

CORRESPONDENCE



Pondering the atypicality of ARDS in COVID-19 is a distraction for the bedside doctor

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I read with interest the editorial by Goligher et al. “Is severe COVID-19 pneumonia a typical or atypical form of ARDS? And does it matter?” [1]. The editorialists address the first question with a thoughtful analysis, but their answer to the second question comes up short.

The corollary to the second question is “To whom does it matter?” The question about atypicality matters to researchers who are rightfully probing the quandaries fomented by the pandemic. For clinicians, however, mulling over this question is a distraction. The critical dilemma for the bedside doctor facing a seriously ill patient affected by coronavirus disease 2019 (COVID-19) is: “To be, or not to be (intubated), that is the question” (with amends to Hamlet) [2]. Thinking about the atypicality of acute respiratory distress syndrome (ARDS) in COVID-19 is to sprinkle additional chaff where a clinician is scouring for the wheat that will resolve the intubation dilemma [3].

The sole ventilator setting in patients with ARDS proven to influence survivability is avoidance of tidal volume of 12 ml/kg. Since tidal volume 12 ml/kg is not used in any patient, making a diagnosis of ARDS does not impact the selection of any ventilator setting [3]. A diagnosis of ARDS does not matter to the bedside doctor caring for a COVID-19 patient. Despite other writings of the editorialists asserting that tidal volume 6 ml/kg represents standard care, there are no data to say that 6 ml/kg is superior to 11 ml/kg (or anything in between) [3].

Goligher et al. enjoin clinicians “to follow the accepted evidence-based framework for the management of

ARDS.” That was the approach of one ARDS-Network center, where patients with COVID-19 were “managed with mechanical ventilation and established ARDS protocols.” Analyzing the reported data, Yaroshetskiy et al. [4] asked why so many of the COVID-19 patients with relatively mild physiological abnormalities were ever intubated.

With COVID-19, a generation of doctors nurtured on protocols and guidelines were left in the lurch when they faced an onslaught of patients requiring decisions based on clinical judgment [2]. The hope of being able to offload responsibility to an external, self-interpreting, authoritative resource is a centuries’ old dream. Even in laboratory science, however, the most critical steps ultimately demand subjective judgments (the choice of transducer, positioning of tangents, and so on).

Evidence-based guidelines can never help a doctor resolve whether a patient is best managed by inserting an endotracheal tube or avoiding its use. That decision is based on clinical judgment, gestalt, and tacit knowledge [2]. I agree with Gattinoni that ventilator management is an important consideration in explaining the “dramatically different outcomes (20–80% mortality rates)” for patients with “an identical disease.” [5] Emerging data reveal a 41.9% decrease in the rate of endotracheal intubation between February–March and April–May, accompanied by a 20.9% decrease in 28-day mortality [6]. In science, arriving at answers is frequently less fruitful than posing the right question. For bedside care of COVID-19 patients, asking whether to intubate or not intubate is the lynchpin—and pondering the atypicality of ARDS is best eschewed [3].

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