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Proning and Escalation: COVID-19 Clinical Practice Guideline

- Prone early:
    - We recommend early proning in severe ARDS without vasodilator trial< 36 hours from ARDS onset, start discussion of prone when P:F< 150, prone within 12 hours of FiO2 > 75%
- Eligibility criteria for proning:
    - No high grade shock (either single agent norepinephrine 20 mcg/min or norepinephrine< 15 mcg/min and vasopressin)
    - Not on CRRT or at risk of impending renal failure (due to difficulties in maintaining dialysis access while proned)
    - The only absolute contraindications to proned ventilation are spinal cord injury and open chest; BMI and patient size are not contraindications

Managing a proned patient

- Proning as per Proning SOP on Clinician Portal
- Maintain deep sedation with target RASS -4 to -5 while proned
- Adjust oxygen parameters: re-assess lung mechanics (plateau pressure and P-V tool to determine optimal PEEP) and adjust PEEP and titrate FiO2
- Assess tidal volume and adjust ventilation parameters .If Vt< 6 ml/kg, may increase to maximum limit of 8 ml/kg while Ppl< 30 (preferred maximum is 6 ml/kg)
- If patient demonstrates improvement on proning then recommend discontinuing continuous neuromuscular blockade and re-assess ventilator dyssynchrony; re-institute if dyssynchronous
- Return to supine ventilation when following criteria are met:
    - Ppl < 25
    - FiO2 < 50%
    - pH> 7.3
    - P:F> 200

Escalation if still hypoxic

- If despite PEEP optimization, paralysis, prone ventilation, optimizing volume status, pulmonary vasodilators (when available) the patient meets the following criteria, and then consider ECMO/cardiology consult
    - Ppl> 30
    - FiO2 > 75%
    - P:F< 80

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