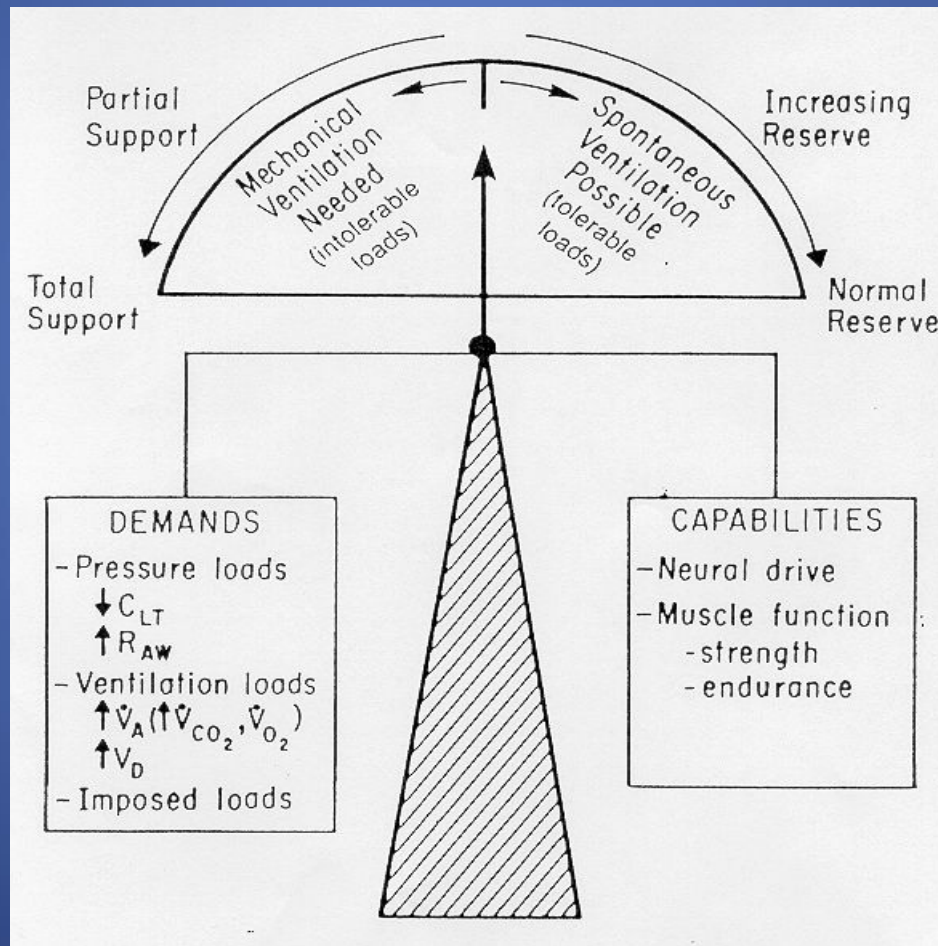


Ventilator Discontinuation:
*The evidence base and “best
practice”*

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Ventilator dependency reflects an imbalance in loads/capacities



Ventilator dependency can also be iatrogenic

- Failure to recognize discontinuation potential
- Imposed loading:
 - insufficient support
 - insensitive/unresponsive triggers
 - flow dys-synchrony
 - cycle dys-synchrony
- Inefficient weaning “rules”
- Unnecessary sedation:
 - Kollef et al (1999) demonstrated sedation protocols reduce ventilator time

The Ventilator Discontinuation Process

- EBM Projects

- AHCPR - McMaster comprehensive evidence based review
 - 5000 papers screened
 - Over 150 quality trials systematically analyzed
 - Published Nov 1999

The Ventilator Discontinuation Process

- EBM Projects

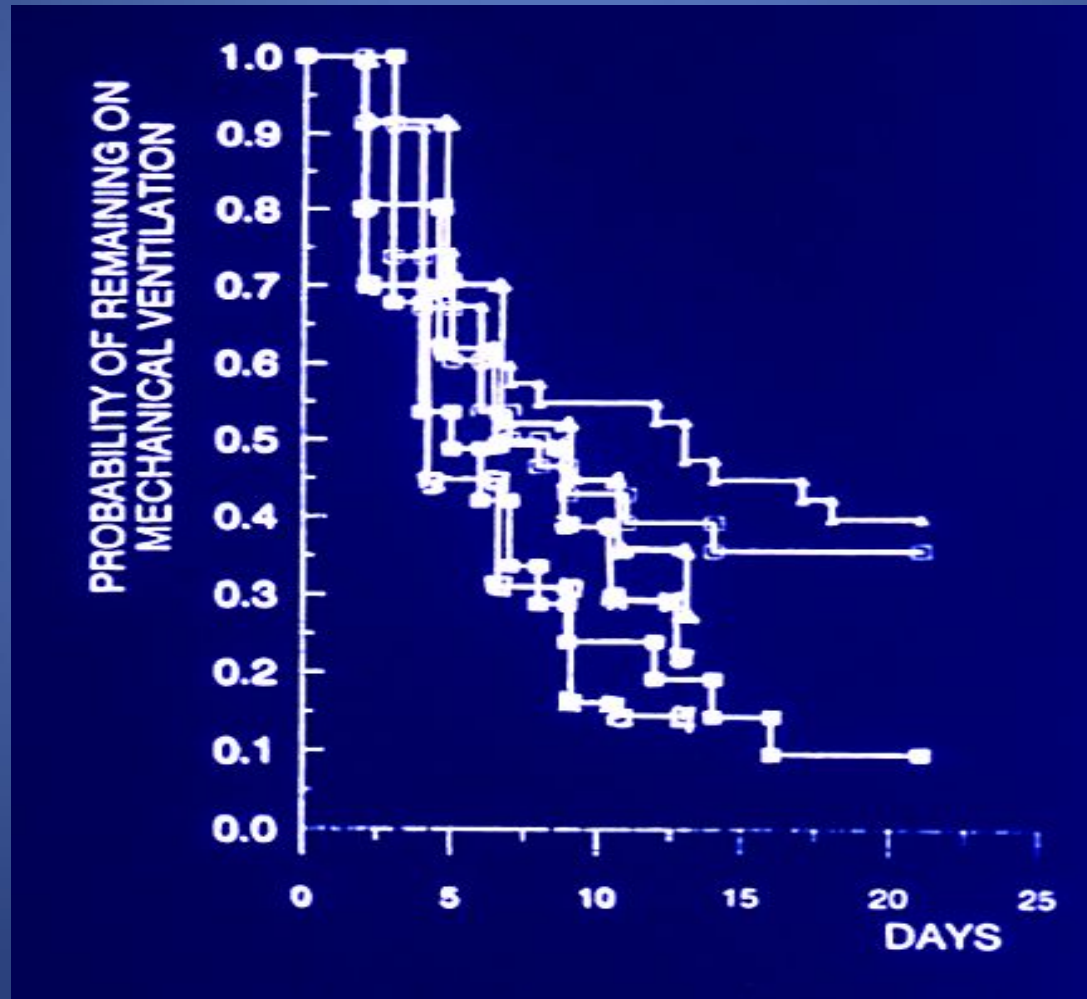
- ACCP/SCCM/AARC Task Force
 - Organized May 1999
 - Used McMaster report + own research + consensus to “fill in the gaps”
 - Developed 12 evidence based guidelines published in Chest Supplement December 2001

McMaster EBM Review - significant LRs

Parameter	Number of studies	Threshold values	Range of positive LRs
<u>A. Measured on ventilator</u>			
Minute ventilation	20	10-15 L/min	.81 to 2.37
Negative insp force	10	-20 to -30 cm H ₂ O	.23 to 2.45*
Pi max	16	-15 to -30 cm H ₂ O	.98 to 3.01
P0.1/MIP	4	.30	2.14 to 25.3
CROP	2	13	1.05 to 19.74
<u>B. Measured during a 1-2 minute period of spontaneous breathing</u>			
Respiratory rate	24	30 to 38	1.00 to 3.89
Tidal volume	18	325-408 ml (4-6 ml/kg)	.71 to 3.83
Resp rate/tidal volume (f/Vt ratio)	20	60 to 105 /L	.84 to 4.67

Although statistically significant, LRs not high enough to drive decisions in isolation

No strategy has been shown to be faster than daily SBTs with an “integrated” assessment



ACCP/SCCM/AARC EBM Guidelines

- Criteria for considering vent discontinuation:
 - stability/reversal of respiratory failure
 - P/F > 150-200, PEEP < 5-8, FiO₂ < 0.4-0.5, pH > 7.25
 - hemodynamic stability (no pressors/inotropes)
 - capable of reliable insp efforts

ACCP/SCCM/AARC EBM Guidelines

- SBT is most effective way of assessing d/c potential:
 - 5 cm H₂O PS, 5 cm H₂O CPAP, ATC, T-piece
 - T-piece closest to mimicking extubation
 - “Integrated assessment”
 - Vent pattern – especially change
 - Gas exchange – especially change
 - Hemodynamics – especially change
 - “Comfort”
 - 30-120 min - 1st 1-5 minutes needs close monitoring

ET tube removal requires ability to protect airway

- Cough is essential
 - Cough velocity (>1 l/sec)
 - White card test
 - Suctioning frequency
- Less important:
 - Gag reflex present
 - Cuff leak
 - Alertness – GCS 8 adequate
- Expected extubation failures: 10-15%

Routine daily SBTs shortens weaning

NEJM 1996;335:1864

Parameter	Intervention (149 Patients)	Control (151 Patients)	P value
APACHE II score	19.8	17.9	0.01
Weaning days	1	3	0.0001
Ventilator days	4.5	6	0.003
Reintubation (%)	6 (4)	15 (10)	0.04
Mechanical ventilation >21 days (%)	9 (6)	20 (13)	0.04
Any complication (%)	30 (20)	62 (41)	0.001
Total ICU costs	\$15,740	\$20,890	0.03

ACCP/SCCM/AARC EBM Guidelines

- For patients who fail the SBT:
 - Search for reversible causes

In between the daily SBT:

- Address the reversible aspects of load/capabilities imbalance:
 - Loads:
 - improve mechanics (edema, airways)
 - metabolic demands
 - Capabilities
 - nutrients/electrolytes
 - provide adequate DO₂ to vent muscles (CO*,Hb)
 - adrenal function
 - *SEDATION STRATEGIES* – SAT vs targeted protocols?

**removal of intrathoracic pressure may precipitate heart failure*

ACCP/SCCM/AARC EBM Guidelines

- For patients who fail the SBT:
 - Search for reversible causes
 - Repeat SBTs q 24 hrs in those maintaining clinical stability
 - In between, provide *stable* and comfortable assisted ventilation
 - Little data demonstrating gradual support reduction reduces VLOS – likely wastes resources and risks fatigue

In between daily SBTs

- Properly load the muscles:
 - “Normalize” amount of load
 - avoid atrophy, avoid fatigue
 - “Optimize” comfort with synchronous flow delivery throughout the breath
 - sensitive/responsive triggering
 - responsive (variable) flow with EVERY breath
 - proper breath termination (cycling)
- Maintain this level without change until next SBT
 - “Weaning” this level has never been shown to improve outcomes

Practical aspects of “normalized”, comfortable loading

- Triggering - max sensitivity, “balance” PEEPi with applied PEEP
- Pressure/flow targets
 - Variable flow easier to synchronize with effort - therefore pressure targeted modes (PS, PA) best
 - Operational pressure range 10-25 cm H₂O - start at 15 and titrate to breathing pattern, comfort
- Cycling - PS uses flow, PA uses time - adjust to comfortable I:E

Newer approaches to improving synchrony

- Proportional assist ventilation
 - Pressure and flow driven by sensed pt flow
- Neurally adjusted ventilator assistance
 - Pressure and flow driven by diaphragm EMG

*All have theoretical appeal and have been shown to support patient effort –
However, no meaningful outcome data*

ACCP/SCCM/AARC EBM Guidelines

- For patients who fail the SBT:
 - Search for reversible causes
 - Repeat SBTs q 24 hrs in those maintaining clinical stability
 - Stable comfortable support – no need to “wean”

ACCP/SCCM/AARC EBM Guidelines

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Is this what is happening?

2174 Successfully Discontinued (> 12 hrs support)

- 55% simple
 - 82% SBTs only, “wean”* 18%
- 39% complex (3 SBT)
 - 47% SBTs, “wean”* 53% at first
 - then “wean”* 71%/SBTs 29%
- 6% prolonged (> 7)
 - 38% SBTs, 62% “wean”* at first
 - then “wean”* 80%/SBTs 20%

*62-71% PSV, 26-29% SIMV

Can weaning be automated?

- Assumes that gradual support reductions help
 - evidence supporting this is weak

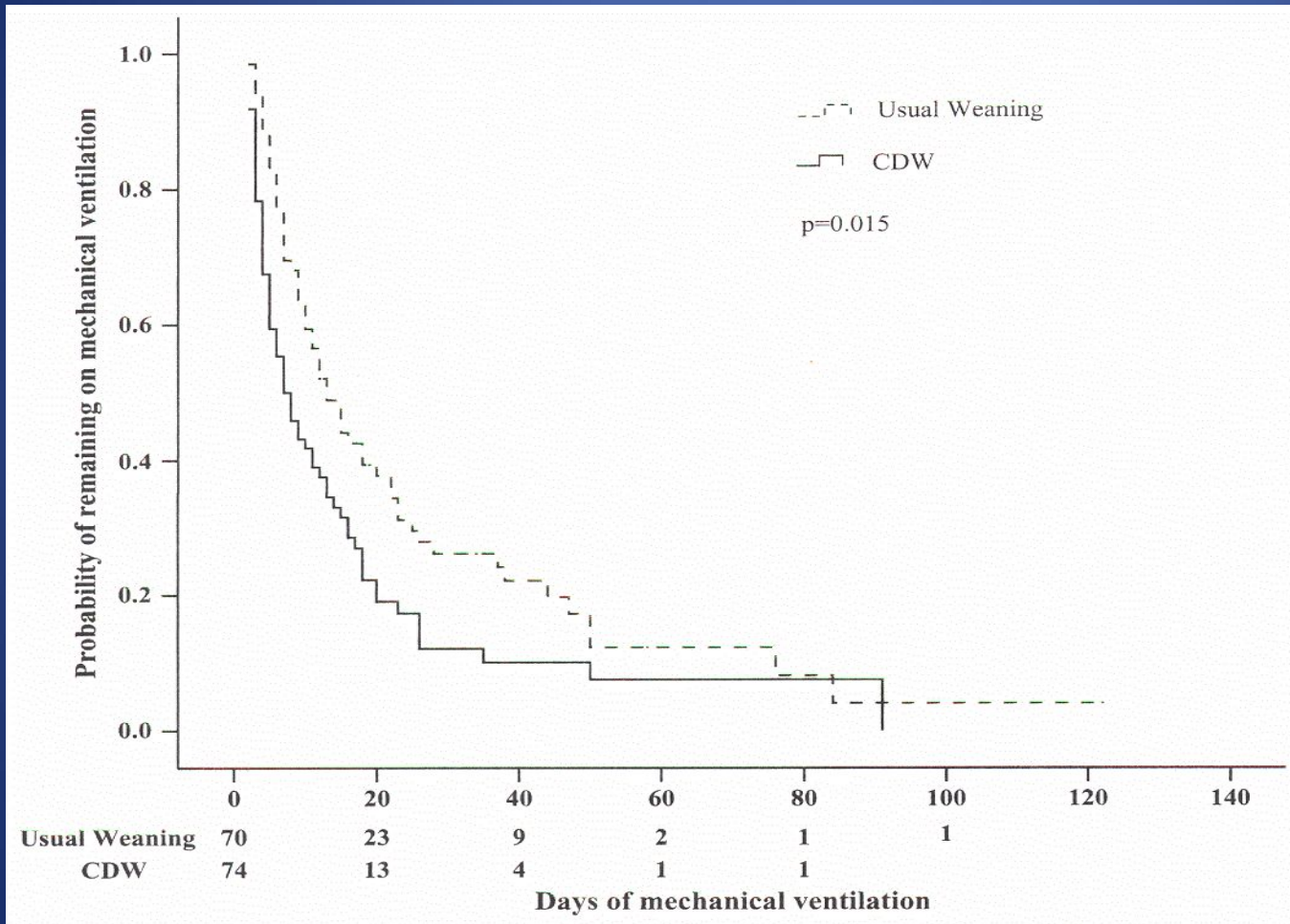
Pressure support reductions based on various feedback algorithms

- VS – target VT
- Smart Care – target VT, MV, ETCO₂

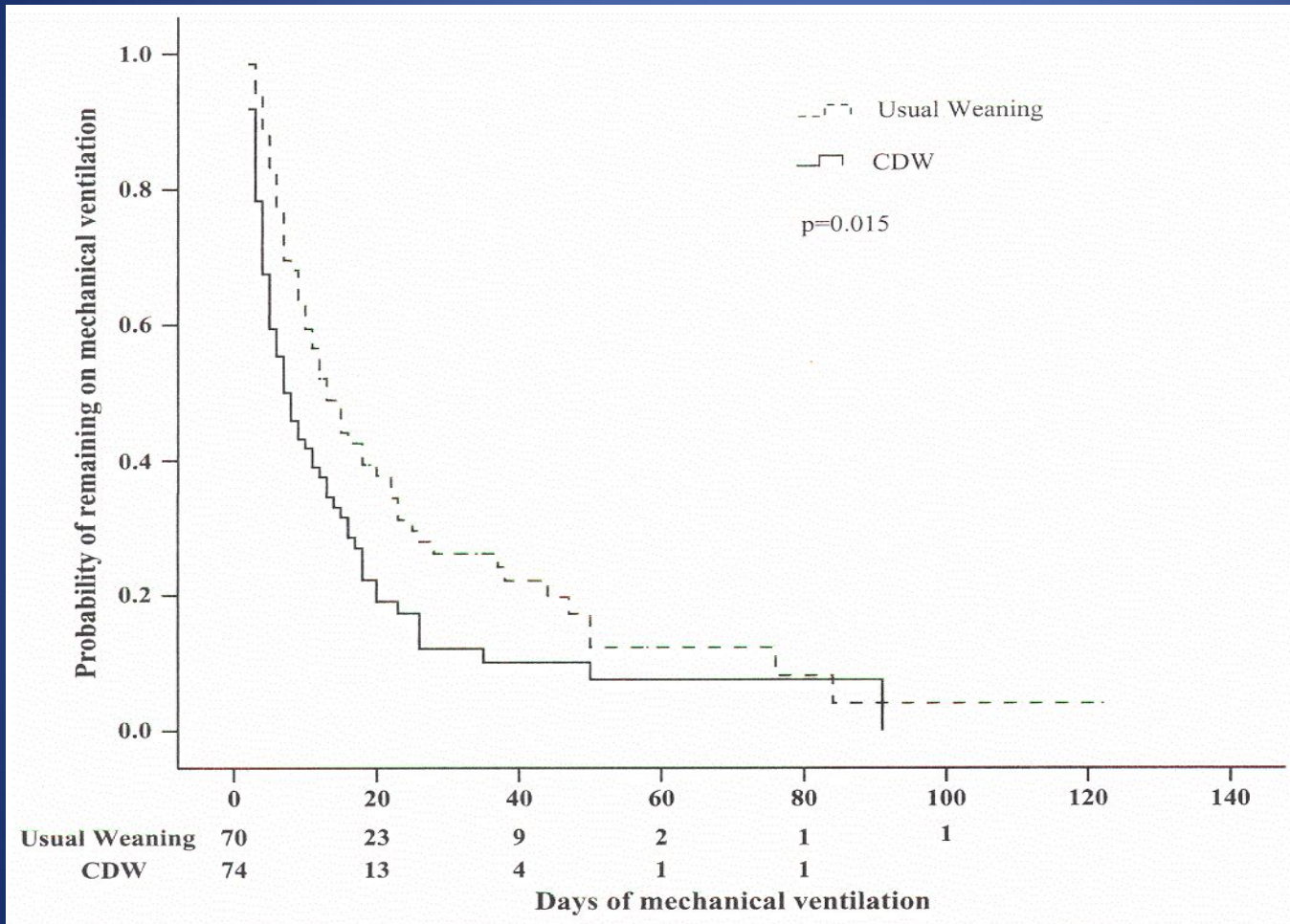
Volume Support (VS, ASV)

- Adjusts pressure to targeted tidal volume
- In theory:
 - As patient recovers, bigger VT, VS drops PS
- In practice:
 - Too high a VT selected – no PS reductions
 - Too low a VT selected – patient overloaded
 - Transient increased efforts from pain/anxiety leads to inappropriate PS reduction
- NO outcome data

SmartCare I

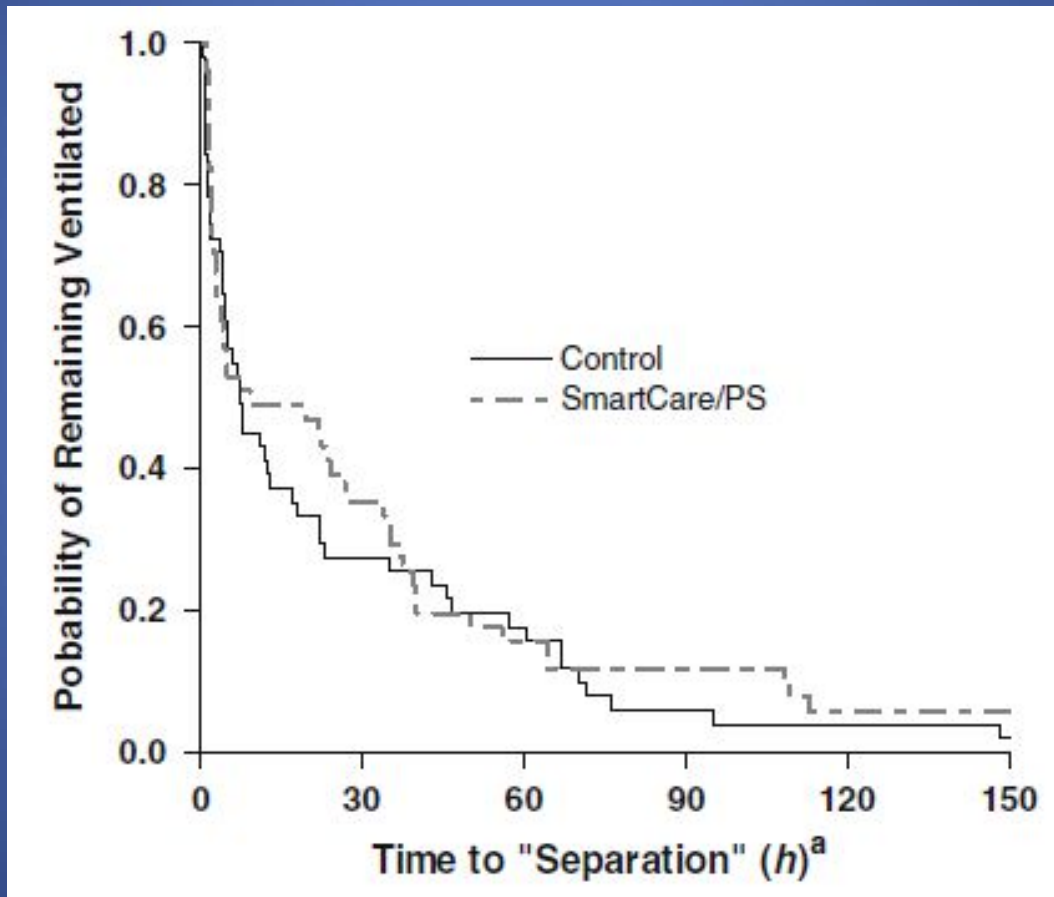


SmartCare I



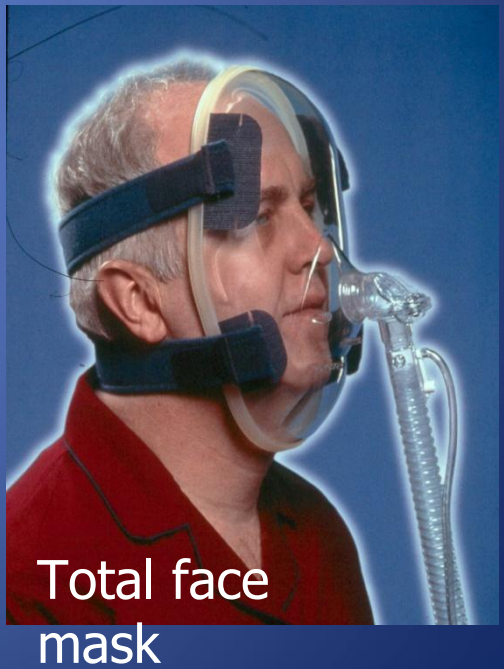
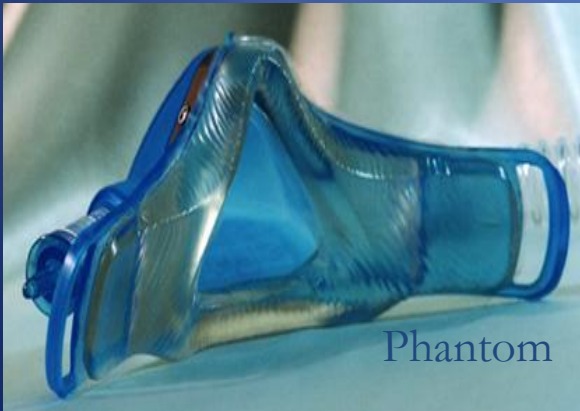
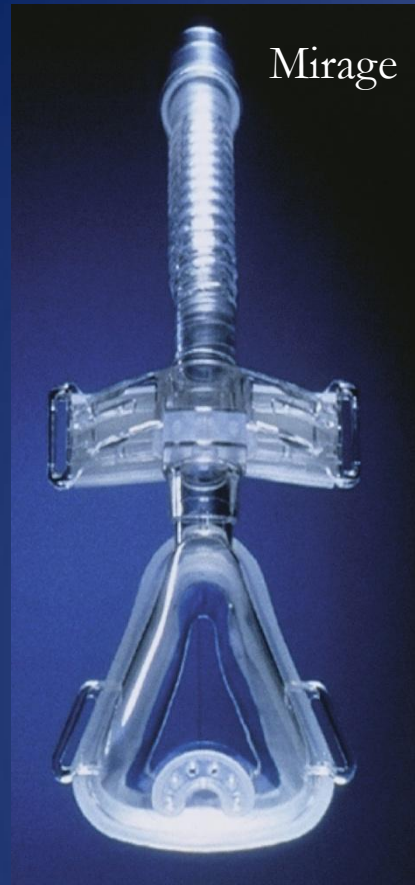
Control group
used SBTs but
may have been
done only 50%

SmartCare II



So is there a role for automatic PS reductions?

- No evidence that says this facilitates muscle recovery
- Patient tolerance to decreasing PS could signal clinicians to initiate SBTs (weaning and weaning success diagnostic, not therapeutic):
 - Rapidly recovering patient (overdose, post op)
 - Slowly recovering after many failed SBTs (PMV population)



NIV and Vent Discontinuation: *Two Scenarios*

- The failed/borderline SBT but good airway protection
 - Supportive evidence, especially in COPD
- The failed extubation:
 - Supportive evidence in COPD
 - May delay life saving intubation in other forms of ARF

Conclusions

- Ventilator dependency is not only disease induced but can be iatrogenic
- Good evidence supports daily screening and SBTs – success enhanced with sedation protocols
- Successful SBTs need a separate airway protection assessment before extubation
- Failed SBTs need 24 hrs of stable support while causes of ARF further addressed – then SBT
- Automated strategies may have utility in rapidly recovering, or PMV (marker, not cause, of recovery)
- NIV useful in selected patients (mostly COPD)