

GRADE

1 • Strong For

2 • Conditional For

2- • Conditional Against

3 • Strong Against

1

Diagnosis & Lung-Protective Ventilation

Berlin Definition	Criterion
Timing	Onset within 1 week of known insult or new/worsening respiratory symptoms
Imaging	Bilateral opacities not fully explained by effusion, collapse, or nodules
Origin of edema	Not fully explained by cardiac failure or fluid overload
Oxygenation	See severity table below (PaO ₂ /FiO ₂ with PEEP/CPAP ≥5 cmH ₂ O)

Severity (PaO ₂ /FiO ₂ , PEEP ≥5)	Mild	Moderate	Severe
Ratio (mm Hg)	201–300	101–200	≤100

1
Mod

Use **low tidal volume ventilation** (4–8 mL/kg predicted body weight) and limit inspiratory pressures — **plateau pressure < 30 cmH₂O** — for all patients with ARDS, regardless of severity.

2

PEEP Strategy

2
Lo-Mod

Use **higher PEEP without lung recruitment maneuvers** rather than lower PEEP for moderate–severe ARDS — titrate via oxygenation-based PEEP/FiO₂ table, maximal compliance, or safe plateau pressure, with continuous monitoring of respiratory mechanics and hemodynamics.

ARDSNET Higher-PEEP Table	FiO ₂ 0.3	0.4	0.5	0.6	0.7	0.8	0.9	1.0
PEEP (cmH ₂ O)	5–8	8–10	10–14	14	14–16	16–18	18–20	20–24

3
Mod

Against prolonged LRMs (PEEP >35 cmH₂O for >60 s) for moderate–severe ARDS — probably increases mortality vs. higher PEEP alone. **Against routine high-frequency oscillatory ventilation** for moderate–severe ARDS (high certainty).

3

Prone Positioning

1
Mod

Prone position for **>12 hours per day** in patients with severe ARDS — pair with deep sedation ± NMBA as needed for tolerance and ventilator synchrony; reassess oxygenation response and skin/line safety with each session.

4

Corticosteroids

2
Mod

Use **corticosteroids** for patients with ARDS — no single agent/dose/duration is endorsed; select a regimen per patient risk profile, or an etiology-defined regimen for conditions with established benefit (e.g., severe CAP, COVID-19, PJP). Typically stopped at extubation; initiation >2 weeks after ARDS onset may be harmful. Monitor for hyperglycemia (↑ risk, moderate certainty) and GI bleeding; use caution if immunocompromised or in regions with endemic tuberculosis/parasitic disease.

5

Neuromuscular Blockade

2
Low

Use **NMBAs in early severe ARDS** — reserve for patients on deep sedation, or with significant ventilator dyssynchrony/deterioration unresolved by ventilator or sedation adjustment; mortality benefit seen mainly vs. deep sedation. Limit duration to a **maximum of 48 hours** whenever possible; watch for ICU-acquired weakness with prolonged use.

6

Venovenous ECMO

2
Low

Use **VV-ECMO in selected patients with severe ARDS**: optimize conventional therapy first (protective ventilation, higher PEEP, NMBA, proning) — their use may obviate escalation to ECMO. Consider in early (<7 d) ARDS with very severe hypoxemia (PaO₂/FiO₂ <80) or hypercapnia (pH <7.25 with PaCO₂ >60), reversible etiology, and few contraindications. Probable mortality benefit but increased bleeding risk — refer early to an experienced, higher-volume center.

Remember — The ARDS bundle: low tidal volume (4–8 mL/kg PBW) with plateau pressure <30 cmH₂O, higher PEEP without prolonged recruitment maneuvers, and prone positioning >12h/day for severe disease. Corticosteroids, NMBA, and VV-ECMO are selective adjuncts layered on top of — never in place of — protective ventilation.