



COVID-19 DOPO OLTRE 3 ANNI, COME È CAMBIATO

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CONFLICTS OF INTEREST



NONE

DO WE STILL NEED THE **INTENSIVIST**?

IN OTHER WORDS: WHAT AM I DOING HERE?

- **PNEUMONIA IN IMMUNOCOMPROMISED**
- **PNEUMONIA IN UNVACCINATED**
- **PNEUMONIA IN COMORBID PATIENTS**
- **“INCIDENTAL” COVID IN CRITICALLY ILL**
- **WE MAY STILL NEED INTENSIVISTS**



THERE IS A **TIME** WINDOW FOR **NON-INVASIVE** SUPPORT

BROCHARD L., SEMIN RESPIR CRIT CARE MED. 2014;35(4):492-500.

Papoutsi et al. *Crit Care* (2021) 25:121
<https://doi.org/10.1186/s13054-021-03540-6>

Critical Care

RESEARCH

Open Access

Effect of timing of intubation on clinical outcomes of critically ill patients with COVID-19: a systematic review and meta-analysis of non-randomized cohort studies



Conclusions: The synthesized evidence suggests that timing of intubation may have no effect on mortality and morbidity of critically ill patients with COVID-19. These results might justify a wait-and-see approach, which may lead to fewer intubations. Relevant guidelines may therefore need to be updated.

WE BETTER INVESTIGATED THE EFFECTS OF **NRS FAILURE**

BALL L ET AL., RESP PHYSIOL NEUROBIOL 2022

Critically ill COVID-19
patients who failed
helmet CPAP and required
intubation (n = 52)

The ICU mortality in the **very late**
(> 7 days of h-CPAP) compared to the
early-intermediate intubation group was 12/16
(75%) versus 16/36 (44%), $p = 0.07$

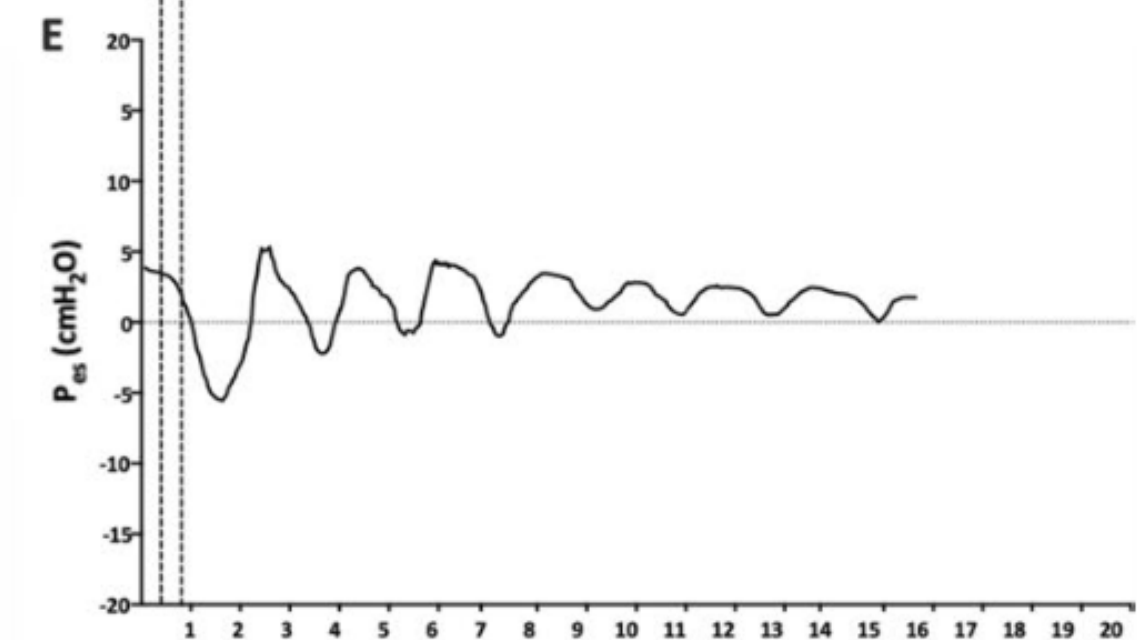
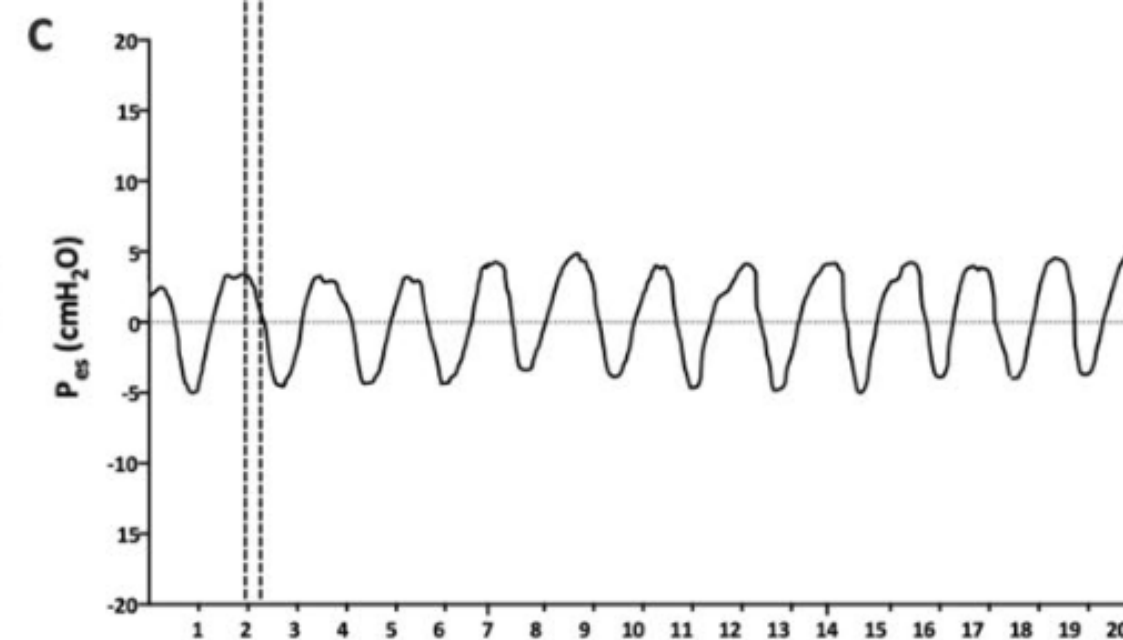
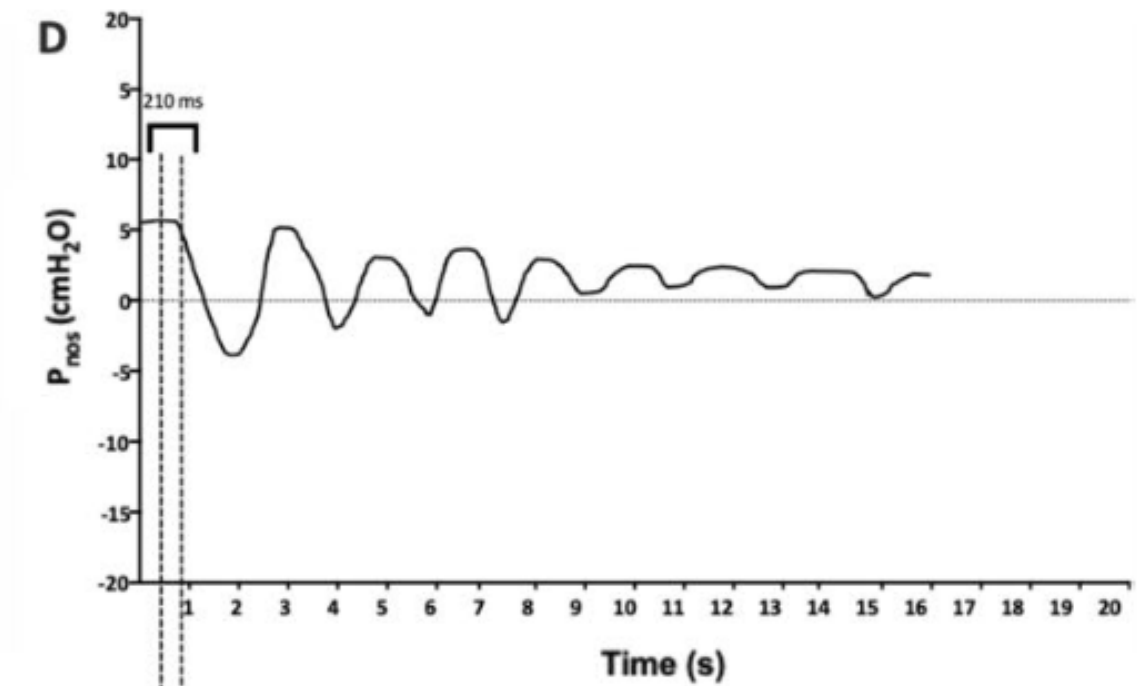
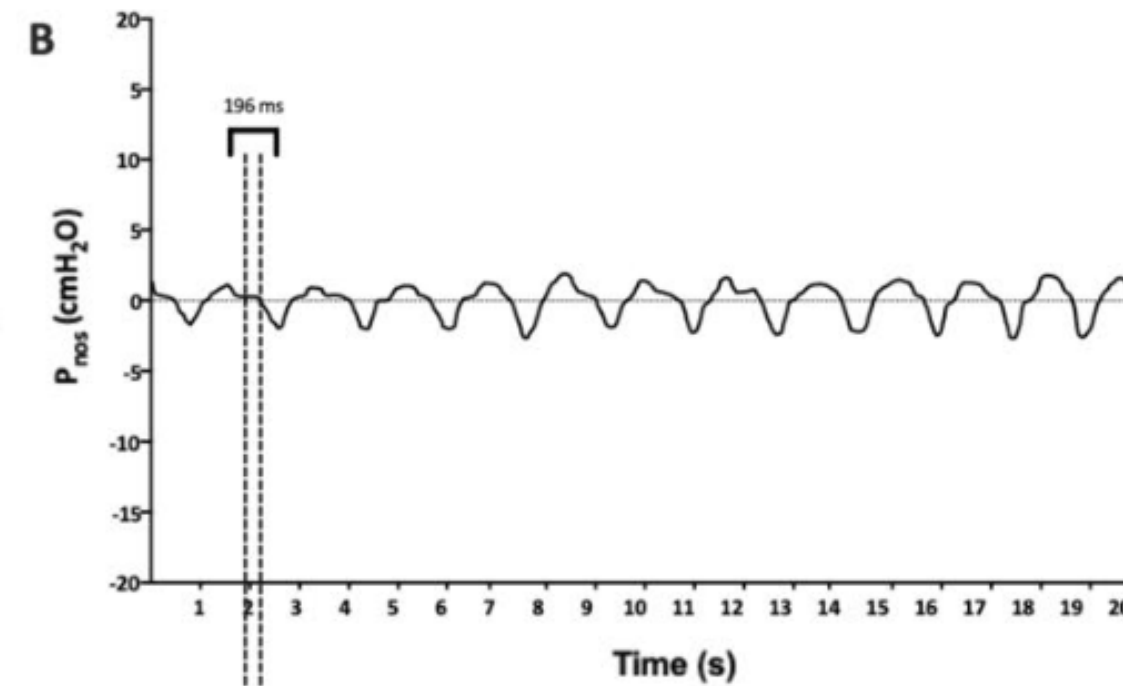
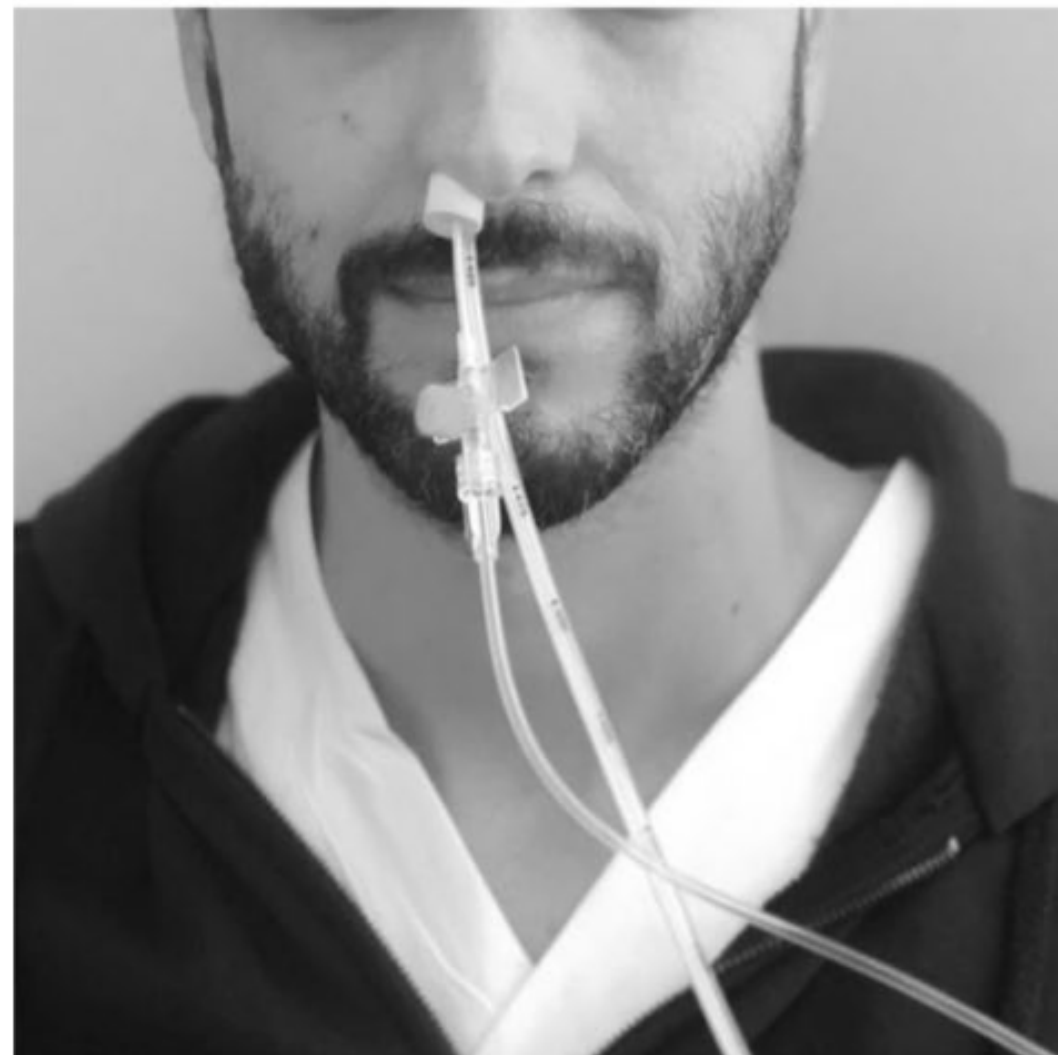


CAN WE ESTIMATE INSPIRATORY EFFORT **NON-INVASIVELY?**

BATTAGLINI D. ET AL., BR J ANAESTH. 2021 SEP;127(3):353-364.

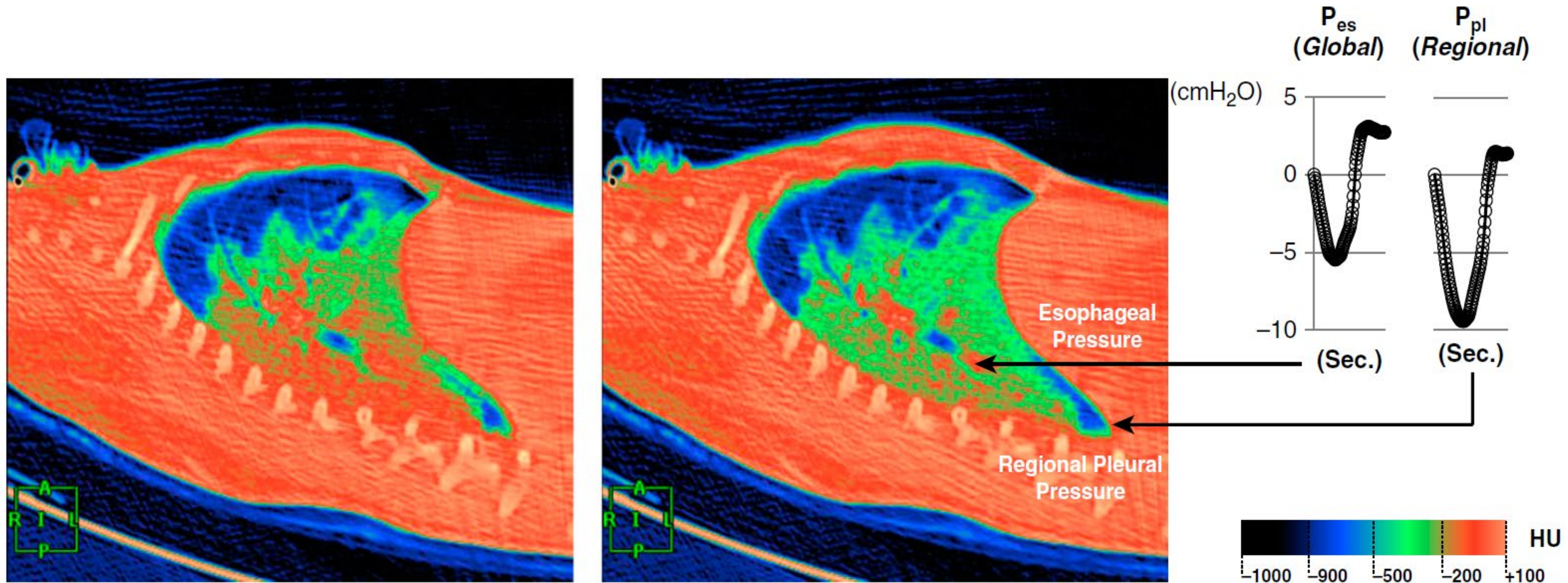
TONELLI R ET AL., CRITICAL CARE 2022

A



RESEARCH QUESTION: CAN I USE **INTRA-TIDAL** P_{NOS} VARIATIONS?

YOSHIDA T ET AL., AM J RESP CRIT CARE MED 2017



CAN ΔP_{NOS} PREDICT THE NEED FOR INTUBATION?

TONELLI, BALL ET AL. AJRCCM 2023

Variable	Overall n=102	Failure n=35	Success N=67	p
Age, years (IQR)	69 (56–75)	67 (56–78)	70 (56–75)	0.6
Diagnosis				
COVID-19, n (%)	91 (89.2)	33 (94.3)	58 (86.6)	0.3
Non COVID-19, n (%)	11 (10.7)	2 (5.7)	9 (13.4)	0.3
Baseline				
PaO ₂ /FiO ₂ , mmHg (IQR)	133 (115–152)	125 (102–141)	140 (123–160)	0.1
ΔP_{es} , cmH ₂ O (IQR)	13.5 (11–16.3)	15.2 (12.6–18)	12.2 (10–15.8)	0.04
ΔP_{nose} , cmH ₂ O (IQR)	6 (4.6–8)	6.8 (5.6–8.2)	5.6 (4.2–7)	0.03
At 2 hours after HFNO				
ROX index, score (IQR)	7.9 (5.9–10.9)	5.6 (5.2–6)	9.2 (8–11.6)	<0.0001
PaO ₂ /FiO ₂ , mmHg (IQR)	131 (112–152)	111 (101–127)	144 (130–175)	<0.0001
ΔP_{es} , cmH ₂ O (IQR)	8 (6–14)	16 (14–17)	6.5 (5–8)	0.010
ΔP_{nose} , cmH ₂ O (IQR)	3.2 (2.7–6)	7 (6–8)	3 (2.1–3.2)	<0.0001

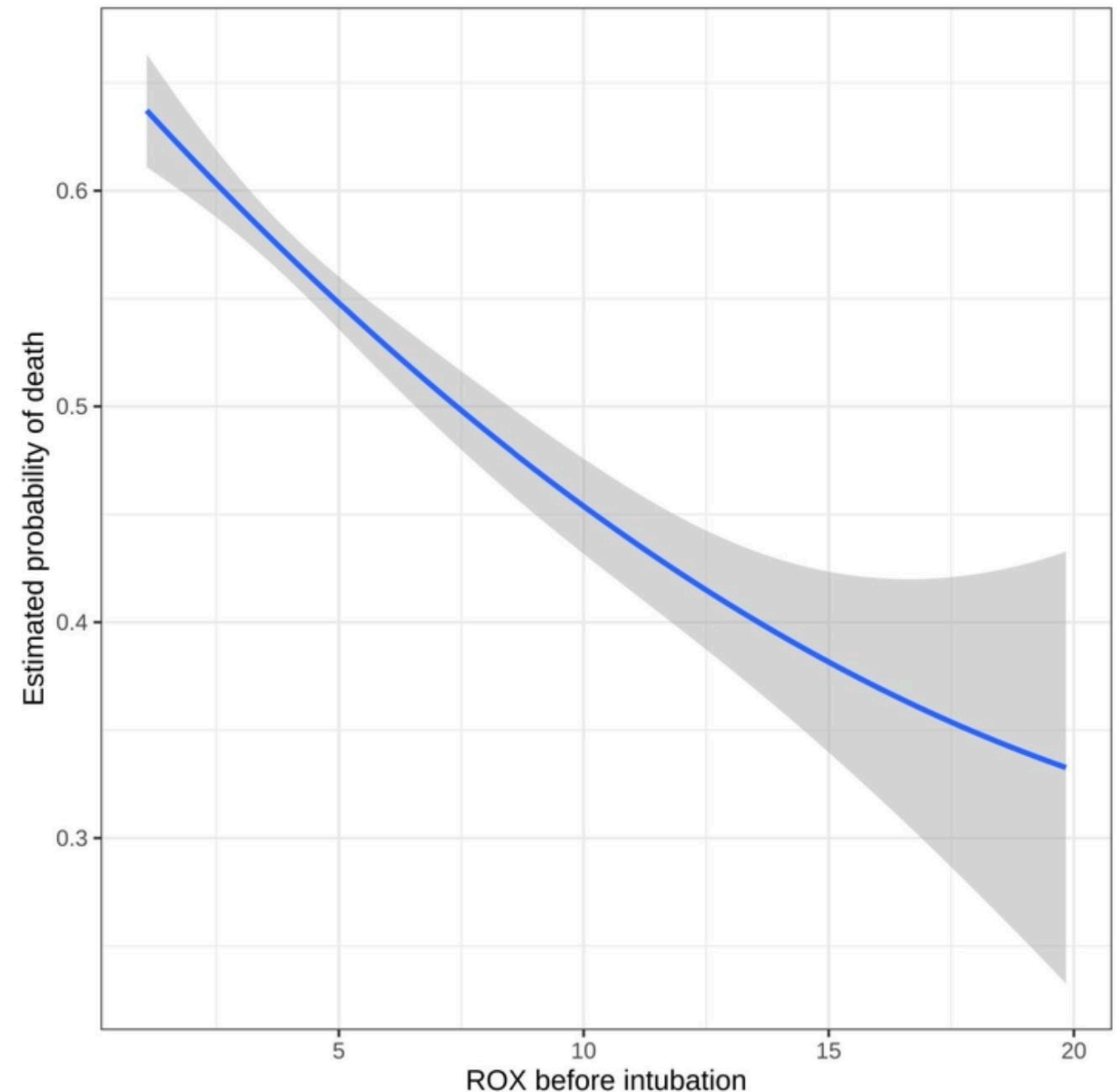
DO WE HAVE SIMPLE CLINICAL TOOLS?

VEST MT ET AL., RESPIR CARE. 2022 MAR 17

$$ROX = \frac{SpO_2/FiO_2}{RR}$$

Analysis Sample of 1087 patients

“Among a cohort of COVID-19 subjects who were ultimately intubated, higher ROX at time of intubation was positively associated with survival.”





KEEP CALM

AND...

IT'S ARDS

YES, BUT....

- ***A VERY HOMOGENEOUS **SUBGROUP** OF ARDS***
- ***WITH INITIALLY HIGHER **COMPLIANCE*****
- ***WITH EARLY DIFFUSE **VASCULAR** INVOLVMENT***

- ***NEED FOR STRICT RESPIRATORY MONITORING!***

COMMENTARY

Open Access

Isn't it time to abandon ARDS? The COVID-19 lesson

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³⁵**Br**eaking

²⁷**Co**VID