

**FERNANDO FRUTOS-VIVAR, MD**Intensive Care Unit, Hospital Universitario de Getafe,
Madrid, Spain**ANDRÉS ESTEBAN, MD, PHD**Intensive Care Unit, Hospital Universitario de Getafe,
Madrid, Spain

When to wean from a ventilator: An evidence-based strategy

ABSTRACT

It is often unclear when and how to wean patients from mechanical ventilation. We have devised an evidence-based protocol in which patients undergo a 30-minute trial of spontaneous breathing with a T tube or pressure support of 7 cm H₂O. Those who can tolerate the trial are extubated, while those who cannot are reconnected to mechanical ventilation but undergo another trial every day until they can be extubated. More study is needed to improve the criteria to predict successful spontaneous breathing and extubation, and to clarify the role of non-invasive ventilation to avoid reintubation.

KEY POINTS

Intensive care units should set up protocols for daily assessment by nurses and respiratory therapists to determine when patients are ready to start the weaning process.

Trials of spontaneous breathing can be conducted by T tube or pressure support and should last only 30 minutes.

If a patient fails the spontaneous breathing trial, wait 24 hours to try again.

Successful extubation is likeliest for patients with a strong cough and minimal endotracheal secretions.

HOW CAN WE BEST determine when a patient is ready to be weaned from mechanical ventilation, and what is the best weaning technique?

The questions are important, as about 30% of patients admitted to intensive care units require mechanical ventilation.¹ If weaning is delayed, costs are increased, as are the risks of nosocomial pneumonia, cardiac-associated morbidity, and death. On the other hand, weaning too soon often results in reintubation, which is associated with complications similar to those of prolonged ventilation.²

Yet, until recently, weaning has been done mostly on an empiric basis.

In the past few years, our group—the Spanish Lung Failure Collaborative Group—and others have been conducting clinical trials aimed at establishing an evidence-based approach to weaning. The findings are extensively reviewed in guidelines from the American College of Chest Physicians, the American Association for Respiratory Care, and the American College of Critical Care Medicine.³

This article discusses our algorithm (FIGURE 1) and issues for further research.

STEP 1: ASSESS READINESS FOR WEANING

Weaning begins when we recognize that the patient has recovered adequately from acute respiratory failure. Thereafter, clinical assessments are needed to determine the patient's readiness for discontinuation of ventilatory support and extubation.

Research suggests that the best way to know when weaning should start is to use a formal protocol managed by nurses, respiratory therapists, or both.^{4–10} The studies used a vari-

Is the patient ready to be weaned from the ventilator? An algorithm

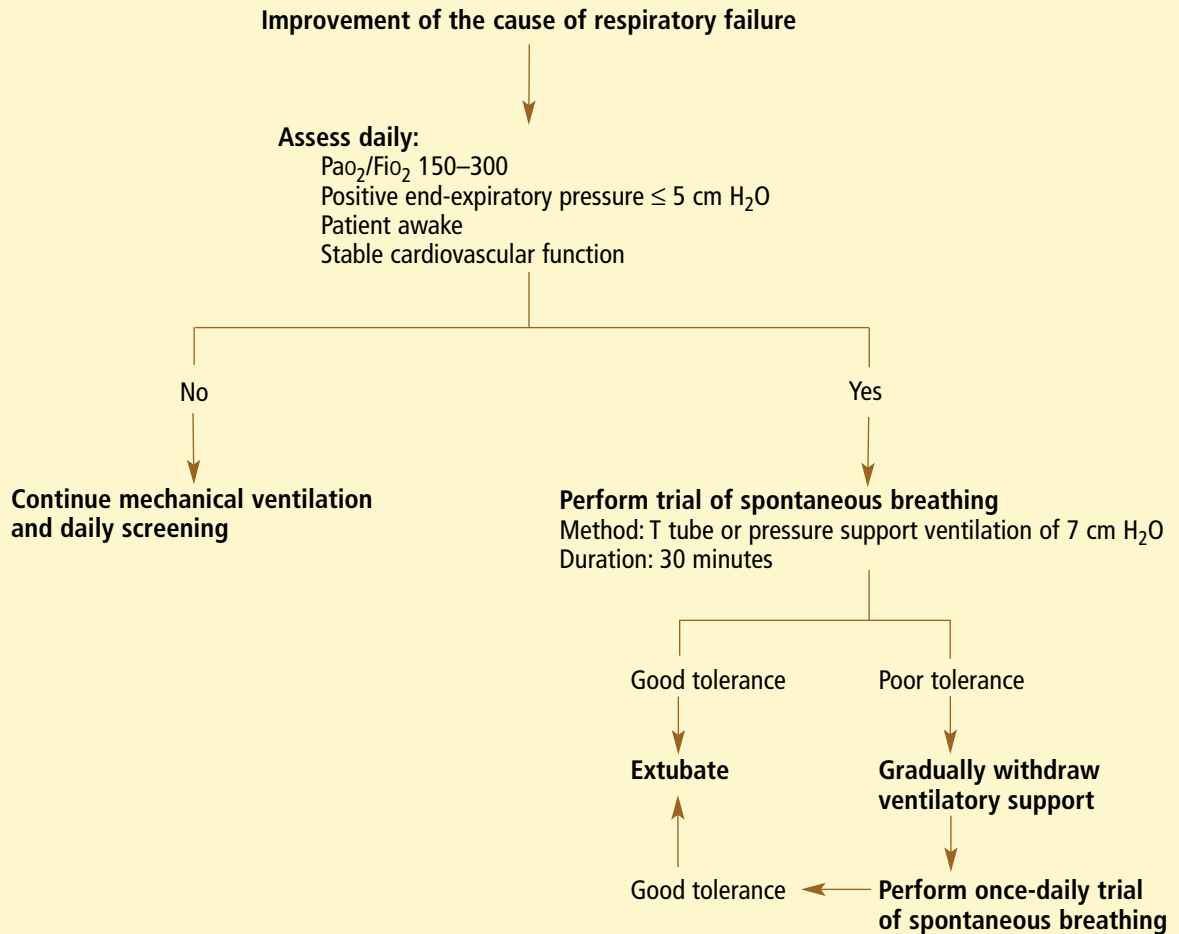


FIGURE 1

ety of clinical criteria for determining readiness for weaning, including oxygenation, hemodynamic stability, temperature, hemoglobin, and mental status (TABLE 1); a weakness of the studies was that the criteria were arbitrarily set by the researchers.

Unresolved issues about readiness for weaning

Questions remain about:

- **Oxygenation.** What is the $\text{PaO}_2/\text{FiO}_2$ threshold that best discriminates patients who are able to tolerate spontaneous breathing?¹¹ Should the level be the same for patients with chronic hypoxemia?
- **Hemoglobin level.** Is a hemoglobin level of 8 g/dL high enough, or is 10 g/dL necessary?¹¹

- **Mental status.** Is it necessary to maintain ventilatory support until the patient is arousable? A recent descriptive study¹² observed that 10 (91%) of 11 patients with severe brain injury (Glasgow coma scale ≤ 4) could be successfully extubated. This finding needs to be confirmed in a randomized controlled study.

STEP 2: PERFORM A TRIAL OF SPONTANEOUS BREATHING

If the patient seems ready for weaning, the next step is to give him or her a short trial of spontaneous breathing.

T tube or pressure support?

Trials of spontaneous breathing are tradition-

**TABLE 1****Criteria for starting weaning****Adequate oxygenation**

$\text{PaO}_2 \geq 60$ mm Hg on $\text{FiO}_2 \leq 0.4$
($\text{PaO}_2/\text{FiO}_2 = 150\text{--}300$) with positive
end-expiratory pressure ≤ 5 cm H_2O

Hemodynamic stability

No myocardial ischemia
or significant hypotension

Temperature $< 38^\circ\text{C}$ **Hemoglobin $\geq 8\text{--}10$ g/dL****Adequate mental status**

Patient awake or easily aroused

TABLE 2**Criteria to determine success
of a trial of spontaneous breathing****Objective criteria**

$\text{SaO}_2 > 90\%$ or $\text{PaO}_2 > 60$ mm Hg on $\text{FiO}_2 < 0.4\text{--}0.5$
Increase in $\text{Paco}_2 < 10$ mm Hg or decrease in pH < 0.10
Respiratory rate < 35 breaths/minute
Heart rate < 140 or increased $< 20\%$ from baseline
Systolic blood pressure $> 80\text{--}160$ mm Hg
or change $< 20\%$ from baseline

Subjective criteria

No signs of increased work of breathing, including thoracoabdominal
paradox or excessive use of accessory respiratory muscles
No other signs of distress, such as diaphoresis or agitation

ally done with a T-tube system. However, one could argue that some patients fail this test because they must work harder to breathe through the endotracheal tube.

Therefore, some investigators advocate using pressure support to counteract this extra work.^{13,14} The mean value of pressure support needed to compensate for the increased work of breathing caused by the ventilatory circuit and the endotracheal tube was found to be 7 cm H_2O (range 4–10).¹⁵

The Spanish Lung Failure Collaborative Group² conducted a study in adult patients to compare the use of a T tube vs pressure support (7 cm H_2O) in trials of spontaneous breathing. Although more patients in the T-tube group failed the trial (22% vs 14%; $P = .03$), there was no difference in the percentage of patients who remained extubated after 48 hours (63% in the T-tube group vs 70% in the pressure support group; $P = .14$).

Farias et al¹⁶ performed a comparable study in children. The rates of successful extubation were similar after a first breathing trial performed with pressure support (10 cm H_2O) or a T tube.

30 Minutes are enough

Trials of spontaneous breathing usually last 2 hours, but patients who fail usually show signs of poor tolerance earlier.^{2,17–20} The Spanish Lung Failure Collaborative Group²¹ conducted a prospective, multicenter study in 526 ventilator-supported patients to compare trials of

spontaneous breathing lasting 30 or 120 minutes. The percentage of patients who remained extubated for 48 hours did not differ between the two groups (75.9% vs 73.0%, $P = .43$).

**Unresolved issues about
spontaneous breathing trials**

- **What constitutes ‘success’?** The criteria for determining whether a trial of spontaneous breathing is a success or failure are similar to those for determining the patient’s readiness for weaning (TABLE 2). However, the utility and accuracy of these criteria need to be assessed.

- **Are arterial blood gas measurements useful?** If a trial of spontaneous breathing is successful, can arterial blood gas measurements help in deciding whether to go to the next step of withdrawing the endotracheal tube?

- **Can CPAP help?** Patients with chronic obstructive pulmonary disease or asthma have auto-positive end-expiratory pressure (auto-PEEP). Can continuous positive airway pressure (CPAP) improve their tolerance to a spontaneous breathing trial?

■ IF THE TRIAL FAILS**Gradual discontinuation
of ventilatory support**

Up to 35% of patients cannot tolerate their first trial of spontaneous breathing. For these patients we have different techniques to facilitate the gradual transition from mechanical

Criteria for weaning have been arbitrary and must be validated

ventilation to spontaneous breathing, using a T tube, pressure support ventilation, or synchronized intermittent mandatory ventilation.

A systematic review²² of four studies^{23–26} that compared two or more of these techniques found none of them superior to the others, although synchronized intermittent mandatory ventilation may lead to a longer weaning process.

Wait 24 hours before another trial

We recommend waiting 24 hours before attempting a new trial of spontaneous breathing.

Jubran and Tobin¹⁹ showed that failures are often due to persistent mechanical alterations in the respiratory system that are unlikely to rapidly reverse. A failed trial can precipitate respiratory muscle fatigue,²⁷ and studies in healthy subjects suggest that complete recovery from fatigue can take longer than 24 hours.²⁸

In addition, Esteban et al²⁶ showed that multiple daily breathing trials offer no advantage over a once-daily trial.

Unresolved issues about gradual weaning

- **Is gradual weaning better?** New modes of weaning such as bilevel positive airway pressure and pressure support should be compared with once-daily trials of spontaneous breathing.
- **Can noninvasive ventilation help?** In two studies,^{29,30} patients in whom a trial of spontaneous breathing failed were immediately extubated and managed with noninvasive ventilation (ie, using a mask); results were good, but perhaps not for all patients.
- **A role for computers?** Can a computerized algorithm reduce the patient's time on the respirator?

■ STEP 3: EXTUBATION

The decision to remove the endotracheal tube should be based on an assessment of airway

patency and the ability of the patient to protect the airway.

No variable has yet been identified that predicts which patients will have to be reintubated. However, upper airway obstruction following extubation is associated with longer duration of mechanical ventilation, female gender, trauma, and repeated intubations.³¹

Cuff-leak test

Several studies evaluated the amount of air that leaks when the cuff of the endotracheal tube is deflated as a predictor of stridor after extubation. In one study, a cuff leak of less than 110 mL identified patients at risk for stridor.³² However, a positive cuff-leak test, defined as no air leakage, did not predict extubation failure in another study.³³

Cough strength and secretions

Most important for successful extubation is the patient's ability to protect the airway by coughing and clearing it of secretions.

In a recent study,¹¹ the probability of successful extubation was highly positively correlated with cough strength and inversely correlated with the amount of secretions in the airway. Patients with moderate to strong coughs were four times more likely to be extubated successfully than those with weak coughs, and those with no or mild secretions were more than eight times as likely to be extubated successfully than those with moderate to abundant secretions. Poor cough strength and greater secretions were synergistic in predicting extubation failure.

Unresolved issues in extubation

- What variables best predict extubation success?
- Can the value of the cuff-leak test be confirmed?
- What is the role of noninvasive ventilation to avoid reintubation?

Risk for airway obstruction:

- Longer ventilation
- Female
- Trauma
- Repeated intubation

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ADDRESS: Andrés Esteban, MD, PhD, Intensive Care Unit, Hospital Universitario de Getafe, Carretera de Toledo km 12,500, 28905-Getafe, Madrid, Spain; e-mail aesteban@hug.es.