auto-PEEP
 - Assess V_T (goal ~ 6 cc/kg predicted bodyweight) and adjust T_{Low} /expiratory flow cutoff 0 to achieve desired V_T
- Set respiratory rate (typically 10-15/min). This is the easiest way to manipulate T_{High} and the I:E ratio.

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Parent Policy:	Title:	Standard Operating Procedure			
InsertLinkToParentPolicy	Trauma ARDS Guideline	Effective Date: 01/19/2021			

DEFINTIONS:

ARDS	Acute Respiratory Distress Syndrome
APRV	Airway Pressure Release Ventilation
I:E Ratio	Ratio of the duration of inspiratory and expiratory phases

References

- 1. The ARDS Definition Task Force. Acute Respiratory Distress Syndrome: The Berlin Definition. JAMA.2012;307(23):2526–2533 {*ARDS definition*}
- 2. The ARDS Network. Ventilation with lower tidal volumes as compared with traditional tidal volumes for acute lung injury and the acute respiratory distress syndrome. NEJM.2000;342(19):1301-1308 {Seminal RCT, showed reduced mortality with $V_T < 6$ cc/kg predicted body weight and $P_{Plat} < 30$ cm H2O}
- 3. Amato MB, et al. Driving pressure and survival in the acute respiratory distress syndrome. NEJM.2015;372:747–55 {Secondary analysis of data from 9 RCTs showing driving pressure more strongly associated with survival than V_T and P_{Plat}}
- Guerin C, et al. Prone Positioning in Severe Acute Respiratory Distress Syndrome. NEJM.2013;368:2159-2168 {RCT, showed prolonged (>16 hr/day) early (<48 hrs after diagnosis) proning decreases mortality in ARDS patients with P/F <150}
- 5. Bloomfield R, et al. Prone Position for Acute Respiratory Failure in Adults. Cochrane Database Syst Rev.2015;Nov 13(11):CD008095 {Cochrane review showing early, prolonged proning in moderate-severe ARDS may improve mortality}
- 6. Dickenson et al. Prone Positioning Therapy in ARDS. Crit Care Clin.2011;27:511-523 {*Review with practical tips for proning*}
- Meduri et al. Prolonged low-dose methylprednisolone treatment is highly effective in reducing duration of mechanical ventilation and mortality in patients with ARDS. J Intensive Care. 2018;6:53 {Individual patient data meta-analysis combining 4 RCTs evaluating prolonged methylprednisolone therapy for ARDS showed a reduction in mortality, with an increase in ventilator-free days}
- 8. Venkatesh et al. Adjunctive Glucocorticoid Therapy in Patients with Septic Shock. N Engl J Med. 2018;378(9):797-808 {ADRENAL RCT, hydrocortisone decreased duration of mechanical ventilation but did not affect mortality in patients with septic shock}
- 9. Annane et al. Hydrocortisone plus Fludrocortisone for Adults with Septic Shock. N Engl J Med. 2018;378(9):809-818 {*APROCCHSS RCT, hydrocortisone + fludrocortisone decreased mortality and duration in of mechanical ventilation in patients with septic shock*}
- 10. Villar et al. Dexamethasone treatment for the acute respiratory distress syndrome: a multicentre, randomised controlled trial. The Lancet Respiratory Medicine. February 2020 {DEXA-ARDS RCT, dexamethasone decreased mortality and duration of mechanical ventilation in patients with ARDS}
- 11. Papazian et al. Neuromuscular Blockers in Early Acute Respiratory Distress Syndrome. NEJM.2010;363:1107-1116 {ACURASYS RCT, early administration of NMB decreased mortality and ventilator time without causing weakness in ARDS patients with P/F <150}
- 12. The PETAL Network. Early Neuromuscular Blockade in Acute Respiratory Distress Syndrome. NEJM.2019;380:1997-2008 {ROSE RCT, early administration of NMB did NOT decrease mortality in ARDS patients with P/F <150}
- 13. Briel M, et al. Higher vs Lower Positive End-Expiratory Pressure in Patients with Acute Lung Injury and Acute Respiratory Distress Syndrome: Systematic Review and Meta-Analysis. JAMA.2010;303:865–873 {Secondary analysis of data from 9 RCTs showing decreased mortality in ARDS patients with P/F < 200 treated with higher PEEP}</p>

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- 14. Cavalcanti AB, et al. Effect of Lung Recruitment and Titrated Positive End-Expiratory Pressure (PEEP) vs. Low PEEP on Mortality in Patients with Acute Respiratory Distress Syndrome: A Randomized Clinical Trial. JAMA. 2017;318:1335–45 {*ART RCT, showed increased mortality in ARDS patients with P/F <200 managed with recruitment maneuvers and PEEP titration*}
- 15. Van der Zee, et al. Recruitment Maneuvers and Higher PEEP, the So-Called Open Lung Concept, in Patients with ARDS. <u>Crit Care.</u> 2019;23(1):73 {*Review of the open lung concept including recruitment maneuvers and PEEP*}
- 16. Bhattacharjee S, et al. Recruitment Maneuver Does Not Provide Any Mortality Benefit Over Lung Protective Strategy Ventilation in Adult Patients with Acute Respiratory Distress Syndrome: A Meta-Analysis and Systematic Review of the Randomized Controlled Trials. J Intensive Care. 2018;6:35 *{Secondary analysis of data from 7 RCTs showing no improvement in mortality in ARDS patients treated with recruitment maneuvers}*
- 17. Hess D. Recruitment Maneuvers and PEEP Titration. Respir Care. 2015;60:1688-1704 {Comprehensive review of recruitment maneuvers and PEEP}
- 18. Habashi NM. Other approaches to open-lung ventilation: airway pressure release ventilation. Crit Care Med. 2005; 33(Suppl): S228-S240 {*Seminal review of APRV, including how to set up*}
- Zhou Y, et al. Early Application of Airway Pressure Release Ventilation May Reduce the Duration of Mechanical Ventilation in Acute Respiratory Distress Syndrome. Intensive Care Med. 2017;43:1648-1659 {RCT, early APRV increased days free from ventilator and oxygenation and decreased P_{Plat}}
- 20. Carsetti et al. Airway Pressure Release Ventilation During Acute Hypoxemic Respiratory Failure: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. Ann Intensive Care. 2019;9(1):44 {Secondary review of 5 RCTs showing lower mortality and increased days free from ventilator in ARDS patients treated with APRV}
- 21. Gebistorf F, et al. Inhaled Nitric Oxide for Acute Respiratory Distress Syndrome (ARDS) in Children and Adults. Cochrane Database Syst Rev. 2016 Jun 27;(6):CD002787 {Cochrane review showing NO improves oxygenation but not mortality and may cause kidney injury}
- 22. Adhikari NK, et al. Inhaled Nitric Oxide Does Not Reduce Mortality in Patients With Acute Respiratory Distress Syndrome Regardless of Severity: Systematic Review and Meta-Analysis. Crit Care Med. 2014;42(2):404-412 *{Secondary review of 9 RCTs showing NO does not improvement in mortality}*
- 23. The ARDS Network. Comparison of Two Fluid-Management Strategies in Acute Lung Injury, NEJM. 2006;354:2564-2575 {*RCT, conservative fluid management strategy increased days free from ventilator, mean difference of 7 liters over 7 days*}
- 24. Peek G, et al. CESAR: Efficacy and Economic Assessment of Conventional Ventilatory Support Versus Extracorporeal Membrane Oxygenation for Severe Adult Respiratory Failure. A Multicenter Randomised Controlled Trial. Lancet. 2009;374:1351-1363 {CESAR RCT, showed that transfer to an ECMO center improved mortality, does NOT necessarily show that ECMO is superior to lung protective ventilation, only ¾ of patients randomized to ECMO went on}
- 25. Combes A, et al. Extracorporeal Membrane Oxygenation for Severe Acute Respiratory Distress Syndrome. NEJM. 2018;378:1965-1975 {*EOLIA RCT, in patients with very severe ARDS no statistically significant mortality difference with ECMO (35 vs. 46%, p=0.09), crossover to ECMO in* 28% in control group}

* Thank you to the University of Michigan Respiratory Care Committee for sharing resources and expertise that were used to help make this algorithm

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