PADIS Focused Update

2025 focused update to the SCCM 2018 PADIS guidelines — anxiety/sedation, delirium, immobility, and sleep disruption in adult ICU patients.

2025 SCCM Focused Update
Pain, Anxiety, Agitation/Sedation, Delirium, Immobility & Sleep (PADIS)
Lewis et al. · Crit Care Med 2025;53:e711–e727

GRADE — 1 · Strong For | 2 · Conditional For | 2- · Conditional Against | 3 · Strong Against | N/R · No Recommendation

1 Anxiety & Sedation

N/R

Insufficient evidence for or against benzodiazepines to treat ICU anxiety. If a patient takes benzodiazepines chronically for baseline anxiety, continue on admission — abrupt cessation may precipitate withdrawal.

2 Mod

Use **dexmedetomidine over propofol** for sedation in mechanically ventilated adults where light sedation and/or delirium reduction are highest priorities. Probably increases bradycardia risk — consider an alternative agent if deep sedation is required or bradycardia risk is high; cost/availability vary by center.

2 Delirium — Antipsychotics

N/R

Unable to issue a recommendation for or against antipsychotics (e.g., haloperidol) vs. usual care for established delirium — possible ↓mortality and more delirium-free days, but low-certainty evidence and unclear mechanism. If used, discontinue at ICU discharge if no longer clinically indicated; monitor QTc and for extrapyramidal symptoms.

3 Immobility — Enhanced Mobilization/Rehabilitation

2 Mod

Provide **enhanced mobilization/rehabilitation** over usual-care mobilization (e.g., cycling, stepping, early/twice-daily, protocolized, or extended-duration therapy) — reduces ICU-acquired weakness (high certainty), duration of mechanical ventilation, delirium, and ICU/hospital length of stay; improves functional outcomes and quality of life. Small increase in arrhythmia risk. Evidence applies mainly to functionally-independent general medical-surgical patients; data insufficient for post-cardiac-surgery patients. Optimal frequency, intensity, and duration remain undefined.

4 Sleep — Melatonin

2 Low

Administer **melatonin over no melatonin** — may reduce delirium prevalence and improve perceived sleep quality, with little effect on total nocturnal sleep duration. Significant heterogeneity in trial dosing/duration/frequency limits a specific regimen; melatonin is not FDA-regulated (quality may vary) — **ramelteon** is an FDA-approved alternative where available.

WHAT CHANGED SINCE THE 2018 PADIS GUIDELINE

DOMAIN	2025 FOCUSED UPDATE	2018 PADIS GUIDELINE
Anxiety	No recommendation on benzodiazepines (new question)	No recommendation previously existed
Sedation	Dexmedetomidine **over** propofol when light sedation/delirium reduction prioritized	Either propofol or dexmedetomidine over benzodiazepines
Delirium	Unable to recommend for/against antipsychotics	Suggested *not* routinely using haloperidol/atypicals
Immobility	Suggest **enhanced** mobilization/rehabilitation over usual care	Suggested performing rehabilitation/mobilization (undefined intensity)
Sleep	Suggest administering melatonin over no melatonin	No recommendation on melatonin for sleep

Remember — This is a focused update addressing five specific questions; the broader 2018 PADIS framework (pain/sedation/delirium assessment tools, the ABCDEF bundle) otherwise remains in place. All recommendations here are conditional, or no-recommendation — individualize to bradycardia/arrhythmia/QTc risk, sedation depth needs, and local resource availability.

Lewis K, Balas MC, Stollings JL, et al. A Focused Update to the Clinical Practice Guidelines for the Prevention and Management of Pain, Anxiety, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult ICU Patients. *Crit Care Med.* 2025;53(3):e711–e727.