Adaptive Support Ventilation (ASV)

This bibliography is a literature reference for users and represents selected relevant publications, without any claim to completeness.

Table of Contents

1 A randomized controlled trial comparing the ventilation duration between Adaptive Support Ventilation and Pressure Assist/Control Ventilation in medical patients in the ICU ........................................ 4
2 Adaptive support ventilation for faster weaning in COPD: a randomised controlled trial ............... 5
3 Adaptive support ventilation for fast tracheal extubation after cardiac surgery: a randomized controlled study ............................................................................................................................................ 6
4 Adaptive Support Ventilation reduces the incidence of atelectasis in patients undergoing coronary artery bypass grafting: A randomized clinical trial........................................................................................................................................ 7
5 A randomized controlled trial of 2 protocols for weaning cardiac surgical patients receiving adaptive support ventilation ............................................................................................................................................ 7
6 A randomized controlled trial of adaptive support ventilation mode to wean patients after fast-track cardiac valvular surgery ............................................................................................................................................ 8
7 Adaptive Support Ventilation versus Synchronized Intermittent Mandatory Ventilation with Pressure Support in weaning patients after orthotopic liver transplantation....................................................... 8
8 Randomized controlled trial comparing adaptive-support ventilation with pressure-regulated volume-controlled ventilation with automode in weaning patients after cardiac surgery ............................................................................................................................................ 9
9 Automatic "respirator/weaning" with adaptive support ventilation: the effect on duration of endotracheal intubation and patient management ............................................................................................................................................ 10
10 Adaptive support ventilation for complete ventilatory support in ARDS: a pilot randomized controlled trial ............................................................................................................................................ 11
12 Effects of implementing adaptive support ventilation in a medical intensive care unit .................... 13
13 Adaptive support ventilation versus conventional ventilation for total ventilatory support in acute respiratory failure ............................................................................................................................................ 14
14 Automatic selection of breathing pattern using adaptive support ventilation .................................. 15
15 Comparisons of metabolic load between adaptive support ventilation and pressure support ventilation in mechanically ventilated ICU patients ............................................................................................................................................ 16
16 Adaptive Support Ventilation attenuates ventilator induced lung injury: human and animal study ...... 16
17 Randomized Controlled Trial of Noninvasive Ventilation with Pressure Support Ventilation and Adaptive Support Ventilation in Acute Exacerbation of COPD: A Feasibility Study .......................................................... 17
18 Comparing the effect of adaptive support ventilation (ASV) and synchronized intermittent mandatory ventilation (SIMV) on respiratory parameters in neurosurgical ICU patients ....................................................... 18
19 Comparing the effects of adaptive support ventilation and synchronized intermittent mandatory ventilation on intubation duration and hospital stay after coronary artery bypass graft surgery

20 Intelligent ventilation in the intensive care unit

21 Adaptive support and pressure support ventilation behavior in response to increased ventilatory demand

22 Determinants of tidal volumes with adaptive support ventilation: a multicentre observational study

23 Evaluation of adaptive support ventilation in paralysed patients and in lung model

24 Clinical experience with adaptive support ventilation for fast-track cardiac surgery

25 Patient-ventilator interactions during partial ventilatory support: a preliminary study comparing the effects of adaptive support ventilation with synchronized intermittent mandatory ventilation plus inspiratory pressure support

26 Automatic weaning from mechanical ventilation using an adaptive lung ventilation controller

27 Correlation between transition percentage of minute volume (TMV%) and outcome of patients with acute respiratory failure

28 The comparison effects of two methods of (Adaptive Support Ventilation Minute Ventilation: 110% and Adaptive Support Ventilation Minute Ventilation: 120%) on mechanical ventilation and hemodynamic changes and length of being in recovery in intensive care units

29 Effects of adaptive support ventilation and synchronized intermittent mandatory ventilation on peripheral circulation and blood gas markers of COPD patients with respiratory failure

30 Comparison of 3 modes of automated weaning from mechanical ventilation: a bench study

31 Adaptive support ventilation prevents ventilator-induced diaphragmatic dysfunction in piglet: an in vivo and in vitro study

32 Correlation between the %MinVol setting and work of breathing during adaptive support ventilation in patients with respiratory failure

33 Adaptive support ventilation: an appropriate mechanical ventilation strategy for acute respiratory distress syndrome?

34 A comparison of adaptive Support Ventilation (ASV) and Conventional Volume-Controlled Ventilation on Respiratory Mechanics in Acute Lung Injury/ARDS

35 Adaptive support ventilation for gynaecological laparoscopic surgery in Trendelenburg position: bringing ICU modes of mechanical ventilation to the operating room

36 Adaptive Support Ventilation as the sole mode of ventilatory support in chronically ventilated patients
Adaptive lung ventilation (ALV) during anesthesia for pulmonary surgery: automatic response to transitions to and from one-lung ventilation ................................. 28
Continuous use of an adaptive lung ventilation controller in critically ill patients in a multi-disciplinary intensive care unit ................................................................. 29
Automatic selection of tidal volume, respiratory frequency and minute ventilation in intubated ICU patients as start up procedure for closed-loop controlled ventilation ........................................ 29
Additional files .............................................................................................................. 30
Advanced modes of mechanical ventilation and optimal targeting schemes ................... 30
Adaptive support ventilation .......................................................................................... 30
The work of breathing .................................................................................................... 30
Automated versus non-automated weaning for reducing the duration of mechanical ventilation for critically ill adults and children ................................................................. 31
Adaptive support ventilation: State of the art review .................................................... 31
Closed loop mechanical ventilation ............................................................................... 32
A randomized controlled trial comparing the ventilation duration between Adaptive Support Ventilation and Pressure Assist/Control Ventilation in medical patients in the ICU

Kirakli C, Naz I, Ediboglu O, Tatar D, Budak A, Tellioglu E
Chest. 2015 Mar 5. [Epub ahead of print]

**Design**
Randomized controlled trial ASV versus Pressure assist control ventilation

**Patients**
229 medical ICU patients from intubation to extubation

**Objectives**
Compare the MV duration, weaning duration, number of manual settings, and weaning success rates

**Main Results**
Total mechanical ventilation duration was significantly shorter in the ASV group, mean 5d [2-6 d] vs 4d [3-9] days). Mechanical ventilation duration until weaning and weaning duration were significantly shorter in the ASV group, mean (84 [43-94] hrs vs. 126 [61-165] hrs; 2 [2-2] hrs vs. 44 [2-80] hrs, respectively). ASV required fewer manual settings to reach the desired pH and PaCO2. The number of patients successfully extubated on the first attempt was significantly higher in the ASV group. Weaning success and mortality at day 28 were comparable between the two groups.

**Conclusion**
ASV shortens total mechanical ventilation duration and the duration of weaning with fewer manual ventilator settings.

*Figure 1: ASV shortens total mechanical ventilation duration compared with pressure assist/control ventilation*
Adaptive support ventilation for faster weaning in COPD: a randomised controlled trial

Kirakli C, Ozdemir I, Ucar ZZ, Cimen P, Kepil S, Ozkan SA
Eur Respir J. 2011 Oct;38(4):774-80

**Design**  Randomized controlled trial ASV versus PS

**Patients**  97 COPD patients

**Objectives**  Compare weaning duration

**Main Results**  ASV shortened weaning times compared to PS (24 h vs 72 h, p=0.041) with similar success rate (35/49 for ASV and 33/48 for PS)

**Conclusion**  ASV was more efficient than PS in COPD patient’s weaning.

*Figure 2: Patients were extubated earlier in ASV group.*
Adaptive support ventilation for fast tracheal extubation after cardiac surgery: a randomized controlled study

Sulzer CF, Chioléro R, Chassot PG, Mueller XM, Revelly JP
Anesthesiology. 2001 Dec;95(6):1339-45

**Design**  Randomized controlled trial ASV versus SIMV-PS with reduction of support in 3 phases

**Patients**  36 patients after coronary artery bypass for fast-track cardiac surgery

**Objectives**  Show that a protocol of weaning based on ASV could reduce the duration of intubation

**Main Results**  Duration of intubation was shorter in the ASV group (3.2 [2.5-4.6] vs. 4.1 [3.1-8.6] h; p < 0.02). Fewer arterial blood gases in ASV group. More fast-track succes in ASV group.

**Conclusion**  Weaning protocol based on ASV was feasible, accelerated tracheal extubation, and simplified ventilatory management in post-cardiac fast-track surgery.

*Figure 3: Patients were extubated earlier in ASV group than in control group.*
### Adaptive Support Ventilation reduces the incidence of atelectasis in patients undergoing coronary artery bypass grafting: A randomized clinical trial

Moradian ST, Saeid Y, Ebadi A, Hemmat A, Ghiasi MS  
Anesth Pain Med. 2017 Apr 22;7(3):e44619  

<table>
<thead>
<tr>
<th>Design</th>
<th>Single-blind randomized clinical trial: ASV versus SIMV and PS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>115 patients undergoing coronary artery bypass grafting; 57 in ASV group, 58 in control group</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare ASV to SIMV and PS in terms of atelectasis, management of ventilation, and outcome in patients undergoing cardiac surgery</td>
</tr>
<tr>
<td>Main Results</td>
<td>The incidence of atelectasis (33% vs 65%), the number of manual changes to ventilator settings (6±2 vs. 8±2), the number of alarms (10±3 vs. 15±5), and the length of hospital stay (6±1.45 vs. 6.69±2.04 days) were lower in the intervention group than in the control group.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV reduced the incidence of atelectasis in patients undergoing coronary artery bypass grafting and improved the process of weaning.</td>
</tr>
</tbody>
</table>

### A randomized controlled trial of 2 protocols for weaning cardiac surgical patients receiving adaptive support ventilation

Tam MK, Wong WT, Gomersall CD, Tian Q, Ng SK, Leung CC, Underwood MJ  

<table>
<thead>
<tr>
<th>Design</th>
<th>Randomized controlled trial: ASV with progressive decrease in target minute ventilation or constant target minute ventilation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>52 patients after elective coronary artery bypass surgery</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the effectiveness of 2 different protocols for weaning</td>
</tr>
<tr>
<td>Main Results</td>
<td>The duration of mechanical ventilation (145 vs. 309 minutes; (p = 0.001)) and intubation (225 vs. 423 minutes; (p = .005)) was shorter in the decremental target minute ventilation group compared with the constant target minute ventilation group. There was no difference in terms of adverse effects or mortality between the groups.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>A progressive decrease in target minute ventilation after cardiac surgery resulted in a shorter duration of ventilation and intubation.</td>
</tr>
</tbody>
</table>
A randomized controlled trial of adaptive support ventilation mode to wean patients after fast-track cardiac valvular surgery

Zhu F, Gomersall CD, Ng SK, Underwood MJ, Lee A
Anesthesiology. 2015 Apr;122(4):832-40

### Design
Randomized controlled trial, ASV versus physician-directed weaning

### Patients
68 patient after fast-track cardiac valvular surgery

### Objectives
Compare the duration of mechanical ventilation

### Main Results
Duration of ventilation was shorter in the ASV group 3.4 [2.3 to 4.9] h than in the control group 5.7 [3.6 to 8.2] h (p = 0.013). ASV was associated with fewer manual ventilator changes and alarms, and lower airway pressure.

### Conclusion
ASV reduces duration of mechanical ventilation after fast-track cardiac valvular surgery and reduces the number of manual ventilator changes and alarms.

Adaptive Support Ventilation versus Synchronized Intermittent Mandatory Ventilation with Pressure Support in weaning patients after orthotopic liver transplantation

Transplant Proc. 2014 Aug 20 [Epub ahead of print]

### Design
Randomized controlled trial, ASV versus SIMV with pressure support

### Patients
20 patients after orthotopic liver transplantation fast-track surgery

### Objectives
Compare the duration of intubation, the number of manual settings, high airway pressure (Paw) episodes, and blood gas analysis between the two modes

### Main Results
The length of intubation was shorter in the ASV group than in the SIMV group (153 ±22 vs 90 ±13 minutes, p = 0.05). Settings modifications were more frequent in the SIMV group vs the ASV group (6 ±2 vs1.5 ±1; p =.003). Peak pressure (Ppeak) was higher in passive patients in the SIMV group. High Paw alarms were more frequent in the SIMV group in passive patients. The values of pH, PaCO2, and e PaO2 did not differ significantly between the two groups.

### Conclusion
ASV is superior in terms of weaning times, and it simplifies respiratory management
| **Design** | Randomized controlled trial ASV versus PRVC in 3 phases: controlled ventilation, assisted ventilation, T-piece trial |
| **Patients** | 48 patients after coronary artery bypass, uncomplicated |
| **Objectives** | Evaluate the duration of intubation, duration of mechanical ventilation, number of arterial blood gases, and number of ventilator setting changes |
| **Main Results** | The duration of intubation and of mechanical ventilation was shorter in the ASV group than in the PRVC group (300 [205-365] vs. 540 [462-580] min; p < 0.05; 165 [120-195] vs. 480 [360-510] min; p < 0.05, respectively). There was no difference in the number of arterial blood gases and setting changes. |
| **Conclusion** | ASV allowed earlier extubation than PRVC in post-cardiac surgery without increasing the number of clinician interventions. |
Automatic “respirator/weaning” with adaptive support ventilation: the effect on duration of endotracheal intubation and patient management

Petter AH, Chioléro RL, Cassina T, Chassot PG, Müller XM, Revelly JP
Anesth Analg. 2003 Dec;97(6):1743-50

<table>
<thead>
<tr>
<th>Design</th>
<th>Randomized controlled trial ASV versus SIMV-PS for post-cardiac fast-track surgery. 3 phases: controlled ventilation, supported ventilation, and SBT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>34 uncomplicated cardiac surgery patients</td>
</tr>
<tr>
<td>Objectives</td>
<td>Evaluate the effect of ASV on ventilator management and its ability to perform respiratory weaning</td>
</tr>
<tr>
<td>Main Results</td>
<td>ASV required fewer ventilator setting manipulations (2.4 ±0.7 vs 4.0 ±0.8 manipulations per patient; p &lt; 0.05) and endured less high-inspiratory pressure alarms (0.7 ±2.4 vs 2.9 ±3.0; p &lt; 0.05) than SIMV-PS. There was no difference in duration of mechanical ventilation and ICU stay.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV resulted in an outcome similar to the control group with less manipulation: it could simplify management of post-cardiac surgery patients.</td>
</tr>
<tr>
<td>Comment</td>
<td>Minute volume settings was left at 100% in the study. A further reduction may have transitioned patients to spontaneous breathing faster.</td>
</tr>
</tbody>
</table>
Adaptive support ventilation for complete ventilatory support in ARDS: a pilot randomized controlled trial

Agarwal R, Srinivasan A, Aggarwal AN, Gupta D
Respirology. 2013 Oct;18(7):1108-1

<table>
<thead>
<tr>
<th>Design</th>
<th>Pilot randomized controlled trial ASV versus VC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>48 ARDS patients</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the outcomes</td>
</tr>
<tr>
<td>Main Results</td>
<td>Duration of mechanical ventilation (6 d for VC vs 5 d for ASV, p=0.51), ICU (9 d for VC vs 8 d for ASV, p=0.9), and hospital stay (11 d for VC vs 11 d for ASV, p=0.97), sedation doses, ease of use, and number of arterial blood gases were similar in the two groups. Vt was between 6 and 7 ml/kg during the first seven days.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV was usable in ARDS patients, providing the same outcomes as VC.</td>
</tr>
<tr>
<td>Comment</td>
<td>The sample size of this study could not show reduction of duration of mechanical ventilation (for comparison = 861 patients were necessary in ARDSnet trial) but there was a nonsignificant reduction of duration of mechanical ventilation and ICU stay in the ASV group.</td>
</tr>
</tbody>
</table>

![Figure 4: Tidal volume was between 6 and 7 mL/kg in ASV](image_url)
Human versus Computer Controlled Selection of Ventilator Settings: An Evaluation of Adaptive Support Ventilation and Mid-Frequency Ventilation

Mireles-Cabodevila E, Diaz-Guzman E, Arroliga AC, Chatburn RL

**Design**  
Comparative simulation study

**Patients**  
Lung simulator: normal lungs, ARDS, obesity, COPD, asthma

**Objectives**  
Compare the automatic settings with survey-derived values

**Main Results**  
Difference between Vt in ASV and clinician selected for normal lungs, ARDS, obesity, COPD were negligible (-0.9 ml to 0.7 ml). For asthma, Vt selected by ASV was greater than that selected by clinician by 3.9 mL.

**Conclusion**  
Negligible differences occurred between ventilator settings selected by ASV and the clinician in different scenarios, except in asthma.

*Figure 5: The only clinically relevant difference between the survey and the ASV settings was the higher Vt in status asthmaticus (but nonsignificant difference). Increasing Vt lead to decreased RR to avoid dynamic hyperinflation.*
Effects of implementing adaptive support ventilation in a medical intensive care unit

Chen CW, Wu CP, Dai YL, Perng WC, Chian CF, Su WL, Huang YC
Respir Care. 2011 Jul;56(7):976-83

Design | Before/after study 6 months before ASV implementing

Patients | 70 patients before (SIMV-PS) and 79 patients ventilated with ASV, in medical ICU

Objectives | Evaluate the effect of ASV in patients recovering from acute respiratory failure

Main Results | In the ASV group, 20% of the patients achieved extubation readiness within 1 day, compared to 4% in the non-ASV group. Patients in the ASV group were more likely to be free from mechanical ventilation at 3 weeks. Time-to-extubation readiness was 2 days shorter in the ASV group.

Conclusion | ASV allowed early identification of extubation readiness and reduced weaning duration.

Figure 6: ASV reduced time to extubation readiness compared to conventional ventilation.
Adaptive support ventilation versus conventional ventilation for total ventilatory support in acute respiratory failure


**Design**
Prospective multicenter (6 european ICU) crossover study VC/PC switched for ASV with isoMV for 30 min, and 30 min more to achieve isoPaCO2, if necessary

**Patients**
88 patients in 3 groups: 22 normal lung, 36 restrictive disease, 30 obstructive disease

**Objectives**
Compare the short-term effects of ASV with VC or PC in passive patient

**Main Results**
PaCO2 was lower with ASV than controlled ventilation for the same MV. For the same PaCO2, ASV was associated with lower MV than controlled ventilation. Work of inspiration was lower during the ASV period. The combination Vt-RR varied with the group: lower Vt in patients with restrictive disease and prolonged Texp in obstructive patients

**Conclusion**
ASV performed more effective ventilation than conventional modes

*Figure 7:* Ventilatory patterns were different between ASV and conventional ventilation. In obstructive patients, ASV provided more effective ventilation with higher Vt and lower RR than conventional ventilation. In restrictive patients, ASV decreased RR.
Automatic selection of breathing pattern using adaptive support ventilation

Arnal JM, Wysocki M, Nafati C, Donati S, Granier I, Corno G, Durand-Gasselin J
Intensive Care Med. 2008 Jan;34(1):75-81

Design
Prospective observational cohort study

Patients
243 ICU patients

Objectives
Compare settings automatically determined by ASV in 5 lung conditions: normas lungs, ARDS, COPD, chest wall stiﬁness, acute respiratory failure.

Main Results
On passive ventilation days, Vt-RR were different according to lung condition. On passive normal ventilation days, Vt was lower (8,3 ml/kgPBW) than in passive COPD days (9,3 ml/kgPBW) and higher than in passive ALI/ARDS days (7,6ml/kgPBW, p < 0,05). On passive normal ventilation day, RR (14/min) was lower than in passive ALI/ARDS days (18/min).

Conclusion
On passive ventilation days, ASV selected different Vt-RR combinations based on respiratory mechanics

Figure 8: Vt and respiratory rate were different in all ventilation days and passive ventilation days according to lung condition.
Comparisons of metabolic load between adaptive support ventilation and pressure support ventilation in mechanically ventilated ICU patients

Chen YH, Hsiao HF, Hsu HW, Cho HY, Huang CC.
Can Respir J. 2020 Jan 28;2020:2092879

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective study: Sequential 20 min in pressure support ventilation (PSV) followed by 20 min in adaptive support ventilation (ASV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>24 ICU patients</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the metabolic load between ASV and PSV</td>
</tr>
<tr>
<td>Main Results</td>
<td>The energy expenditure in ASV was lower than in PSV at support levels of 0 cmH2O, 8 cmH2O, and 12 cmH2O. The VO2, VCO2, and P0.1 in PSV were significantly higher than those in ASV.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV set for full support was associated with a lower metabolic load and respiratory drive than PSV</td>
</tr>
</tbody>
</table>

Adaptive Support Ventilation attenuates ventilator induced lung injury: human and animal study

Dai YL, Wu CP, Yang GG, Chang H, Peng CK, Huang KL

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective randomized trial (adaptive support ventilation (ASV) versus pressure-control ventilation (PCV)) and animal study (ASV versus volume-control ventilation (VCV))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>15 ARDS patients and 18 piglets</td>
</tr>
<tr>
<td>Objectives</td>
<td>Evaluate whether ASV can provide a protective ventilation pattern to decrease the risk of ventilator-induced lung injury (VILI)</td>
</tr>
<tr>
<td>Main Results</td>
<td>In the ARDS patients, there was no difference in respiratory parameters between the groups. In the animal experiments, the ASV group had lower alveolar strain, less lung injury and greater alveolar fluid clearance compared with the VCV group.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV mode is capable of providing a ventilation pattern fitting into the lung-protective strategy and may effectively reduce the risk or severity of VILI in an animal model</td>
</tr>
</tbody>
</table>
Randomized Controlled Trial of Noninvasive Ventilation with Pressure Support Ventilation and Adaptive Support Ventilation in Acute Exacerbation of COPD: A Feasibility Study

Sehgal IS, Kalpakam H, Dhoria S, Aggarwal AN, Prasad KT, Agarwal R
COPD. 2019 Apr;16(2):168-173

Design
Randomized controlled trial Adaptive Support Ventilation (ASV) versus Pressure Support Ventilation (PSV) during Noninvasive Ventilation (NIV)

Patients
74 patients with acute exacerbation of COPD: 38 in PSV group, 36 in ASV group

Objectives
Compare the delivery of NIV with PSV and ASV in terms of NIV failure and outcomes

Main Results
The NIV failure rate was similar in the two groups (PSV vs. ASV: 34.2% vs. 22.2%, p = 0.31). There was a non-significant decrease in both the intubation rate (21.1% in PSV vs. 11.1% in ASV) and the requirement of NIV within 48 h (7.9% in PSV vs. 0% in ASV) in the ASV group. There was no difference in outcomes.

Conclusion
The application of NIV using ASV was associated with a similar success rate to PS in patients with acute exacerbation of COPD.

Comment
The inspiratory pressure was higher in the ASV group, which could explain the lower NIV failure rate.
Comparing the effect of adaptive support ventilation (ASV) and synchronized intermittent mandatory ventilation (SIMV) on respiratory parameters in neurosurgical ICU patients

Ghodrati M, Pournajafian A, Khatibi A, Niakan M, Hemadi MH, Zamani MM

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective crossover study, 30 minutes in ASV and 30 minutes in SIMV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>60 neurosurgical ICU patients</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the respiratory parameters for ventilation in ASV and in SIMV</td>
</tr>
<tr>
<td>Main Results</td>
<td>In ASV, peak airway pressure (17.3±4.2 cmH2O), tidal volume (6.8±1.8 ml/kg) and respiratory dead space (66.8±56.3 ml) were significantly lower than in SIMV: 21.5±5.0 cmH2O, 10.0±1.2 ml/kg, and 91.9±71.2 ml, respectively. Dynamic compliance was better in ASV (40.7±17.6 ml/cmH2O vs. 35.5±15.5 ml/cmH2O), but the difference was not statistically significant.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV provides more protective ventilation in neurosurgical ICU patients than SIMV</td>
</tr>
<tr>
<td>Comment</td>
<td>Low impact factor journal, short period of observation (30 min in each mode)</td>
</tr>
</tbody>
</table>

Comparing the effects of adaptive support ventilation and synchronized intermittent mandatory ventilation on intubation duration and hospital stay after coronary artery bypass graft surgery

Yazdannik A, Zarei H, Massoumi G

<table>
<thead>
<tr>
<th>Design</th>
<th>Randomized controlled trial comparing ASV with SIMV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>64 patients after coronary artery bypass surgery</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the effect of ASV and SIMV on the length of mechanical ventilation and hospital stay</td>
</tr>
<tr>
<td>Main Results</td>
<td>The mean duration of intubation was significantly lower in the ASV group than in the SIMV group (4.83 h vs. 6.71 h, p &lt; 0.001). The length of the hospital stay in the ASV and the SIMV groups was 140.6 h and 145.1 h (p = 0.006), respectively.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>According to the results of this study, using ASV after a coronary artery bypass graft led to a decrease in the intubation duration and hospital stay when compared with SIMV.</td>
</tr>
</tbody>
</table>
Intelligent ventilation in the intensive care unit

Sviri S, Bayya A, Levin P, Khalaila R, Stav I, Linton D

<table>
<thead>
<tr>
<th>Design</th>
<th>Retrospective study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>1016 medical ICU patients</td>
</tr>
<tr>
<td>Objectives</td>
<td>Describe the clinical experience</td>
</tr>
<tr>
<td>Main Results</td>
<td>Duration of ventilation = 6 d. Weaning succes rate = 81%. 84% of patients ventilated with ASV mode. 96% able to wean solely using ASV mode. Less than 1% of all patient ventilated with ASV developed pneumothorax.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV was a safe and feasible mode of ventilation for complicated medical ICU patients.</td>
</tr>
</tbody>
</table>

Adaptive support and pressure support ventilation behavior in response to increased ventilatory demand

Jaber S, Sebbane M, Verzilli D, Matecki S, Wysocki M, Eledjam JJ, Brochard L
Anesthesiology. 2009 Mar;110(3):620-7

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective randomized crossover study: ASV, APV, PS at baseline and with increase in dead space, in random order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>14 ICU patients during assisted ventilation</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare ASV to APV and PS in respiratory demand increase</td>
</tr>
<tr>
<td>Main Results</td>
<td>Adding dead space increased MV, PaCO2, work of breathing. ASV and PS ended with similar Pinsp level (12 cmH2O) while APV Pinsp decreased (6 cmH2O).</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Following an increase in respiratory demand, ASV maintained the same level of pressure support; while adaptive pressure control modes such as APV, PRVC, and Autoflow, may reduce pressure support.</td>
</tr>
</tbody>
</table>
Determinants of tidal volumes with adaptive support ventilation: a multicentre observational study

Dongelmans DA, Veelo DP, Bindels A, Binnekade JM, Koppenol K, Koopmans M, Korevaar JC, Kuiper MA, Schultz MJ
Anesth Analg. 2008 Sep;107(3):932-7

**Design**
Prospective multicenter (3 Dutch ICU) observational comparative study in postcardiothoracic surgery

**Patients**
346 patients: 262 in ASV and 84 in PC-PS

**Objectives**
Determine Vt and factors that influence Vt

**Main Results**
In ASV, Vt was dependent on only two parameters: the RR and the correctness of set body weight

**Conclusion**
RR was automatically selected so the only clinically important factor was the correctness of set body weight.

Evaluation of adaptive support ventilation in paralysed patients and in lung model

Belliato M, Palo A, Pasero D, Iotti GA, Mojoli F, Braschi A
Int J Artif Organs. 2004 Aug;27(8):709-16

**Design**
Prospective observational and simulation study, 45 min in ASV during controlled ventilation, and simulation with the same parameters and increased by 30% of MV

**Patients**
21 post-operative patients

**Objectives**
Evaluate the respiratory pattern selected by ASV in 3 lung conditions: normal lungs, restrictive diseases, and obstructive diseases

**Main Results**
ASV selected higher Vt and lower RR in obstructive patients than in normal lung or restrictive patients. In simulation, patterns were the same. In the hyperventilation test, ASV chose a balanced increase in both Vt and RR.

**Conclusion**
ASV selected different parameters according to lung condition, and respiratory mechanics. In case of increase of target MV (hyperventilation), Vt and RR were increased.
Clinical experience with adaptive support ventilation for fast-track cardiac surgery

Cassina T, Chioléro R, Mauri R, Revelly JP

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective observational study ASV for post-cardiac fast-track surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>155 uncomplicated cardiac surgery patients until recovery</td>
</tr>
<tr>
<td>Objectives</td>
<td>Evaluate ASV for ventilatory management during the post-operative period</td>
</tr>
<tr>
<td>Main Results</td>
<td>Tidal volume was 8.7 ±1.4 ml/kgPBW, plateau pressure was 20.3 ±3.9 cmH2O, and arterial blood gas measurements were satisfactory. 86% were extubated within 6 h. No reintubation for respiratory failure. Considered easy to use by nurses and clinicians.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV was safe, feasible, and easy to apply, and allowed rapid extubation in post-cardiac surgery</td>
</tr>
</tbody>
</table>

Patient-ventilator interactions during partial ventilatory support: a preliminary study comparing the effects of adaptive support ventilation with synchronized intermittent mandatory ventilation plus inspiratory pressure support

Tassaux D, Dalmas E, Gratadour P, Jolliet P
Crit Care Med. 2002 Apr;30(4):801-7

| Design | Prospective, crossover interventional study, 45 min in SIMV, then 45 min in ASV, then 45 min in SIMV |
| Patients | 10 patients intubated for respiratory failure in the early weaning period |
| Objectives | Describe the effects of ASV and SIMV on patient-ventilator interactions |
| Main Results | MV was the same in the 3 phases but Vt increased and RR decreased in ASV period. During ASV, tidal volume increased (538 ±91 vs. 671 ±100 ml, p < .05) and total respiratory rate decreased (22 ±7 vs. 17 ±3 breaths/min, p < .05) vs. SIMV-PS. P 0.1 and sternocleidomastoid activity decreased in ASV period. Arterial blood gases and hemodynamic status remained stable. |
| Conclusion | ASV decreased inspiratory load and improved quality of patient-ventilator interaction. |
**Automatic weaning from mechanical ventilation using an adaptive lung ventilation controller**

Linton DM, Potgieter PD, Davis S, Fourie AT, Brunner JX, Laubscher TP  
Chest. 1994 Dec;106(6):1843-50  

<table>
<thead>
<tr>
<th><strong>Design</strong></th>
<th>Prospective open study using ASV during weaning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients</strong></td>
<td>27 long-term ventilated ICU patients fulfilling weaning criteria</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Evaluate ASV in weaning of mechanical ventilation in 3 groups: normal lungs, parenchymal lung disease, and COPD</td>
</tr>
<tr>
<td><strong>Main Results</strong></td>
<td>ASV compared to SIMV reduced PS and mandatory rate in patients ready to be extubated. When the PS level was maintained, patients failed weaning.</td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td>ASV was useful for indicating weaning readiness, sooner than PS.</td>
</tr>
</tbody>
</table>

**Correlation between transition percentage of minute volume (TMV%) and outcome of patients with acute respiratory failure**

Peng CK, Wu SF, Yang SH, Hsieh CF, Huang CC, Huang YC, Wu CP  

<table>
<thead>
<tr>
<th><strong>Design</strong></th>
<th>Prospective interventional study; TMV% determined by increasing %MinVol until a mandatory breath was delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients</strong></td>
<td>337 ICU patients with acute respiratory failure</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Test whether higher TMV% is associated with poorer outcomes</td>
</tr>
<tr>
<td><strong>Main Results</strong></td>
<td>The TMV% measured on the first day of mechanical ventilation in patients who were weaned off the ventilator on the first day (n = 75), who were still on the ventilator on the second day (n = 249) and who died (n = 13) in the first 24 h was 106 ± 21.6%, 135 ± 53.3% and 225 ± 47.5% (p = 0.001), respectively. In patients whose TMV% increased between day 1 and day 2, the adjusted Odd Ratio for mortality was 7.0 (95%CI=2.7-18.3, p&lt;0.001) compared to patients whose TMV% decreased.</td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td>High TMV% or an increase in TMV% was associated with poorer outcomes.</td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td>The most severe patients needed a higher level of support and had poorer outcomes; this is due to the disease.</td>
</tr>
</tbody>
</table>
The comparison effects of two methods of (Adaptive Support Ventilation Minute Ventilation: 110% and Adaptive Support Ventilation Minute Ventilation: 120%) on mechanical ventilation and hemodynamic changes and length of being in recovery in intensive care units

Kiaei BA, Kashefi P, Hashemi ST, Moradi D, Mobasheri A
Adv Biomed Res. 2017 May 2;6:52

<table>
<thead>
<tr>
<th>Design</th>
<th>Randomized controlled trial; ASV 110% of MV and ASV 120% of MV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>40 ICU patients</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the differences in duration of mechanical ventilation and hemodynamic changes during recovery and length of stay</td>
</tr>
<tr>
<td>Main Results</td>
<td>Duration of mechanical ventilation was 12.3 ± 3.66 days in group 110% and 10.8 ± 2.07 days in group 120%. Length of stay was 16.35 ± 3.51 days in group 110% and 15.5 ± 2.62 days in group 120%. These differences were not statistically significant. The heart rate in the ASV MV 120% group was decreased compared to the ASV MV 110% (P = 0.017).</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV MV 120% may decrease the duration of mechanical ventilation and length of stay.</td>
</tr>
</tbody>
</table>
Effects of adaptive support ventilation and synchronized intermittent mandatory ventilation on peripheral circulation and blood gas markers of COPD patients with respiratory failure

Han L, Wang Y, Gan Y, Xu L
Cell Biochem Biophys. 2014 Apr;70(1):481-4

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective cross over study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>86 patients with exacerbation of COPD under invasive ventilation</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the effects on Vt-RR combination, hemodynamic variables and blood gas analysis, between ASV and SIMV</td>
</tr>
<tr>
<td>Main Results</td>
<td>RR, Vt and Pinsp were decreased during the ASV period compared to SIMV period. Heart rate, systolic and diastolic blood pressure, central venous pressure were decreased during the ASV period. PaO2 and pH were increased during ASV period.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV delivered more physiologic ventilation improving clinical status in COPD, compared with SIMV</td>
</tr>
<tr>
<td>Comment</td>
<td>Data at inclusion are not provided. The period of ventilation were not randomized and SIMV period was always the first one.</td>
</tr>
</tbody>
</table>
Comparison of 3 modes of automated weaning from mechanical ventilation: a bench study

Morato JB, Sakuma MT, Ferreira JC, Caruso P

<table>
<thead>
<tr>
<th>Design</th>
<th>Simulation study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>Lung simulator</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the weaning performance of ASV, mandatory rate ventilation, and Smartcare</td>
</tr>
<tr>
<td>Main Results</td>
<td>ASV correctly recognized weaning success, weaning failure, weaning success with anxiety, weaning success with irregular breathing, and weaning failure with ineffective effort. The 3 modes incorrectly recognized weaning success with Cheynes-Stokes. Time to Pinsp stabilization was shorter for ASV (1-2 min for all situations) than for Smartcare (8-78 min). ASV had higher rates of PS oscillations per 5 min (4-15), compared with Smartcare (0-1).</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV recognized weaning success or failure, except with Cheynes-Stokes, with quick PS stabilization and a high rate of oscillations</td>
</tr>
</tbody>
</table>

Adaptive support ventilation prevents ventilator-induced diaphragmatic dysfunction in piglet: an in vivo and in vitro study

Anesthesiology. 2010 Jun;112(6):1435-43

<table>
<thead>
<tr>
<th>Design</th>
<th>Animal study ASV versus controlled ventilation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>12 anesthetized piglets for 72 h 6/group</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the effects of ASV with those of controlled ventilation on diaphragmatic dysfunction</td>
</tr>
<tr>
<td>Main Results</td>
<td>Controlled ventilation decreased transdiaphragmatic pressure, ASV didn’t decrease this pressure. Controlled ventilation was associated with atrophy of the diaphragm, atrophy was not detected in ASV group</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV maintained diaphragmatic contractile activity, which protects against ventilator-induced diaphragmatic dysfunction</td>
</tr>
</tbody>
</table>
Correlation between the %MinVol setting and work of breathing during adaptive support ventilation in patients with respiratory failure

Wu CP, Lin Hl, Perng WC, Yang SH, Chen CW, Huang YC, Huang KL
Respir Care. 2010 Mar;55(3):334-41

**Design**
Prospective interventional study in active patients, with ASV and %MV increased by 10% until mandatory breath delivered

**Patients**
22 ICU patients on PS

**Objectives**
Determine the ASV target point TP (delivery of mandatory breath) and measure the work of breathing WOB at %MV TP, %MV TP + 20%, %MV TP - 20%

**Main Results**
%MV TP was 165% +/- 54% At %MV TP +20% WOB decreased At %MV - 20% WOB increased

**Conclusion**
In active patients, increasing %MV decreased WOB.

Adaptive support ventilation: an appropriate mechanical ventilation strategy for acute respiratory distress syndrome?

Sulemanji D, Marchese A, Garbarini P, Wysocki M, Kacmarek RM
Anesthesiology. 2009 Oct;111(4):863-70

**Design**
Simulation study ASV versus VC with Vt = 6 ml/Kg predictive body weight

**Patients**
Lung simulator

**Objectives**
Compared ASV with fixed Vt of 6 ml/kgIBW in different scenarios: 60 and 80 kg, PEEP at 8, 12, and 16 cmH2O; MV 120, 150, and 200%

**Main Results**
In Group I = 60 kg, the number of scenarios with Pplat of 28 cmH2O or more was 14 for ASV (26%) and 19 for 6 ml/kg (35%). In group II=80 kg, the number of scenarios PP of 28 cmH2O or more was 10 for ASV (19%) and 21 for 6 ml/kg (39%).

**Conclusion**
ASV was better able to prevent VILI than fixed Vt by automatically adjusting Pinsp, sacrificing Vt.
### A comparison of adaptive Support Ventilation (ASV) and Conventional Volume-Controlled Ventilation on Respiratory Mechanics in Acute Lung Injury/ARDS

Choi I, Choi J, Hong S, Lim C, Koh Y  
Kor J crit Care Med. 2009 Aug; 24(2): 59-63

<table>
<thead>
<tr>
<th><strong>Design</strong></th>
<th>Prospective crossover study, VC 30 min, then ASV 30 min, then VC 30 min</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients</strong></td>
<td>13 ARDS</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Compare respiratory and hemodynamic effects between ASV and VC in ARDS patients</td>
</tr>
<tr>
<td><strong>Main Results</strong></td>
<td>During ASV period, Vt increased (373 mL vs 429 mL, p&lt;0.05), RR (22/min vs 19/min, p&lt;0.05) and Pinsp (32 cmH2O vs 26, p&lt;0.05) decreased compared with VC, without change in arterial blood gases nor in hemodynamic status</td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td>ASV was usable in ARDS patients, decreased pressure, and maintained arterial blood gases.</td>
</tr>
</tbody>
</table>

### Adaptive support ventilation for gynaecological laparoscopic surgery in Trendelenburg position: bringing ICU modes of mechanical ventilation to the operating room


<table>
<thead>
<tr>
<th><strong>Design</strong></th>
<th>Prospective interventional study during gynaecological laparoscopic surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients</strong></td>
<td>22 female patients</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Test the efficacy of ASV to adapt ventilator settings during pneumoperitoneum and Trendelembourg position</td>
</tr>
<tr>
<td><strong>Main Results</strong></td>
<td>Compliance decreased and resistance increased during pneumo-trend period, MV was kept constant by an increase in Pinsp by 3.2 ±0.9 cmH2O (p &lt; 0.01), RR by 1.3 ±0.5/min, and Tinsp/Ttot by 43%; these parameters returned toward baseline at final time. PaCO2 increased during the pneumoperitoneum (CO2 insufflation) and decreased at final time.</td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td>ASV adapted ventilator settings to the changes in the respiratory mechanics, keeping MV constant and provided adequate gas exchanges.</td>
</tr>
</tbody>
</table>
Adaptive Support Ventilation as the sole mode of ventilatory support in chronically ventilated patients

Linton DM, Renov G, Lafair J, Vasiliev L, Friedman G
Crit Care Resusc. 2006 Mar;8(1):11-4

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective observational study %MV was reduced 10% a week, from 90% to 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>27 patients chronically ventilated, for at least 3 months prior to admission</td>
</tr>
<tr>
<td>Objectives</td>
<td>Describe the outcomes</td>
</tr>
<tr>
<td>Main Results</td>
<td>12 patients were weaned within 2 weeks and 2 months. 9 remained in 60% VM. 2 were partially ventilated at home. 4 patients died on ventilation.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>ASV was safe in achieving weaning automatically</td>
</tr>
</tbody>
</table>

Adaptive lung ventilation (ALV) during anesthesia for pulmonary surgery: automatic response to transitions to and from one-lung ventilation

Weiler N, Eberle B, Heinrichs W

<table>
<thead>
<tr>
<th>Design</th>
<th>Prospective observational study ASV during pulmonary surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>9 patients during pulmonary surgery and one-lung ventilation</td>
</tr>
<tr>
<td>Objectives</td>
<td>Describe the change in respiratory mechanics and the adaptation of ventilatory pattern to and from one-lung ventilation</td>
</tr>
<tr>
<td>Main Results</td>
<td>Institution of one-lung ventilation was followed by a reproducible response of the ASV. The sudden changes in respiratory mechanics (resistance increased, compliance decreased but RC was stable) caused a transient reduction in Vt by 42 (8-59)%, with RR unaffected. In order to re-establish the preset MV, the controller increased Pinsp from 18 (14-23) to 27 (19-39) cmH2O. The controller was effective in maintaining MV.</td>
</tr>
<tr>
<td>Conclusion</td>
<td>The ASV controller successfully managed the transition to and from one-lung ventilation.</td>
</tr>
</tbody>
</table>
Continuous use of an adaptive lung ventilation controller in critically ill patients in a multi-disciplinary intensive care unit

Linton D, Brunner J, Laubscher T

**Design**          Prospective observational study in long-term ventilated ICU patients

**Patients**        6 ICU patients

**Objectives**      Evaluate the safety of ASV from initiation to weaning

**Main Results**    Patients were ventilated for a mean of 51.6 h. PS was maintained at a mean level of 14.8 cmH2O. ASV selected appropriate synchronized pressure support ventilatory pattern from initiation to weaning. It allowed and encouraged spontaneous efforts.

**Conclusion**      ASV provided clinically acceptable, safe, and effective ventilation during the entire mechanical ventilation period.

Automatic selection of tidal volume, respiratory frequency and minute ventilation in intubated ICU patients as start up procedure for closed-loop controlled ventilation

Laubscher TP, Frutiger A, Fanconi S, Jutzi H, Brunner JX

**Design**          Multicenter prospective open study Connection for 1 min for test-breaths

**Patients**        25 adult ICU patients + 17 critically ill children

**Objectives**      Test a computerized method for selecting Vt, RR, and MV as startup procedure for closed-loop controlled mechanical ventilation

**Main Results**    The computerized parameters calculated with test breaths didn’t differ from the conventional parameters at the initiation of mechanical ventilation

**Conclusion**      Automatic selection of ventilation parameters started mechanical ventilation with the same parameters as manual settings .
Additional files

Advanced modes of mechanical ventilation and optimal targeting schemes

van der Staay M, Chatburn RL
Intensive Care Med Exp. 2018 Aug 22;6(1):30

**Objectives**

Recent research results provide new incentives to recognize and prevent ventilator-induced lung injury (VILI) and create targeting schemes for new modes of mechanical ventilation

**Conclusion**

Minimization of breathing power, inspiratory power, and inspiratory pressure are the underlying goals of optimum targeting schemes used in ASV

Adaptive support ventilation

Campbell RS, Branson RD, Johannigman JA
Respir Care Clin N Am. 2001 Sep;7(3):425-40

**Design**

Original article

**Conclusion**

Explains the ASV principle and the settings.

The work of breathing

Otis AB
Physiol Rev. 1954 Jul;34(3):449-58

**Design**

Physiological study

**Conclusion**

Supports the ASV principle of selecting a Vt-RR combination according to the least work of breathing principle.
Automated versus non-automated weaning for reducing the duration of mechanical ventilation for critically ill adults and children

Rose L, Schultz MJ, Cardwell CR, Jouvet P, McAuley DF, Blackwood B
Cochrane Database Syst Rev. 2013 Jun 6;6:CD009235

<table>
<thead>
<tr>
<th>Design</th>
<th>Meta-analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>1143 adults ICU patients + 30 critically ill children</td>
</tr>
<tr>
<td>Objectives</td>
<td>Compare the duration of weaning from mechanical ventilation, duration of ventilation, ICU and hospital length of stay, mortality, and adverse events between automated closed-loop systems versus nonautomated strategies</td>
</tr>
<tr>
<td>Main Results</td>
<td>Closed-loop systems reduced weaning duration in mixed or medical ICU populations, duration of ventilation, and ICU length of stay. There was no difference in mortality rates or hospital stay</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Automated closed-loop systems, such as ASV, reduce duration of weaning, ventilation, and ICU stay.</td>
</tr>
</tbody>
</table>

Adaptive support ventilation: State of the art review

Fernández J, Miguelena D, Mulett H, Godoy J, Martinón-Torres F
Indian J Crit Care Med. 2013 Jan;17(1):16-22

<table>
<thead>
<tr>
<th>Design</th>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conclusion</td>
<td>Discusses ASV, appropriate ventilator settings, advantages, particular effects on oxygenation and ventilation, and monitoring.</td>
</tr>
</tbody>
</table>
Closed loop mechanical ventilation

Wysocki M, Jouvet P, Jaber S

<table>
<thead>
<tr>
<th>Design</th>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conclusion</strong></td>
<td>Provides overview of technical and engineering considerations regarding closed-loop controlled ventilation.</td>
</tr>
</tbody>
</table>