

## **CCAT Mechanical Ventilation Clinical Practice Guideline**

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- I. Background and Introductory Information
  - A. Mechanical ventilation can injure the lung. Appropriate ventilator strategies will minimize ventilator induced lung injury.
  - B. Lung protective ventilation is appropriate for most CCATT patients, even if they do not have ARDS.
    - 1. The same pathophysiologic processes are likely at work, even if they have not reached a level that meets the formal ARDS definition.
    - 2. There is evidence that lung protective ventilation decreases ARDS development in patients at risk, which describes most CCATT patients.
  - C. This document closely follows the ventilation strategy from the ARDSNet ARMA trial.
    - 1. This is the least harmful strategy formally studied and validated in a large trial.
    - 2. Some experts may choose to deviate from the strategy in an individual patient.
    - 3. The strategy has been modified in some respects to simplify its use.
- II. Determining Stability for Flight
  - A. Stability for flight is a multi-factorial decision based on the patient, sending facility, CCATT team, and flight characteristics.
  - B. Patient characteristics
    - 1. PEEP and  $F_{iO_2}$ 
      - a. PEEP /  $F_{iO_2}$  greater than 14 / 70% (See Appendix B) should prompt careful consideration of risks and benefits. Such patients have little room to increase  $F_{iO_2}$  or mean airway pressure if their condition worsens during flight. **This does not mean patients on these settings cannot be transported safely.**
      - b. All patients, including those on mechanical ventilation, will experience a decrease in  $PO_2$  as ambient pressure decreases.
        - (1) Patients with marginal gas exchange will require additional support during flight.
        - (2) Cabin altitude restriction (CAR) will lessen the impact on gas exchange.
    - 2. Patients on aggressive support that has been stable over time are better candidates for transport than those with increasing support leading up to flight time.
    - 3. Concurrent hemodynamic compromise or traumatic brain injury will complicate ventilator management and should be considered in assessing stability for flight.
  - C. Sending facility characteristics
    - 1. Type of ventilators available
    - 2. Availability of rescue therapies (proning, inhaled nitric oxide/prostacyclin, advanced mechanical ventilation techniques, etc.)
    - 3. Personnel experience and expertise
    - 4. Current beds available and anticipated casualties
  - D. Expertise of CCATT team members with advanced mechanical ventilation strategies
  - E. Flight characteristics
    - 1. Flight duration
    - 2. Aircraft type
    - 3. Patient load and complexity
    - 4. Altitude restriction

### III. Pre-flight Preparation

#### A. Ventilator

1. Most patients can be safely transported using the Impact 731 ventilator.
  - a. Allows for volume control or pressure control ventilation.
  - b. Altitude compensated.
  - c. Rated for patients 5kg and above.
  - d. Cannot do inverse ratio.
2. The LTV 1000 ventilator offers additional capability needed in some patients but also has limitations.
  - a. Inverse ratio ventilation.
  - b. Better choice for pediatric transports.
  - c. Unable to compensate for altitude.
  - d. Unable to achieve 100% FiO<sub>2</sub> due to turbine (93-94% highest FiO<sub>2</sub> attainable).

#### B. Oxygen

1. Oxygen requirements should be calculated for all patients.
  - a. **The LTV 1000 with high F<sub>i</sub>O<sub>2</sub> and minute ventilation can exhaust a full PTLOX during a long mission. Never forego the oxygen calculation.**
  - b. Refer to Appendix A.
    - (1) There is no safety factor in the calculations.
    - (2) Additional oxygen beyond calculated requirement should be determined by each team on a case by case basis based on patient and transport characteristics.
2. Each mechanically ventilated patient should ideally have a dedicated PTLOX.
3. It is possible to have two patients on one PTLOX; AE will make that determination if necessary.

#### C. Patient Preparation

1. Note ET tube depth at the teeth that correlates to appropriate placement by CXR.
2. Secure ET tube using a dedicated securing device.
  - a. If burns or facial trauma preclude this, consider securing tube to upper central incisor using silk suture or wire.
  - b. Be certain that lips and tongue are not injured by device.
3. Avoid exposing airway to atmospheric pressure during ventilator changeover if PEEP is  $\geq 10$  cm H<sub>2</sub>O.
  - a. Lung de-recruitment occurs rapidly with exposure to atmospheric pressure.
  - b. Gently clamp ET tube using a Kelly clamp while the circuit is broken for ventilator changeover.
  - c. Pad the Kelly clamp with tape or short pieces of rubber tubing to avoid damage to the ET tube.
  - d. Do not clamp wire reinforced tubes as they will kink permanently.
4. All ventilated patients should have a heat-moisture exchanger (HME) in place.
5. Check ET tube cuff pressure prior to departure.
  - a. Proper ET tube cuff inflation is mandatory to avoid aspiration, de-recruitment and ventilator malfunction (pressure too low) or damage to tracheal mucosa (pressure too high).
  - b. Palpating ET tube cuff is inaccurate and should not be relied upon to estimate cuff pressure. **Use a cuff manometer.**
  - c. Goal is 20 – 30 cm H<sub>2</sub>O (15-22 mm Hg).

**This document serves as a guide only and does not supersede clinical judgment.**

- d. ET tube cuffs should be filled with air. Do not use saline.
6. All ventilated patients should have the head of bed elevated at least 30° unless there is a contraindication.
  - a. Most patients will not have a contraindication. Ask the sending physician or neurosurgeon for clarification if necessary.
  - b. The backrest designed for the NATO litter is the most appropriate way to elevate the head of bed.
7. All ventilated patients should have continuous end-tidal CO<sub>2</sub> monitoring.
  - a. Use caution interpreting the absolute value as it may not accurately reflect PaCO<sub>2</sub>.
    - (1) The difference between PaCO<sub>2</sub> and end-tidal CO<sub>2</sub> reflects dead space, which can change rapidly in critically ill patients.
    - (2) There is also likely to be some measurement error.
  - b. The true value is the ability to immediately detect circuit disconnections and ventilator failures by observing changes in the waveform and to identify trends in CO<sub>2</sub> that may prompt arterial blood gas measurement.
  - c. Providers skilled with end-tidal CO<sub>2</sub> monitoring may infer hemodynamic data from end-tidal CO<sub>2</sub> data.
8. All ventilated patients require gastric decompression prior to flight. Oro-gastric tube preferred to naso-gastric tube to prevention sinusitis.
9. Consider repeat CXR if > 12 hrs has elapsed since most recent one or clinical condition has changed significantly.
10. Tube feeds not administered through a small bowel feeding tube should be discontinued prior to flight.

#### IV. Basic Ventilator Management

##### A. Mode of Ventilation

1. Avoiding injurious ventilator settings is far more important than the mode of ventilation.
2. There is no outcome based evidence favoring one mode of ventilation over another.
3. Patients in the landmark ARDSNet ARMA trial were all ventilated in volume control ventilation.
4. Pressure control has some theoretical advantages:
  - a. Decelerating flow waveform is more comfortable and may improve gas mixing.
  - b. Inverting I:E ratio is an option for increasing the mean airway pressure that is not available on the Impact 731.

##### B. Ventilator Settings

1. Tidal Volume (V<sub>T</sub>)
  - a. If using volume control:
    - (1) Start with V<sub>T</sub> at 6 cc/kg
    - (2) Decrease V<sub>T</sub> as needed to achieve peak inspiratory pressure (PIP) ≤ 35 (preferably ≤ 30)
    - (3) Do not go below V<sub>T</sub> = 4 cc/kg.
  - b. If using pressure control:
    - (1) Start with PIP 30-35 cm H<sub>2</sub>O.
      - (a) The difference between PEEP and PIP will determine V<sub>T</sub> and is known as driving pressure or ΔP.
      - (b) Changes in PEEP or PIP without concomitant changes in the other will change ΔP, thereby changing V<sub>T</sub>.

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- (2) Incrementally decrease  $\Delta P$  (by decreasing PIP and/or increasing PEEP) as needed to achieve  $V_T = 6$  cc/kg.
  - (3) It is acceptable to target a  $V_T$  as low as 4 cc/kg if required to maintain  $PIP \leq 30 - 35$  cm H<sub>2</sub>O.
  - c. **Tidal volume should be based on predicted body weight (PBW) according to:  $PBW = 50 + 2.3$  (height in inches – 60) for males. Refer to Appendix B.**
  - d.  $V_T = 8$  cc/kg is acceptable in spontaneously breathing patients who are fighting the ventilator as long as the PIP or set pressure remains  $\leq 35$  (preferably  $\leq 30$ ).
  - e. Do not increase tidal volume to control pCO<sub>2</sub>.
2. Respiratory Rate
    - a. Respiratory rate should be 6 – 35
    - b. Adjust to achieve pH  $\geq 7.3$
    - c. The actual pCO<sub>2</sub> is not important, only the pH. **\*\*\*NOT APPLICABLE TO TBI PATIENTS\*\*\***
      - (1) Respiratory acidosis is typically very well tolerated.
      - (2) Trying to normalize pCO<sub>2</sub> will worsen ventilator induced lung injury.
  3. PEEP and F<sub>I</sub>O<sub>2</sub>
    - a. Set initial PEEP and F<sub>I</sub>O<sub>2</sub> based on MTF settings or your best estimate of what the patient needs. Minimum PEEP is 5 cm H<sub>2</sub>O.
    - b. Titrate PEEP and F<sub>I</sub>O<sub>2</sub> to achieve SaO<sub>2</sub> 92 – 96 % according to the ARDSNet ARMA table in Appendix B.
    - c. Recheck PIP and  $V_T$  after any change in PEEP. Adjust  $V_T$  or  $\Delta P$  as needed.
      - (1) Increasing PEEP may increase PIP and necessitate decreasing  $V_T$  in volume control ventilation.
      - (2) The LTV 1000 and 731 ventilators are not PEEP compensated.
        - (a) Increasing PEEP without a concomitant increase in PIP will decrease  $\Delta P$  and  $V_T$ .
        - (b) Decreasing PEEP without a concomitant decrease in PIP will increase  $\Delta P$  and  $V_T$ .
- C. Alarms
1. Alarms should be set to alert the team to malfunctions or changes in physiology without causing frequent false alarms. The following guidance is a starting point but each team will determine appropriate alarm settings for each mission.
  2. Suggested initial settings
    - a. High pressure alarm should be set 50% above the baseline PIP (1.5 X current PIP).
    - b. Low pressure alarm should be set 50% below the baseline PIP (0.5 X current PIP).
    - c. High respiratory rate alarm (731 only) should be set 10 above the patient's current respiratory rate.
    - d. Low respiratory rate alarm (731 only) should be set 10 below the set rate.
    - e. Minute ventilation alarm (LTV 1000 only) should be set 50 % below the baseline minute ventilation (0.5 X current minute ventilation)
- V. Ongoing Management
- A. Airway suctioning
    1. Suctioning every 4 hours is appropriate without copious secretions or mucous plugging.
    2. Frequent suctioning may lead to lung de-recruitment and worsen gas exchange in patients with ARDS.
  - B. ET tube cuff pressure

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1. Significant changes may occur on ascent and descent (pressure increases with ascent, decreases with descent).
  2. Pressure should be checked and **documented** with manometer before departure, at cruise altitude, during descent and after landing.
- C. Mouth care
1. Regular mouth care decreases the ventilator associated pneumonia risk.
  2. Chlorhexidine is the preferred agent.
  3. Recommended frequency is every 4 hours, workload permitting. Document on 3899.
- D. Monitoring and adjusting ventilator settings
1. Lung mechanics and gas exchange may change considerably during a long transport.
  2. It is imperative to monitor for changes and adjust ventilator settings to meet mechanical ventilation goals.
  3. Excessive  $V_T$  and inspiratory pressures are harmful and should be corrected when they are identified.
    - a. In volume control ventilation, incrementally change  $V_T$  by 50 cc's every 10 minutes until the desired values are achieved.
    - b. In pressure control ventilation, incrementally change PIP by 2 cm H<sub>2</sub>O every 10 minutes until the desired values are achieved.
  4. SaO<sub>2</sub> should be maintained 92 – 96 % by titrating F<sub>I</sub>O<sub>2</sub> and PEEP according to the ARDSNet ARMA table.
    - a. F<sub>I</sub>O<sub>2</sub> can be weaned up or down rapidly as any adverse effects can be quickly remedied by reversing the change.
    - b. PEEP decreases
      - (1) Rapid decreases may cause lung de-recruitment that is harmful and difficult to reverse.
      - (2) Decrease by no more than 3 cm H<sub>2</sub>O in a six hour period.
    - c. PEEP increases
      - (1) Increasing PEEP can decrease cardiac output by decreasing venous return to the heart.
      - (2) Volume loading may be needed as PEEP increases, especially when PEEP exceeds 10 cm H<sub>2</sub>O.
- E. Management of Oxygen Desaturation
1. Confirm ET tube is in trachea using end-tidal CO<sub>2</sub>.
  2. If desaturation is severe switch immediately to manual bag ventilation with high flow oxygen and PEEP valve.
  3. Exclude equipment malfunction, loss of O<sub>2</sub> supply, circuit disconnection.
  4. Suction the airway (consider simultaneous bag ventilation) to verify patency and clear mucous plugs.
  5. Consider increasing sedation or pharmacological paralysis if ventilator dysynchrony is present.
  6. Consider pneumothorax/hemothorax.
    - a. Review peak pressure trend if using volume ventilation.
    - b. Review  $V_T$  trend if using pressure control ventilation.  $V_T$  will decrease if significant pneumothorax develops and  $\Delta P$  is not changed.
    - c. Evaluate existing chest tubes for proper function.

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- d. Needle decompress the chest and place a chest tube if there is suspicion of pneumothorax and concurrent hemodynamic compromise.
- 7. Consider recruitment maneuver and increasing PEEP to next level on titration table.
  - a. Additional lung can often be recruited using sustained inflations of the lung.
  - b. Classic recruitment maneuver consists of inflation to 30 - 40 cm H<sub>2</sub>O for 30 - 40 seconds, which is difficult to do on transport ventilators.
  - c. Recruitment maneuver can be performed with bag-valve manual ventilation.
    - (1) Set PEEP valve on bag-valve unit to 15 - 20 cm H<sub>2</sub>O.
    - (2) Deliver five sequential breaths, each held for 5 - 8 seconds.
    - (3) Watch blood pressure closely and terminate maneuver immediately if hypotension develops.
    - (4) Clamp endotracheal tube while switching between ventilator and bag. Exposure to atmospheric pressure will quickly result in lung derecruitment, hypoxemia and increased ventilator induced lung injury.
- F. Monitoring oxygen utilization
  - 1. When using PTLOX, periodically check amount of oxygen consumed.
  - 2. Oxygen consumption may vary between ventilators, even with the same settings.
  - 3. Leaks in system may cause excessive oxygen consumption.
  - 4. Comparing actual to predicted oxygen consumption will allow early detection of excess utilization that may necessitate troubleshooting, changes in management or diverting aircraft in extreme cases.

CCAT Mechanical Ventilation Clinical Practice Guideline  
Appendix A – Oxygen Requirements

Oxygen Consumption Tables for LTV 1000 Ventilator

Liters of Gaseous Oxygen Consumed Per Hour

		Minute Ventilation																
		4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
FiO2	0.3	96	103	109	116	123	130	137	144	150	157	164	171	178	185	191	198	205
	0.4	202	216	231	245	260	274	289	303	317	332	346	361	375	390	404	418	433
	0.5	308	330	352	374	396	418	441	463	485	507	529	551	573	595	617	639	661
	0.6	415	444	474	504	533	563	592	622	652	681	711	741	770	800	829	859	889
	0.7	521	558	595	633	670	707	744	782	819	856	893	930	968	1005	1042	1079	1116
	0.8	627	672	717	762	807	851	896	941	986	1031	1075	1120	1165	1210	1255	1299	1344
	0.9	734	786	838	891	943	996	1048	1101	1153	1205	1258	1310	1363	1415	1467	1520	1572
	1	840	900	960	1020	1080	1140	1200	1260	1320	1380	1440	1500	1560	1620	1680	1740	1800

Find the correct minute ventilation column then go down to the correct FiO2 row. The number where these intersect is the liters of gaseous oxygen consumed per hour. There is no safety factor in this calculation. The amount of safety factor needed should be determined by the team on a case-by-case basis.

Liters of Liquid Oxygen Consumed Per Hour

		Minute Ventilation																
		4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
FiO2	0.3	0.12	0.13	0.14	0.15	0.15	0.16	0.17	0.18	0.19	0.20	0.21	0.21	0.22	0.23	0.24	0.25	0.26
	0.4	0.25	0.27	0.29	0.31	0.32	0.34	0.36	0.38	0.40	0.41	0.43	0.45	0.47	0.49	0.51	0.52	0.54
	0.5	0.39	0.41	0.44	0.47	0.50	0.52	0.55	0.58	0.61	0.63	0.66	0.69	0.72	0.74	0.77	0.80	0.83
	0.6	0.52	0.56	0.59	0.63	0.67	0.70	0.74	0.78	0.81	0.85	0.89	0.93	0.96	1.00	1.04	1.07	1.11
	0.7	0.65	0.70	0.74	0.79	0.84	0.88	0.93	0.98	1.02	1.07	1.12	1.16	1.21	1.26	1.30	1.35	1.40
	0.8	0.78	0.84	0.90	0.95	1.01	1.06	1.12	1.18	1.23	1.29	1.34	1.40	1.46	1.51	1.57	1.62	1.68
	0.9	0.92	0.98	1.05	1.11	1.18	1.24	1.31	1.38	1.44	1.51	1.57	1.64	1.70	1.77	1.83	1.90	1.97
	1	1.05	1.13	1.20	1.28	1.35	1.43	1.50	1.58	1.65	1.73	1.80	1.88	1.95	2.03	2.10	2.18	2.25

Find the correct minute ventilation column then go down to the correct FiO2 row. The number where these intersect is the liters of liquid oxygen consumed per hour. 1 L liquid oxygen = 800 L gaseous oxygen. There is no safety factor in this calculation. The amount of safety factor needed should be determined by the team on a case-by-case basis.

Hours of Use Per Liter of Liquid Oxygen

		Minute Ventilation																
		4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
FiO2	0.3	8.36	7.80	7.31	6.88	6.50	6.16	5.85	5.57	5.32	5.09	4.88	4.68	4.50	4.33	4.18	4.04	3.90
	0.4	3.96	3.70	3.46	3.26	3.08	2.92	2.77	2.64	2.52	2.41	2.31	2.22	2.13	2.05	1.98	1.91	1.85
	0.5	2.59	2.42	2.27	2.14	2.02	1.91	1.82	1.73	1.65	1.58	1.51	1.45	1.40	1.35	1.30	1.25	1.21
	0.6	1.93	1.80	1.69	1.59	1.50	1.42	1.35	1.29	1.23	1.17	1.13	1.08	1.04	1.00	0.96	0.93	0.90
	0.7	1.54	1.43	1.34	1.26	1.19	1.13	1.07	1.02	0.98	0.93	0.90	0.86	0.83	0.80	0.77	0.74	0.72
	0.8	1.28	1.19	1.12	1.05	0.99	0.94	0.89	0.85	0.81	0.78	0.74	0.71	0.69	0.66	0.64	0.62	0.60
	0.9	1.09	1.02	0.95	0.90	0.85	0.80	0.76	0.73	0.69	0.66	0.64	0.61	0.59	0.57	0.55	0.53	0.51
	1	0.95	0.89	0.83	0.78	0.74	0.70	0.67	0.63	0.61	0.58	0.56	0.53	0.51	0.49	0.48	0.46	0.44

Find the correct minute ventilation column then go down to the correct FiO2 row. The number where these intersect is the number of hours that a 1 L of liquid oxygen will operate the ventilator. 1 L liquid oxygen = 800 L gaseous oxygen. There is no safety factor in this calculation. The amount of safety factor needed should be determined by the team on a case-by-case basis.

Minutes of Use Per Full D Cylinder

		Minute Ventilation																
		4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
FiO2	0.3	171	159	149	140	133	126	119	114	109	104	99	96	92	88	85	82	80
	0.4	81	75	71	67	63	60	57	54	51	49	47	45	43	42	40	39	38
	0.5	53	49	46	44	41	39	37	35	34	32	31	30	28	27	26	26	25
	0.6	39	37	34	32	31	29	28	26	25	24	23	22	21	20	20	19	18
	0.7	31	29	27	26	24	23	22	21	20	19	18	18	17	16	16	15	15
	0.8	26	24	23	21	20	19	18	17	17	16	15	15	14	13	13	13	12
	0.9	22	21	19	18	17	16	16	15	14	14	13	12	12	12	11	11	10
	1	19	18	17	16	15	14	14	13	12	12	11	11	10	10	10	9	9

Find the correct minute ventilation column then go down to the correct FiO2 row. The number where these intersect is the number of minutes that a full D cylinder will operate the ventilator. Assumes full D cylinder contains 1800 psi, is empty at 100 psi and tank factor 0.16. There is no safety factor in this calculation. The amount of safety factor needed should be determined by the team on a case-by-case basis.

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## CCAT Mechanical Ventilation Clinical Practice Guideline

### Appendix B – Mechanical Ventilation in ARDS

\*\*\*\*\*NOT APPLICABLE TO PATIENTS WITH TBI\*\*\*\*\*

#### Volume Control Ventilation

1. Set the I:E ratio at 1:2 to 1:4. The 731 ventilator defaults to a 1:2.5 I:E Ratio.
2. Set PEEP and FiO<sub>2</sub> according to ARDSNet ARMA Trial PEEP table to achieve SaO<sub>2</sub> 92 - 96%<sup>1</sup>. Note that the LTV 1000 is limited to PEEP 20 and the 731 limited to PEEP 25.
3. **Set tidal volume at 6 cc/Kg and note peak inspiratory pressure (PIP)<sup>2</sup>. If necessary, decrease tidal volume by 1 cc/Kg as needed to keep peak inspiratory pressure ≤ 35 cm H<sub>2</sub>O (preferably ≤ 30). Do not go below 4 cc/Kg. Use table below as reference for appropriate tidal volume<sup>3</sup>.**
4. Adjust respiratory rate to achieve pH ≥ 7.3<sup>4</sup>. The actual PCO<sub>2</sub> is not important, only the pH.

#### Pressure Control Ventilation

1. Set I time to achieve I:E ratio of 1:2 to 1:4.
2. Set PEEP and FiO<sub>2</sub> according to ARDSNet ARMA Trial PEEP table to achieve SaO<sub>2</sub> 92 - 96%<sup>1</sup>. Note that the LTV 1000 is limited to PEEP 20 and the 731 limited to PEEP 25.
3. **Set inspiratory pressure to achieve a tidal volume of 6 cc/kg. If this value is > 30 cm H<sub>2</sub>O then decrease until it is ≤ 30 cm H<sub>2</sub>O or until tidal volume is 4 cc/kg. Use table below as reference for appropriate tidal volume<sup>3</sup>.**
4. Adjust respiratory rate to achieve pH ≥ 7.3<sup>4</sup>. The actual PCO<sub>2</sub> is not important, only the pH.

Tidal Volumes for Ventilation of Patients with ARDS - ARDSNet ARMA Trial																	
Male Patients					Female Patients												
Height				cc's per Kg													
ft	in	cm	Pre Wt (Kg)	4	5	6	7	8	9	10	4	5	6	7	8	9	10
5'6"	66	168	64	255	320	385	445	510	575	640	180	230	275	320	365	410	455
5'8"	68	173	68	275	340	410	480	545	615	685	200	250	300	350	400	450	500
5'10"	70	178	73	290	365	440	510	585	655	730	220	275	330	385	440	490	545
6'	72	183	78	310	390	465	545	620	700	775	235	295	355	415	475	535	595
6'2"	74	188	82	330	410	495	575	660	740	820	255	320	385	445	510	575	640
6'4"	76	193	87	345	435	520	610	695	780	870	275	345	410	480	550	615	685
6'6"	78	198	91	365	455	550	640	730	825	915	290	365	440	510	585	660	730

PEEP Titration Table - ARDSNet ARMA Trial																	
PEEP	5	5	8	8	10	10	10	12	14	14	14	16	18	18	20	22	24
FiO <sub>2</sub>	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	1	1	1
<-----Move across table to keep SaO <sub>2</sub> 92 – 96 %-----> Patients falling in shaded area are not necessarily too sick for flight but risks and benefits should be considered as described in the CPG.																	

<sup>1</sup>Increasing PEEP can decrease cardiac output and may cause significant hypotension in hypovolemic patients. Additional volume loading may be necessary to maintain hemodynamics.

<sup>2</sup>This is a fairly accurate indicator of plateau pressure in our patient population. Plateau pressure is the correct parameter to follow but it cannot be easily measured with the Impact 731 ventilator.

<sup>3</sup>Measuring the patient's "wingspan" should be used as an estimate of height. Sternum to fingertip multiplied x 2.

<sup>4</sup>A pH of 7.2 may be an appropriate target if hemodynamics are relatively normal.