REVIEW

Mechanical ventilation in patients subjected to extracorporeal membrane oxygenation (ECMO)

M. López Sanchez

Servicio de Medicina Intensiva, Hospital Universitario Marqués de Valdecilla, Santander, Cantabria, Spain

Received 7 November 2016; accepted 14 December 2016
Available online 21 September 2017

KEYWORDS
Mechanical ventilation; Acute respiratory distress syndrome; Extracorporeal membrane oxygenation; Venovenous extracorporeal membrane oxygenation; Lung rest; Protective ventilation; Ultraprotective ventilation; Ventilator induced lung injury; Extracorporeal CO₂ removal; Driving pressure

Abstract
Mechanical ventilation (MV) is a crucial element in the management of acute respiratory distress syndrome (ARDS), because there is high level evidence that a low tidal volume of 6 ml/kg (protective ventilation) improves survival. In these patients with refractory respiratory insufficiency, venovenous extracorporeal membrane oxygenation (ECMO) can be used. This salvage technique improves oxygenation, promotes CO₂ clearance, and facilitates protective and ultraprotective MV, potentially minimizing ventilation-induced lung injury.

Although numerous trials have investigated different ventilation strategies in patients with ARDS, consensus is lacking on the optimal MV settings during venovenous ECMO. Although the concept of “lung rest” was introduced years ago, there are no evidence-based guidelines on its use in application to MV in patients supported by ECMO. How MV in ECMO patients can promote lung recovery and weaning from ventilation is not clear.

The purpose of this review is to describe the ventilation strategies used during venovenous ECMO in clinical practice.

© 2017 Elsevier España, S.L.U. and SEMICYUC. All rights reserved.

Please cite this article as: López Sanchez M. Ventilación mecánica en pacientes tratados con membrana de oxigenación extracorpórea (ECMO). Med Intensiva. 2017;41:491–496.
E-mail address: martalopez@humv.es
PALABRAS CLAVE
Ventilación mecánica; Síndrome de distrés respiratorio agudo; Membrana de oxidación extracorpórea; Membrana de oxidación extracorpórea venovenosa; Lung rest; Ventilación protectora; Ventilación ultraprotectora; Lesión pulmonar asociada a ventilación mecánica; Sistemas depuradores de carbónico; Driving pressure

Introduction

Mechanical ventilation (MV) constitutes the basis of management in patients with acute respiratory distress syndrome (ARDS) and respiratory failure of other origins. To date, only MV with low tidal volume (VT) and limitation of plateau pressure (Pp) has been found to reduce mortality in these patients. In more recent studies, MV in prone decubitus has been observed to improve survival in patients with severe ARDS.

Despite the technological advances in recent years, mortality due to ARDS remains high (40–50%). In the more serious presentations of the syndrome, with PaO2/FIO2 ≤ 100 mmHg, according to the new definition of Berlin, the expectable mortality rate would be 45%, though historically it has been reported that mortality can exceed 60%. However, in a recent study involving 98 patients with ARDS, the in-hospital mortality rate was 37.7%, and did not differ between moderate and severe ARDS. In this regard, mortality was seen to depend on other factors such as Pp > 30 cmH2O during the first 72 h.

Extracorporeal membrane oxygenation (ECMO) allows ventilatory support in the form of venovenous ECMO (VV ECMO) or cardiac and respiratory support through venoarterial ECMO (VA ECMO). The use of ECMO has increased in recent years, fundamentally due to the good outcomes obtained with the technique (particularly with VV ECMO) in the influenza A (H1N1) epidemic, where survival rates of 77% were reached with ECMO in reference centers, and also as a consequence of the technological improvements (use of centrifuge pumps, oxygenation membranes of longer duration), greater biocompatibility of the systems, and lesser anticoagulation needs.

Extracorporeal membrane oxygenation is a rescue strategy in refractory respiratory failure that affords oxygenation and CO2 clearance. However, it also allows us to apply a protective (VT 4–8 ml/kg ideal b.w., Pp < 28–30 cmH2O) or "ultraprotective" ventilation strategy (VT ≤ 4 ml/kg ideal b.w., Pp < 25 cmH2O) in order to minimize ventilator-induced lung injury (VILI). Carbon dioxide removal (ECCO2R) is simpler than VV ECMO, and has been shown to lower the concentration of cytokines at pulmonary level (in bronchoalveolar lavage [BAL]) when ventilating with VT ≤ 6 ml/kg ideal b.w., thereby affording effective elimination of CO2. These systems effectively clear CO2 in patients with hypercapnia of different etiologies, but also allow ultraprotective ventilation in patients with severe ARDS – the benefits of which remain to be determined. In the absence of VV ECMO or ECCO2R, we would be obliged to accept permissive hypercapnia and/or hypoxemia levels that are not clearly established. Nevertheless, although this type of ventilation with VV ECMO or ECCO2R appears promising, no beneficial impact in terms of mortality has yet been established, and currently most centers place priority on weaning from extracorporeal devices versus weaning from the ventilator.

There are no clinical evidence-based guidelines recommending a concrete form of ventilation in patients subjected to VV ECMO, though 77% of the centers with experience apply the "lung rest" concept, with low VT, low respiratory frequency (RF), and high positive end-expiratory pressure (PEEP).

Ventilator-induced lung injury

Ventilator-induced lung injury occurs at four levels. The use of high plateau pressures induces barotrauma; injury derived from ventilation with high VT causes volutrauma; and the activation of certain inflammatory processes in the alveolar endothelial and epithelial cells induced by aggressive MV
Mechanical ventilation in patients subjected to extracorporeal membrane oxygenation

493
gives rise to biotrauma. Furthermore, the cyclic opening and
closing of the alveolar units produces atelectrauma—the lat-
ter being defined as the percentage of collapsed lung that
opens at the end of inspiration and collapses again at the
end of expiration. 14

The lung with ARDS is heterogeneous. Studies involv-
ing thoracic computed tomography (CT) have demonstrated
the existence of areas with collapsed alveoli in dependent
zones and others with ventilated alveoli in non-dependent
zones, which are those that receive most of the VT. The use
of protective ventilation with VT 6 ml/kg produces alveolar
overdistension in almost 30% of all cases of ARDS. 1 Patients
with ARDS and treated with ECMO are intensely hypoxemic,
with large zones of collapsed lung, often affecting all four
lung quadrants. As a result, the ventilated alveoli receive
most of the VT and are subject to overdistension despite
the adoption of protective ventilation measures. 15 However,
it does not seem that VT exclusively plays an important
role in the development of VILI, though we need regional
and dynamic data on pulmonary ventilation and circulation
in patients with ARDS in order to evaluate the application
of different ventilation strategies. In this regard, and in
addition to thoracic CT, electrical impedance tomography
(EIT) affords real-time visioning of regional ventilation and
produces information about how the different ventilatory
parameters affect the lung, with a view to minimizing VILI. 16

The degree to which cyclic alveolar opening and clos-
ing, and alveolar overdistension, contribute to VILI is not
clear. A study involving patients with acute lung injury (ALI)
and ARDS treated with high PEEP measured alveolar inflam-
matory activity using positron-emission tomography (PET)
and alveolar distension with CT at the end of inspiration
and at the end of expiration. Inflammation in the venti-
lated lung regions and in the rest of the lung was related to
Pp > 26–27 cmH 2 O, though no association was found between
metabolic activity and cyclic alveolar opening and closing. 17

The use of high PEEP to improve alveolar recruitment,
minimizing alveolar overdistension, has not been shown to
reduce mortality in patients with ARDS. 18 In patients treated
with ECMO, the use of high PEEP (>10 cmH 2 O) in the first
three days of extracorporeal support was independently cor-
related to a decrease in mortality. 19

Therefore, a protective ventilation strategy should
always be adopted in patients with ARDS with or with-
out ECMO, though we do not know how to use PEEP for
reducing VILI in these individuals, where the existence of
pulmonary heterogeneity is a fact. The increase in PEEP pro-
tects the lungs, provided it is accompanied by a change in
lung mechanics, i.e., the same VT should result in improved
respiratory compliance (C RS ). 20 In this regard, studies
involving high PEEP have not demonstrated benefits in terms
of survival, 21 though PEEP has been shown to offer benefit
in patients with increased lung recruitability. 22

A decrease in driving pressure (△P = VT/C RS ) is the fac-
tor that has been associated to improved survival in ARDS
patients, considering that C RS is closely related to the aer-
at ed lung volume, i.e., functional lung size. 20 Calculated
as Pp-PEEP (cmH 2 O), a decrease in △P is associated to an
improved prognosis, while an increase is associated to a
poorer prognosis.

Mode of mechanical ventilation with
extracorporeal membrane oxygenation

The MV mode to be used in patients subjected to ECMO
has not been established, and no comparative studies are
available. Table 1 shows the different ventilation modes in
patients subjected to VV ECMO, according to the opinion of
different expert sources.

In a recent international study involving 141 centers from
28 countries on all continents and belonging to the Extracor-
poral Life Support Organization (ELSO), most of the centers
(62%) were seen to use controlled MV modes, while only
27% used assist modes in patients with VV ECMO. 13 In
the international study recently published by Camporota et al.,
involving 133 surveyed centers, the pressure control mode
was used in 64.4% of the centers, the pressure assist mode
in 47.3%, bilevel positive airway pressure (BIPAP) in 17.1%,
volume control mode in 11.6%, airway pressure release ve-
nilation (APRV) in 4.6%, and neurally adjusted ventilatory
assist (NAVA) and high-frequency ventilation in 1% of the
centers. 23 Lastly, in a multicenter study in three hospitals in
Australia and France, 55% of the patients subjected to ECMO
(VV ECMO the 98% of the cases) received pressure control
modes. 19

In general, pressure modes allow daily monitoring of VT,
providing information on the improvement or worsening of
lung compliance, and make it possible to increase VT to at
least 6 ml/kg for starting weaning from VV ECMO. The incon-
venience is that the limitation of VT may prove difficult in
assist mode. 24 The APRV mode requires spontaneous ventila-
tion of the patient, and may be an alternative to the pressure
control mode in patients with spontaneous ventilation. 15

In the early stages of ARDS it is more difficult to main-
tain spontaneous ventilation, and the patient is often under
neuromuscular block. After this phase, spontaneous ventilation
allows respiratory muscle and diaphragmatic training, with a
decrease in the sedation requirements, though when poorly
applied it can worsen patient-ventilator asynchrony. 24 The

<table>
<thead>
<tr>
<th>Source</th>
<th>MV objective</th>
<th>MV mode</th>
<th>VT</th>
<th>Pp</th>
<th>PEEP (cmH 2 O)</th>
<th>RF (rpm)</th>
<th>PEEP</th>
<th>FiO 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELSO guides 2013 25</td>
<td>Lung rest</td>
<td>PCV</td>
<td>-</td>
<td>&lt;25</td>
<td>10–15</td>
<td>5</td>
<td>&lt;0.4</td>
<td></td>
</tr>
<tr>
<td>European Network of MV (REVA) 27</td>
<td>Lung rest</td>
<td>VCV</td>
<td>-</td>
<td>&lt;20–25</td>
<td>≥10</td>
<td>6–20</td>
<td>0.3–0.5</td>
<td></td>
</tr>
<tr>
<td>Consensus Conference ECMO 26</td>
<td>Lung rest</td>
<td>-</td>
<td>-</td>
<td>Minimize Pp</td>
<td>Minimum PEEP</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

PEEP: positive end-expiratory pressure; Pp: plateau pressure; FiO 2 : inspired fraction of oxygen; RF: respiratory frequency; REVA: Réseau Européen de Recherche en Ventilation Artificielle; PCV: pressure control ventilation; VCV: volume control ventilation; MV: mechanical ventilation; VT: tidal volume.
NAVA mode in patients subjected to ECMO reduces patient-ventilator asynchrony in the lung function recovery phase.\textsuperscript{25}

**Tidal volume and plateau pressure with extracorporeal membrane oxygenation**

Of the centers belonging to the ELSO, and with regard to the Vt used, 76% claimed to ventilate their patients with Vt $\leq 6$ ml/kg, while 21% specified no Vt value during support with VV ECMO.\textsuperscript{13} In animals, a reduction of Vt $< 4$ ml/kg ideal b.w. has been associated with a decrease in lung edema and injury.\textsuperscript{26} In the Xravent multicenter study, "ultraprotective ventilation" with ECO2R versus protective ventilation did not result in a decrease in the days of MV, though a reduction of alveolar interleuking-6 levels was observed,\textsuperscript{12} as previously reported.\textsuperscript{10} In the post hoc analysis, in the group of patients with PaO$_2$/FiO$_2$ $\leq 150$ mmHg, a decrease was recorded in the days of MV in the group subjected to ECO2R (40.9 ± 12.8 vs 28.2 ± 16.4; $p = 0.033$).\textsuperscript{12}

According to a recent systematic review involving 2042 patients in 49 studies, the tendency is to use an "ultraprotective" strategy, ventilating with Vt $\leq 4$ ml/kg in order to limit Pp to $\leq 30$ cmH$_2$O. This practice possibly reflects the impossibility of maintaining adequate ventilation without a risk of lung injury before starting extracorporeal support.\textsuperscript{15} In another international survey, 31% of the centers were seen to ventilate patients with ECMO using an "ultraprotective" strategy.\textsuperscript{13} According to different studies, the way in which we use MV during support with VV ECMO appears to have an impact upon mortality.\textsuperscript{15,26,27} The study published by Pham et al. shows the reduction of Pp on the first day of ECMO to be independently associated to lowered mortality.\textsuperscript{28} Likewise, in an international multicenter study, one of the predictors of mortality in patients treated with ECMO was Pp $> 30$ cmH$_2$O before introducing ECMO.\textsuperscript{19}

The Predicting death for severe ARDS on v-ECMO (PRESERVE) mortality risk score takes 8 pre-ECMO parameters into account in predicting the probability of survival in patients with severe ARDS treated with VV ECMO. Patient age, body mass index, immunosuppression, the use of prone decubitus, the days of MV, the SOFA score, PEEP and Pp $> 30$ cmH$_2$O were the calculated parameters.\textsuperscript{29}

There are no recommendations on how to proceed in lowering Vt once VV ECMO support has been started. A reduction in the first 1–3 days of support to $< 4$ ml/kg ideal b.w. could be proposed.\textsuperscript{19} In a recent study, only the parameter Pp $\leq 31$ cmH$_2$O was associated to in-hospital survival.\textsuperscript{30}

**Positive end-expiratory pressure with extracorporeal membrane oxygenation**

In patients with ARDS, PEEP is used to maintain alveolar recruitment, improve oxygenation and prevent VILI (atelectrauma with cyclic alveolar opening and closing). However, alveolar overdistension and the increase in right ventricular afterload are deleterious effects of the indiscriminate use of PEEP.

The PEEP level to be used in patients treated with ECMO is subject to controversy. The reduction of Vt, particularly when "ultraprotective ventilation" is used (Vt $< 4$ ml/kg ideal b.w.), can produce atelectasis with worsening of the ventilation/perfusion ratio. The ELSO therefore recommends a PEEP level of 10 cmH$_2$O, in contrast to the protocol established by Richard et al. in the Consensus Conference, where the recommendation is simply to use "minimum PEEP" for "minimum Pp" (Table 1). Higher PEEP levels could cause alveolar overdistension,\textsuperscript{18} as well as reduce venous return in patients with VV ECMO and worsen right ventricular function in VA ECMO.\textsuperscript{19}

In patients with VV ECMO, PEEP is not necessary to improve oxygenation, except in intensely hypoxemic individuals or cases requiring high blood flows (>5 l/min) during support (e.g., septic shock patients). In contrast to VV ECMO, the ECCO2R systems require PEEP and FiO$_2$ in the respirator in order to improve oxygenation, since they operate with a much lower blood flow than VV ECMO, and CO$_2$ clearance is fundamentally dependent upon the flow of gas.\textsuperscript{11,13,12}

In ECMO, the use of high PEEP levels would favor alveolar recruitment, which in turn could accelerate lung recovery through the prevention of capillary loss and macrophage activation generated in lung hypoxemic regions induced by the presence of atelectasis.\textsuperscript{10,18,33}

In an international survey involving 133 centers, 63% used a fixed PEEP level, 21% introduced adjustments according to compliance, 9.3% did so according to the radiological findings, and 7.3% introduced adjustments according to EIT. In turn, 34.9% of the centers used PEEP $\geq 10$ cmH$_2$O, while 27.9% used PEEP levels below this value. Only 15.5% used PEEP 15–20 cmH$_2$O.\textsuperscript{33}

As has been commented above, in a retrospective study, the use of PEEP $< 10$ cmH$_2$O during the first three days of treatment with ECMO was associated to increased mortality. On the other hand, in a more recent retrospective study involving 62 patients, a one-point PEEP increment was seen to be associated to a 36.2% decrease in the odds ratio for survival 30 days after discharge (95%CI 10.8–54.4%; $p = 0.009$)(PEEP survivors 8.5 ± 2, survivors 7.3 ± 2; $p = 0.04$).\textsuperscript{10} In patients exposed to increased overdistension, the effect of PEEP may prove deleterious, and in patients with more recruitable areas we could perhaps use higher PEEP levels.\textsuperscript{34}

It therefore would be very difficult to recommend a PEEP level in these patients. Table 1 shows the different recommendations of groups of experts. The latest ELSO guides warn that “in patients with respiratory failure and ECMO, it could be a mistake to try to recruit lung volume in the early stages”. This would speak in favor of the risk of pulmonary overdistension in certain patients, recommending PEEP levels of between 5 and 15 cmH$_2$O.\textsuperscript{36} In the same sense, according to the only European Consensus Conference on ECMO of 2014, the recommendation for ventilating ARDS patients with ECMO would be to “adjust MV to minimize Pp while we apply minimum PEEP".\textsuperscript{36} In patients with ARDS due to influenza A (H1N1), the Réseau Europeen de Recherche en Ventilation Artificielle (REVA) recommended lowering Vt to maintain Pp $\leq 20–25$ cmH$_2$O, with the application of PEEP $\geq 10$ cmH$_2$O.\textsuperscript{37}

As has been commented above, driving pressure ($\Delta P = Pp - PEEP$) is the factor that has been associated to improved survival in ARDS patients.\textsuperscript{30} In patients with ECMO, previous studies have shown high $\Delta P$ to be associated to
poorer survival. In a recent study carried out to assess the association among the different ventilatory parameters during ECMO indicated for refractory hypoxemia in ARDS, the authors concluded that increased ΔP is the only ventilatory parameter during ECMO showing an independent association to in-hospital mortality in these patients. In this study, Serpa-Neto et al. included 545 patients from 9 studies, where in addition to ΔP, advanced age, the male sex and a low body mass index were also seen to be independently associated to mortality.

Respiratory frequency

The RF to be used in patients subjected to ECMO has likewise not been established. The ELSO recommended a low RF (4–5 rpm) to avoid mechanical lung "stress", though in general the range is between 4 and 30 rpm as evidenced by the literature. In general, the adjustment of RF aims to ensure maintenance of the arterial pH, but this concept changes in patients subjected to VV ECMO, where maintenance of the arterial pH and PaCO2 are directly dependent upon the flow of gas in the oxygenation membrane. In this context, PaCO2 is to be slowly reduced once support has been started, with a gas/blood flow of 1:1 in ECMO.

In a recent international survey, 55% of the centers ventilated their patients subjected to ECMO with a RF of 5–10 rpm, possibly reflecting a tendency to ventilate with lower RF as in the "lung rest" model proposed byGattinoni et al. years ago, and in which ventilation with a low RF (3–5 rpm) and a low peak inspiratory pressure with an ECCO2R system in patients suffering severe ARDS of pulmonary origin resulted in improved lung function in 72.8% of the patients. In this regard, the latest recommendations of the ELSO are to "use MV with low parameters in order to allow lung rest".

Fraction of inspired O2 in patients with extracorporeal membrane oxygenation

It is clear that in order to minimize VILI we must lower FiO2 to minimum levels, with the purpose of maintaining SatPO2 > 80% in VV ECMO, or between 84 and 88% according to the different groups.

Conclusions

In patients with ARDS, MV with the reduction of Pp has been shown to reduce mortality. However, there are no clear evidences, guides or recommendations on how to ventilate patients subjected to ECMO. A decrease in driving pressure has been associated to improved in-hospital survival among patients with severe ARDS treated with ECMO. The monitoring of this MV parameter therefore could be recommended in the same way as in patients without ECMO.

Since extracorporeal systems oxygenate and clear CO2, protective and "ultraprotective" MV is possible, and would allow a reduction of VILI in these patients. The lowering of Vt (<4 ml/kg ideal b.w.), Pp (<25 cmH2O), PEEP (5–15 cmH2O) and RF allows us to maintain lung rest, avoiding alveolar overdistension, biaima and atelectrauma. Further studies are needed to demonstrate the impact of this ventilatory strategy upon the mortality of patients with severe ARDS treated with VV ECMO or ECCO2R systems.

Conflicts of interest

There are no conflicts of interest.

Acknowledgements

None.

References


