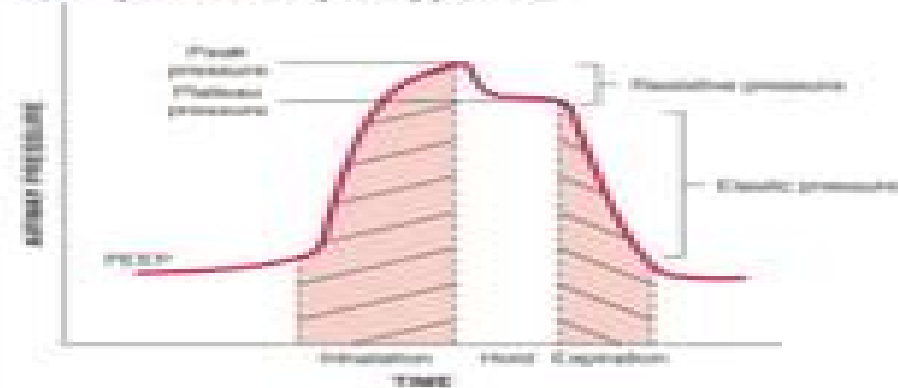


Components of airway pressure during mechanical ventilation, illustrated by an inspiratory-hold maneuver

SPG12P = postulated small-expenditure potentials.



Elastic pressure is the product of the elastic recoil of the lungs and chest wall (elastance) and the volume of gas delivered. For a given volume, elastic pressure is increased by increased lung stiffness (as in pulmonary fibrosis) or restricted excursion of the chest wall or diaphragm (eg, in tense ascites or muscle rigidity). Because elastance is the inverse of compliance, high elastance is the same as low compliance.

End-expiratory pressure in the alveoli is normally the same as atmospheric pressure. However, when the alveoli fail to empty completely because of airway obstruction, airflow limitation, or shortened expiratory time, end-expiratory pressure may be positive relative to the atmosphere. This pressure is called **intrinsic PEEP** or **autoPEEP** to differentiate it from externally applied (therapeutic) PEEP, which is created by adjusting the mechanical ventilator or by placing a tight-fitting mask that applies positive pressure throughout the respiratory cycle.

Any elevation in peak airway pressure (e.g., > 25 cm H₂O) should prompt measurement of the end-inspiratory pressure (plateau pressure) by an end-inspiratory hold maneuver to determine the relative contributions of resistive and elastic pressures. The maneuver begins, the inflation valve closed for an additional 0.3 to 0.5 sec after inspiration, delaying exhalation. During this time, airway pressure falls from its peak value as airflow ceases. The resulting end-inspiratory pressure represents the elastic pressure since PEEP is subtracted (assuming the patient is not making active inspiratory or expiratory muscle contractions at the time of measurement). The difference between peak and plateau pressure is the resistive pressure.

Elevated relative pressure (eg, > 10 cm H₂O) suggests that the endotracheal tube has been kinked or plugged with secretions or that an intraluminal mass or foreign body is present.

Increased elastic pressure (e.g., = 10 atm H_2O) suggests a decreased lung compliance due to

- Edema, fibrosis, or **acute interstitial pneumonia**
- Large **pleural effusions**, **bronchothorax** or **hemothorax**
- Extrapulmonary restriction as may result from circumferential burns or other chest wall deformity, ascites, pregnancy, or massive obesity
- A tidal volume too large for the amount of lung being ventilated (eg, a normal tidal volume being delivered to a single lung because the endotracheal tube is malpositioned)

Technique: PEEP (causal PEEPs) can be measured in the passive patient through an end-expiratory hold maneuver; immediately before a breath, the expiratory port is closed for 2 sec. Flow ceases, eliminating resistive pressure; the resulting pressure

Merck Manual Mechanical Ventilation

**Marianne Saunorus Baird, Susan
Bethel**



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