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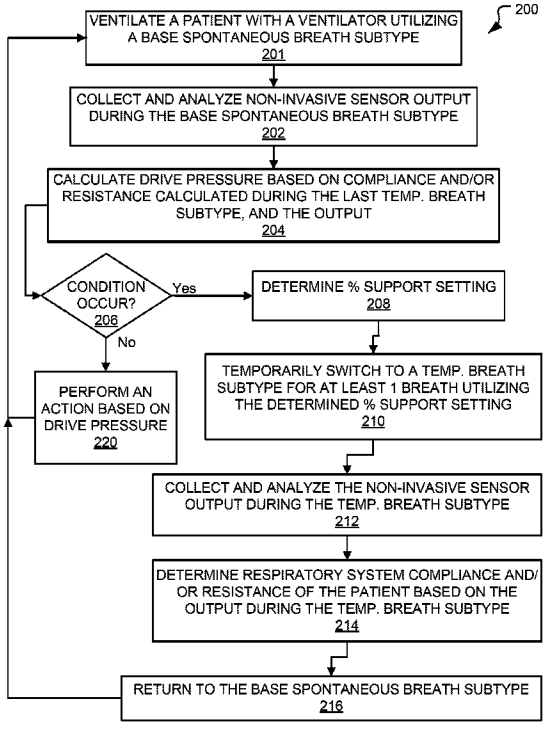

(57) Abrégé/Abstract:
This disclosure describes systems and methods for providing drive pressure ventilation of a patient. The disclosure describes a novel breath type that provides a spontaneous breath type that allows for the calculation of drive pressure that does not require invasive monitoring.

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(54) Title: METHODS AND SYSTEMS FOR DRIVE PRESSURE SPONTANEOUS VENTILATION

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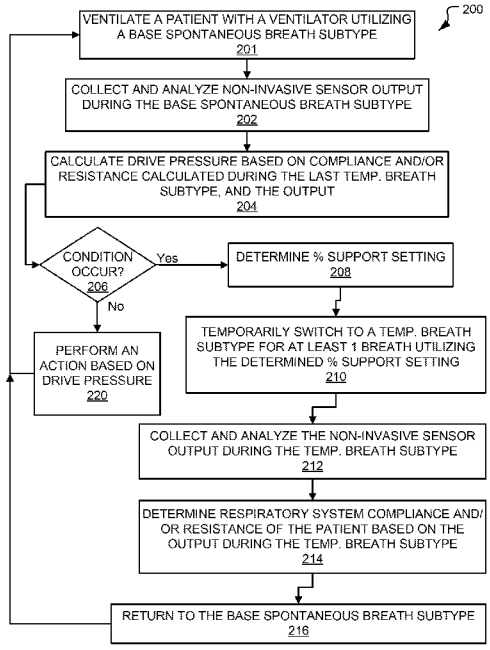

FIG. 2

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METHODS AND SYSTEMS FOR DRIVE PRESSURE SPONTANEOUS VENTILATION

Background

Medical ventilator systems have long been used to provide ventilatory and supplemental oxygen support to patients. These ventilators typically comprise a source of pressurized gas, such air or oxygen, which is fluidly connected to the patient through a conduit or tubing. As each patient may require a different ventilation strategy, modern ventilators can be customized for the particular needs of an individual patient. For example, several different ventilator modes or settings have been created to provide better ventilation for patients in various different scenarios.

Summary

This disclosure describes systems and methods for providing drive pressure ventilation of a patient. The disclosure describes a novel breath type that provides spontaneous ventilation that allows for the calculation of drive pressure that does not require invasive monitoring. To accomplish this goal, the drive pressure (DP) breath type (also referred to herein as drive pressure ventilation) briefly interrupts and smoothly transitions from a base spontaneous breath subtype, into a temporary breath subtype in response to the detection of a condition. As such, ventilator systems and methods utilizing the DP breath type as disclosed herein may adjust ventilator parameters and/or perform other actions based on a monitored dynamic drive pressure.

The base spontaneous breath subtype does not include a proportional assist (PA) breath subtype.

In one embodiment, there is provided a ventilator system for delivering drive pressure ventilation to a patient. The ventilator system includes a pressure generating system that generates a flow of breathing gas, and a ventilation tubing system including a patient interface for connecting the pressure generating system to the patient. The ventilator system further includes one or more non-invasive sensors operatively coupled to at least one of the pressure generating system or the ventilation tubing system, wherein the one or more non-

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invasive sensors generate output indicative of at least one of flow, volume or pressure. The ventilator system further includes a controller that collects and analyzes the output of the sensors to determine a condition. The controller is configured to, in response to the condition, temporarily switch the ventilator system from a spontaneous breath subtype into a proportional assist (PA) breath subtype for at least one breath, estimate a respiratory system compliance of the patient during the PA breath subtype based on the output collected during the PA breath subtype, after the at least one breath, switch the ventilator system from the PA breath subtype back to the spontaneous breath subtype, after a return to the spontaneous breath subtype, and calculate a drive pressure of the patient based on the respiratory system compliance and the output after the return, the drive pressure being a pressure represented in cmH_2O that is applied within the patient's lungs to cause inflation. The system further includes a display for displaying the drive pressure.

The controller may compare the drive pressure to a threshold to form a comparison. The controller may determine that the drive pressure breaches the threshold based on the comparison to form a determination. In response to the determination, the controller may provide an alert.

In further response to the determination, the controller may adjust a ventilation parameter for the ventilator system.

The ventilation parameter may be at least one of oxygen percentage, rise time, trigger sensitivity, peak flow rate, peak inspiratory pressure, tidal volume, PEEP, or a target setting.

The controller may utilize a predetermined percent support setting for the PA breath subtype.

These and various other features as well as advantages which characterize the systems and methods described herein will be apparent from a reading of the following detailed description and a review of the associated drawings. Additional features are set forth in the description which follows, and in part will be apparent from the description, or may be learned by practice of the technology. The benefits and features of the technology will be realized from a reading of the disclosure and the appended drawings.

It is to be understood that both the foregoing general description and the following detailed description are exemplary and explanatory.

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Brief Description of the Drawings

The following drawing figures, which form a part of this application, are illustrative of embodiments of systems and methods described below and are not meant to limit the scope of the disclosure in any manner.

FIG. 1 is a schematic diagram illustrating an example of a ventilator in accordance with aspects of the disclosure.

FIG. 2 is flow a diagram illustrating an example of a method for ventilating a patient on a ventilator in a drive pressure breath type, in accordance with aspects of the invention.

FIG. 3 is a chart illustrating an example of a normalized respiratory mechanics plane in accordance with aspects of the disclosure.

FIG. 4 is a chart illustrating an example of a normalized respiratory plane with provided patient trend line in accordance with aspects of the disclosure.

FIG. 5 is a chart illustrating an example of a normalized respiratory plane with provided boundaries in accordance with aspects of the disclosure.

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Detailed Description

Although the techniques introduced above and discussed in detail below may be implemented for a variety of medical devices, the present disclosure will discuss the implementation of these techniques in the context of a medical ventilator for use in providing ventilation support to a human patient. A person of skill in the art will understand that the technology described in the context of a medical ventilator for human patients could be adapted for use with other systems such as ventilators for non-human patients and general gas transport systems.

Medical ventilators are used to provide a breathing gas to a patient who may otherwise be unable to breathe sufficiently. In modern medical facilities, pressurized air and oxygen sources are often available from wall outlets. Accordingly, ventilators may

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provide pressure regulating valves (or regulators) connected to centralized sources of pressurized air and pressurized oxygen. The regulating valves function to regulate flow so that respiratory gas having a desired concentration of oxygen is supplied to the patient at desired pressures and rates. Ventilators capable of operating independently of external sources of pressurized air are also available.

While operating a ventilator, it is desirable to control the percentage of oxygen in the gas supplied by the ventilator to the patient. Further, as each patient may require a different ventilation strategy, modern ventilators can be customized for the particular needs of an individual patient.

For the purposes of this disclosure, a "breath" refers to a single cycle of inspiration and exhalation delivered with the assistance of a ventilator. The term "breath type" refers to some specific definition or set of rules dictating how the pressure and flow of respiratory gas is controlled by the ventilator during a breath.

A ventilation "mode", on the other hand, is a set of rules controlling how multiple subsequent breaths should be delivered. Modes may be mandatory, that is controlled by the ventilator, or spontaneous, that is that allow a breath to be delivered or controlled upon detection of a patient's effort to inhale, exhale or both. For example, a simple mandatory mode of ventilation is to deliver one breath of a specified mandatory breath type at a clinician-selected respiratory rate (e.g., one breath every 6 seconds). Until the mode is changed, ventilators will continue to provide breaths of the specified breath type as dictated by the rules defining the mode. For example, breath types may be mandatory mode breath types (that is, the initiation and termination of the breath is made by the ventilator) or spontaneous mode breath types (which refers to breath types in which the breath is initiated and terminated by the patient). Examples of breath types utilized in the spontaneous mode of ventilation include proportional assist (PA) breath type, volume support (VS) breath type, pressure support (PS) breath type, and etc. Examples of mandatory breath types include a volume control breath type, a pressure control breath type, and etc.

Positive pressure delivery during mechanical ventilation can be injurious to the lung. Therefore, measurements and methods that would allow for minimizing the lung injury have been utilized by mechanical ventilators to reduce lung injuries. Previously, studies showed that utilizing low tidal volume was likely to prevent ventilator-induced lung injury (VILI). However, newer studies have shown that low tidal volumes only increase the chance of patient survival (or reduce the likelihood VILI) if this low tidal

volume is associated with decreases in patient drive pressure. Further, studies have shown that increases in patient drive pressure, particularly above 15 cm of H_2O, are strongly associated with decreased patient survival rates. As such, patient drive pressure may be a better mechanical ventilation parameter than tidal volume for survival prediction and/or ventilation control.

Patient drive is the pressure that is applied 'inside the lungs' causing them to inflate. This 'driving pressure' is what the lungs are exposed to in order to inflate them against the compliance of the lung. For a mechanically ventilated patient, the patient drive pressure can be calculated as the pressure above baseline pressure applied by the ventilator at the patient wye (i.e., Pwye – Pend exp), minus the pressure to overcome the artificial airway (i.e., RTUBE*QLUNG), minus the pressure created by the respiratory muscles (i.e., Pmus). Accordingly, the equation for calculating drive pressure is listed below:

$$Pdrive = Pwye - Pend\ exp - RTUBE\ QLUNG - Pmus, \quad (EQ\ \#1)$$

where:

Pdrive is patient drive pressure;

Pwye is pressure at the wye;

Pend exp is pressure at the end of exhalation;

RTUBE is the resistance of the endotracheal tube or tracheostomy tube;

QLUNG is lung flow; and

Pmus, is muscle pressure.

During mandatory modes of ventilation, the patient is sedated. As such, during mandatory modes of ventilation, the muscle pressure of the patient is zero since the patient is passive. Accordingly, if an inspiratory pause is applied to the patient during the mandatory mode of ventilation, such that the pressure on either side of the artificial airway (endotracheal tube or tracheostomy tube) is the same, the lung flow (QLUNG) will be zero and the above Equation #1 simplifies to:

$$Pdrive = Pwye - Pend\ exp, \quad (EQ\ \#\ 2).$$

However, in order for the above equation to work, the patient must be ventilated utilizing a mandatory mode of ventilation and the patient must be passive (such as sedated). As such, several ventilators are capable of calculating and displaying drive pressure during mandatory modes of ventilation on a passive patient with use of an inspiratory pause. However, if the patient is not passive, then the ventilator, even during a mandatory mode of ventilation, is not capable of calculating patient drive pressure. During a spontaneous mode of ventilation, the patient is not passive so the patient's muscle pressure varies

throughout each breath and patient drive pressure is, therefore, a much more difficult calculation. Currently, the only ventilators that are capable of calculating drive pressure during a spontaneous mode of ventilation or during any mode of ventilation where the patient is not passive, requires invasive monitoring techniques.

Accordingly, the current disclosure describes a drive pressure (DP) breath type for ventilating a patient. The DP breath type (also referred to herein as drive pressure ventilation) is a spontaneous breath type that allows for the calculation of drive pressure that does not require invasive monitoring. To accomplish this goal, the DP breath type briefly interrupts and smoothly transitions from a base spontaneous breath subtype into a temporary proportional assist (PA) breath subtype for a predetermined period in response to a condition and then smoothly transitions back into the base spontaneous breath subtype. In some aspects, the DP breath type accomplishes the smooth transition by determining a percent support setting for the PA breath subtype based on the target settings of the base spontaneous breath subtype and/or based on non-invasively monitored/measured parameters. In other aspects, a predetermined percent support setting is utilized for the transition by the DP breath type. As such, ventilator systems and methods utilizing the DP breath type may adjust ventilator parameters and/or perform other actions based on a monitored drive pressure.

FIG. 1 is a schematic diagram illustrating an example of a ventilator **100** connected to a human patient **150**. Ventilator **100** includes a pneumatic system **102** (also referred to as a pressure generating system **102**) for circulating breathing gases to and from patient **150** via the ventilation tubing system **130**, which couples the patient **150** to the pneumatic system **102** via an invasive (e.g., endotracheal tube, as shown) or a non-invasive (e.g., nasal mask) patient interface **180**.

Ventilation tubing system **130** (or patient circuit **130**) may be a two-limb (shown) or a one-limb circuit for carrying gases to and from the patient **150**. In a two-limb embodiment, a fitting, typically referred to as a "wye-fitting" **170**, may be provided to couple a patient interface **180** (as shown, an endotracheal tube) to an inspiratory limb **132** and an expiratory limb **134** of the ventilation tubing system **130**.

Pneumatic system **102** may be configured in a variety of ways. In the present example, pneumatic system **102** includes an expiratory module **108** coupled with the expiratory limb **134** and an inspiratory module **104** coupled with the inspiratory limb **132**. Compressor **106** or other source(s) of pressurized gases (e.g., air, oxygen, and/or helium)

is coupled with inspiratory module **104** and the expiratory module **108** to provide a gas source for ventilatory support via inspiratory limb **132**.

The inspiratory module **104** is configured to deliver gases to the patient **150** according to prescribed ventilatory settings. In some embodiments, inspiratory module **104** is configured to provide ventilation according to various breath types, e.g., via a DP breath type, or via any other suitable breath types.

The expiratory module **108** is configured to release gases from the patient's lungs according to prescribed ventilatory settings. Specifically, expiratory module **108** is associated with and/or controls an expiratory valve for releasing gases from the patient **150**.

The ventilator **100** may also include one or more non-invasive sensors **107** communicatively coupled to ventilator **100**. Sensors are referred to herein as non-invasive when the sensors are located externally to patient. For example, sensors located in the patient wye **170**, in the expiratory module **108**, in the inspiratory module **104**, or on the patient's finger are all external to the patient and are non-invasive. Sensors are referred to herein as invasive when the sensors are located within the patient or placed inside the patient's body, such as sensors located in an endotracheal tube, near a patient diaphragm, or on an esophageal balloon. While invasive sensors can provide great patient data or measurements, these sensors can often be hard to maintain or keep properly positioned. For example, an esophageal balloon can easily be knocked out of proper position in response to patient movement. Once moved, all of the data recorded from the sensors on the balloon are inaccurate. Further, if condensation or material corrupts the sensor and interferes with accurate measurements, the invasive sensor has to be removed from the body to service and/or clean it. Further, because invasive sensors are located within the patient, they usually require the patient to be sedated or undergo a surgical procedure for implantation or positioning adjustment. As such, invasive sensors are burdensome to the patient, hard to implant, hard to maintain, and hard to keep positioned when compared to non-invasive sensors. The embodiment of FIG. 1 illustrates a sensor **107** in pneumatic system **102**.

Sensors **107** may communicate with various components of ventilator **100**, e.g., pneumatic system **102**, other sensors **107**, processor **116**, condition module **117**, drive pressure module **118**, treatment module **119**, and/or any other suitable components and/or modules. In one embodiment, sensors **107** generate output and send this output to pneumatic system **102**, other sensors **107**, processor **116**, condition module **117**, drive

pressure module **118**, treatment module **119** and any other suitable components and/or modules. Sensors **107** may employ any suitable sensory or derivative technique for monitoring one or more patient parameters or ventilator parameters associated with the ventilation of a patient **150**. Sensors **107** may detect changes in patient parameters indicative of patient triggering, for example. Sensors **107** may be placed in any suitable non-invasive location, e.g., within the ventilatory circuitry (excluding an endotracheal tube) or other devices communicatively coupled to the ventilator **100**. Further, sensors **107** may be placed within the ventilatory circuitry or within components or modules of ventilator **100**. For example, sensors **107** may be coupled to the inspiratory and/or expiratory modules for detecting changes in circuit pressure and/or flow. In other examples, sensors **107** may be affixed to the ventilatory tubing or may be embedded in the tubing itself. Additionally or alternatively, sensors **107** may be affixed or embedded in or near wye-fitting **170** and/or in a non-invasive patient interface . Indeed, any non-invasive sensory device useful for monitoring changes in measurable parameters during ventilatory treatment may be employed in accordance with embodiments described herein. In some aspects, the ventilator **100** does not utilize any invasive sensors or sensory devices.

As should be appreciated, with reference to the Equation of Motion, ventilatory parameters are highly interrelated and, according to embodiments, may be either directly or indirectly monitored. That is, parameters may be directly monitored by one or more sensors **107**, as described above, or may be indirectly monitored or estimated/calculated using a model, such as a model derived from the Equation of Motion:

$$Pmus = Pwye - Pend\,exp - (RTUBE + Rrs)QLUNG - \frac{\int QLUNGdt}{Crs}, \text{ EQ \#3}$$

where:

Rrs is respiratory system resistance;

Crs is respiratory system compliance; and

∫QLUNGdt is lung flow integrated over time.

The pneumatic system **102** may include a variety of other components, including mixing modules, valves, tubing, accumulators, filters, etc. Controller **110** is operatively coupled with pneumatic system **102**, signal measurement and acquisition systems, and an operator interface **120** that may enable an operator to interact with the ventilator **100** (e.g., change ventilator settings, select operational modes, view monitored parameters, etc.).

In one embodiment, the operator interface **120** of the ventilator **100** includes a display **122** communicatively coupled to ventilator **100**. Display **122** provides various

input screens, for receiving clinician input, and various display screens, for presenting useful information to the clinician. In one embodiment, the display **122** is configured to include a graphical user interface (GUI). The GUI may be an interactive display, e.g., a touch-sensitive screen or otherwise, and may provide various windows and elements for receiving input and interface command operations. Alternatively, other suitable means of communication with the ventilator **100** may be provided, for instance by a wheel, keyboard, mouse, or other suitable interactive device. Thus, operator interface **120** may accept commands and input through display **122**. Display **122** may also provide useful information in the form of various ventilatory data regarding the physical condition of a patient **150**. The useful information may be derived by the ventilator **100**, based on data collected by a processor **116**, and the useful information may be displayed to the clinician in the form of graphs, wave representations, pie graphs, text, or other suitable forms of graphic display. For example, patient data may be displayed on the GUI and/or display **122**. Additionally or alternatively, patient data may be communicated to a remote monitoring system coupled via any suitable means to the ventilator **100**. In one embodiment, the display **122** may display one or more of an alert, a current drive pressure, a past drive pressure, a drive pressure graph, a recommendation, a drive pressure breach of a threshold, a ventilation parameter change, a current patient effort, a diaphragmatic pressure, a patient respiratory compliance, a patient respiratory resistance, a desired drive pressure range, a trigger sensitivity, a condition, a tidal volume, a flow, a pressure, a target setting, a breath type, a ventilation mode, and/or etc.

Controller **110** is a command and control computing devices and may include memory **112**, one or more processors **116**, storage **114**, and/or other components of the type commonly found in command and control computing devices. Controller **110** may further include a condition module **117**, a drive pressure module **118**, and/or a treatment module **119** as illustrated in FIG. 1. A module as used herein may also refer to a command and control computing device. A module as used herein may refer to memory, one or more processors, storage, and/or other components of the type commonly found in command and control computing devices. In alternative embodiments, the condition module **117**, the drive pressure module **118**, and the treatment module **119** may be located in other components of the ventilator **100**, such as the pressure generating system **102** (also known as the pneumatic system **102**).

The memory **112** includes non-transitory, computer-readable storage medium that stores software that is executed by the processor **116** and which controls the operation of

the ventilator **100**. In an embodiment, the memory **112** includes one or more solid-state storage devices such as flash memory chips. In an alternative embodiment, the memory **112** may be mass storage connected to the processor **116** through a mass storage controller (not shown) and a communications bus (not shown). Although the description of computer-readable media contained herein refers to a solid-state storage, it should be appreciated by those skilled in the art that computer-readable storage media can be any available non-transitory medium that can be accessed by the processor **116**. That is, computer-readable storage media includes non-transitory, volatile and non-volatile, removable and non-removable media implemented in any method or technology for storage of information such as computer-readable instructions, data structures, program modules or other data. For example, computer-readable storage media includes RAM, ROM, EPROM, EEPROM, flash memory or other solid state memory technology, CD-ROM, DVD, or other optical storage, magnetic cassettes, magnetic tape, magnetic disk storage or other magnetic storage devices, or any other medium which can be used to store the desired information and which can be accessed by the computer.

The inspiratory module **104** receives a selected DP breath type from the controller **110**. The DP breath type utilizes a mix of two different breath types (referred to herein as breath subtypes) and smoothly transitions between the two different breath types. The two different breath types utilized within the DP breath type are referred to herein as a base breath subtype and a temporary breath subtype that is triggered upon the detection or occurrence of a condition. The base breath subtype is any spontaneous breath type other than the PA breath type, such as a PS or VS breath type. In some aspects, the base spontaneous breath subtype is predetermined for the DP breath type. In other aspects, the base spontaneous breath subtype is selected by the clinician. Depending upon the base spontaneous breath subtype, other inputs, such as a target setting, may be required from the clinician for operating the DP breath type. A target setting as utilized herein refers to a setting that has to be input for a breath type or breath subtype to function or work. For example, if the base spontaneous breath subtype is a PS breath type, the ventilator **100** may require a target pressure input from the clinician. For example, if the base spontaneous breath subtype is a VS breath type, ventilator **100** may require a target tidal volume input from the clinician. However, other inputs, such as patient interface type, ventilation tubing system size, PEEP levels, and/or etc. may also be required from the clinician for operating the DP breath type depending upon the type of ventilator and/or the base spontaneous breath subtype. The temporary breath subtype is a PA breath type.

When the PA breath type is being utilized as the temporary breath subtype during a DP breath type, the PA breath type is referred to herein a PA breath subtype. As such, while the use of different breath types, such as PA, PS, VS are discussed herein, these breath types are not being implemented, but instead are being utilized as breath subtype or portion within the DP breath type. During the DP breath type, the controller **110** sends instructions to the inspiratory module **104** and/or the expiratory module **108** for delivering the base spontaneous breath subtype while the condition module **117** of the controller **110** monitors for a condition.

Initiation and execution of a DP breath type requires detection of an inspiratory trigger. In some aspects, a patient trigger is calculated based on a measured or monitored patient inspiration flow. Any suitable type of triggering detection for determining a patient trigger may be utilized by the ventilator **100**, such as nasal detection, diaphragm detection, and/or brain signal detection. Further, the ventilator **100** may detect patient triggering via a pressure-monitoring method, a flow-monitoring method, direct or indirect measurement of neuromuscular signals, or any other suitable method. Sensors **107** suitable for this detection may include any suitable sensing device as known by a person of skill in the art for a ventilator.

According to an embodiment, a pressure-triggering method may involve the ventilator **100** monitoring the circuit pressure, and detecting a slight drop in circuit pressure. The slight drop in circuit pressure may indicate that the patient's respiratory muscles are creating a slight negative pressure that in turn generates a pressure gradient between the patient's lungs and the airway opening in an effort to inspire. The ventilator **100** may interpret the slight drop in circuit pressure as a patient trigger and may consequently initiate inspiration by delivering respiratory gases.

Alternatively, the ventilator **100** may detect a flow-triggered event. Specifically, the ventilator **100** may monitor the circuit flow, as described above. If the ventilator **100** detects a slight drop in the base flow through the exhalation module during exhalation, this may indicate, again, that the patient **150** is attempting to inspire. In this case, the ventilator **100** is detecting a drop in bias flow (or baseline flow) attributable to a slight redirection of gases into the patient's lungs (in response to a slightly negative pressure gradient as discussed above). Bias flow refers to a constant flow existing in the circuit during exhalation that enables the ventilator **100** to detect expiratory flow changes and patient triggering.

In response to a detection of a patient trigger, the controller **110** sends instruction to the inspiratory module **104** to deliver breathing gas to the patient based on the parameters of DP breath type.

During ventilation with the base spontaneous breath subtype, the condition module **117** monitors input to determine the occurrence of one or more conditions. In some aspects, the condition module **117** monitors the measurements from the non-invasive sensors. In other aspects, the condition module **117** monitors other received ventilator data or calculations to determine the occurrence of the condition. In some aspects, the condition may be any event that is indicative of a change in patient respiratory system compliance and/or patient respiratory system resistance, such as a predetermined pressure differential, volume differential, a tidal volume differential, a specific flow waveform shape, a specific volume waveform shape, a specific pressure waveform shape, a predetermined change in pressure, a predetermined change in flow, a predetermined change in tidal volume and/or etc. For example, the condition may be a change in non-invasively monitored flow, pressure, and/or of volume of at least 25%. In other aspects, the condition is an expiration of a set period or predetermined number of breaths, since the last PA breath subtype switch or since the start of the last PA breath subtype. For example, the condition may be the expiration of 30, 60, 90, or 120 minutes or the occurrence of 400, 300, or 200 breaths since the last temporary switch into the PA breath subtype or the start of the last PA breath subtype. In other examples, the condition module **117** monitors for the following condition to occur: 1) expiration of 1 hour since the last PA breath subtype; or 2) a 25% change in one of non-invasively measured pressure, flow, or tidal volume during the base spontaneous breath subtype. If the DP breath type was just initialized, the conditions discussed above may be monitored from the start of ventilation or the start of the DP breath type instead of since the last temporary switch into the PA breath subtype or the start of the last PA breath subtype. If the condition module **117** detects a condition, the condition module **117** of the controller **110** determines a percent support setting and sends instructions to the pressure generating system **102** to provide a short temporary switch into a PA breath subtype utilizing the determined percent support setting.

In some aspects, the condition module **117** determines a percent support setting by utilizing a predetermined or preset percent support setting. In other aspects, the condition module **117** determines a percent support setting based on a target setting for the base spontaneous breath subtype. For example, if the target pressure for the PS breath type is

10 cm H_2O, then the condition module **117** will determine a percent supporting setting to achieve approximately the same pressure level. In another example, if the target volume for a VS breath type is 400 ml, then the condition module **117** will determine a percent support setting to achieve approximately the same volume level. In other aspects, the percent setting is determined by the condition module **117** based on outputs from the non-invasive sensor. For example, if inspiratory pressure measurement is 9.8 cm H_2O from inspiratory pressure sensor, then the condition module **117** will determine a percent support setting to achieve approximately the same pressure level. In further aspects, the condition module **117** may utilize additional ventilator parameters or inputs to the target setting and/or the outputs from the non-invasive sensor to determine a percent support setting, such as mask type, patient circuit diameter, and etc.

The PA breath subtype is an effort-based breath type that dynamically determines the amount of ventilatory support to deliver based on a continuous estimation/calculation of patient effort and respiratory characteristics. Patient effort as discussed in the PA breath type is not a muscle pressure (Pmus). In contrast, the patient effort during the PA breath type refers to resistive and elastic pressure drops. The resulting dynamically generated profile is computed in real- or quasi-real-time and used by the ventilator as a set of points for control of applicable parameters.

Initiation and execution of an effort-based breath type, such as PA breath type or PA breath subtype, has two operation prerequisites: (1) detection of an inspiratory trigger; and (2) detection and measurement of an appreciable amount of patient respiratory effort to constitute a sufficient reference above a ventilator's control signal error deadband. Advanced, sophisticated triggering technologies detect initiation of inspiratory efforts efficiently. Patient effort is calculated based on measured patient inspiration flow. Patient effort is utilized to calculate a target airway pressure for the inspiration. The delivered airway pressure as used herein is the airway pressure measured at the ventilator-patient interface. The target airway pressure is resistive pressure (Presistive) plus elastic pressure (Pelastic) plus positive end exhalation pressure (PEEP), where Presistive and Pelastic are scaled by the percent support setting.

A PA breath type or subtype refers to a type of ventilation in which the ventilator acts as an inspiratory amplifier that provides pressure support based on the patient's effort. Usually, the degree of amplification (the "percent support setting") during a PA breath type is set by an operator or clinician, for example as a percentage based on the patient's

effort. However, during the DP breath type, the condition module **117** determines the percent support setting provided during the PA breath subtype.

In one implementation of a PA breath subtype, the ventilator may continuously monitor the patient's instantaneous inspiratory flow and instantaneous net lung volume, which are indicators of the patient's inspiratory effort. These signals, together with ongoing estimates of the patient's lung compliance and lung/airway resistance and the Equation of Motion ($Pmus = Pwye - Pend\,exp - (RTUBE + Rrs)QLUNG - \frac{\int QLUNGdt}{Crs}$), allow the ventilator to estimate/calculate a patient effort and derive therefrom a target airway pressure to provide the support that assists the patient's inspiratory muscles to the degree selected by the operator as the percent support setting. In this equation, the patient effort is inspiratory muscle pressure and is negative. The percent support setting as determined by the condition module **117** divides the total work of breathing calculated between the patient and the ventilator.

Unlike other spontaneous breath subtypes, the PA breath subtype can calculate compliance and resistance without having to utilize an invasive sensor. As such, the PA breath subtype is a spontaneous breath type that is able to calculate dynamic respiratory system compliance and respiratory system resistance. In other spontaneous breath subtypes, an invasive sensor located in an esophageal balloon is needed. However, as discussed above, an esophageal balloon can easily become dislodged if the patient moves affecting sensor accuracy, is highly invasive to implant, and/or is uncomfortable for a spontaneously breathing patient. Due to the disruptive nature of the esophageal balloon, the esophageal balloon is rarely utilized during a spontaneous breath subtype.

Due to the unique configuration of the PA breath subtype, the PA breath subtype is capable of determining a patient respiratory system compliance and/or resistance in an end exhalation hold of 300 ms or 0.3 seconds, which will usually go unnoticed by a spontaneously breathing patient. In a typical PA breath type, this 300 ms end expiratory hold is provided intermittently at random. During the DP breath type, the 300 ms end expiratory hold is provided in the first, second, third, or fourth breath of the temporary PA breath subtype portion of the DP breath type. Any additional 300 ms holds are provided after a predetermined number of breaths or after a set time period during the PA breath subtype. In other words, the PA breath subtype does not provide the 300 ms end expiratory hold at random but instead at predetermined intervals. As such, the DP breath type is able to calculate patient respiratory compliance and patient respiratory system

resistance without having to utilize an invasive sensor measurement. The DP breath type utilizes the following equation to determine patient respiratory system compliance:

$$C_{RAW} = (V_{LUNG} / \text{Pressure\_delta}).$$

The DP breath type utilizes the following equation to determine patient respiratory system resistance:

$$R_{RAW} = R_{RAW+ET} - R_{ET},$$

where:

R_{RAW} is patient respiratory system resistance;

R_{RAW+ET} is the combined resistance of the patient respiratory system and the endotracheal tube/tracheostomy tube resistance; and

R_{ET} is endotracheal tube/tracheostomy tube resistance.

R_{RAW+ET} is the difference in lung pressure and wye pressure divided by the estimated lung flow. The lung pressure is based upon the lung pressure at the beginning of exhalation minus exhaled volume times the elastance. Wye pressure is estimated as the measured pressure inside the ventilator compensated for inspiratory limb resistance.

During the PA breath subtype, the drive pressure module **118** calculates patient respiratory resistance and/or compliance based on non-invasive sensor output. The condition module **117** provides the PA breath subtype for at least one breath. In some aspects, the condition module **117** provides the PA breath subtype for at least three breaths. In some aspects, the condition module **117** provides the PA breath subtype until a predetermined number of patient respiratory compliance and/or resistance measurements have been made by the ventilator **100**. In some aspects, the condition module **117** provides the PA breath subtype until at least two or three patient respiratory compliance and/or resistance measurements have been made by the ventilator **100**. In other aspects, the condition module **117** provides the PA breath subtype until at least one, two, three, four, or five patient respiratory compliance and/or resistance measurements have been made by the ventilator **100**. The predetermined number of patient respiratory compliance and/or resistance measurements can be completed in 1 breath, 2 breaths, 3 breaths, 5 breaths, 7 breaths, 8 breaths, 10 breaths, 12 breaths, 15 breaths, 20 breaths, 25 breaths or 30 breaths. In other aspects, a predetermined number of patient respiratory compliance and/or resistance measurements can be completed by the condition module **117** in 4 to 12 breaths.

After the temporary PA breath subtype portion has been completed (e.g., the predetermined number of patient respiratory compliance and/or resistance measurements

have been made by the ventilator **100**), the condition module **117** switches the ventilation of the patient back to the previously utilized base spontaneous breath subtype.

After the return to the previously utilized base spontaneous breath subtype, the drive pressure module **118** monitors respiratory data of the patient, such as the non-invasive sensor output. In some aspects, the drive pressure module **118** estimates a dynamic drive pressure waveform of the patient during the spontaneous breath subtype based on the respiratory data and the respiratory system compliance and/or compliance. Next, the drive pressure module **118** calculates a drive pressure of the patient during the spontaneous breath subtype utilizing the respiratory system compliance and/or the respiratory system resistance, and the respiratory data. The drive pressure calculated by the drive pressure module **118** can be dynamic and/or static.

In some aspects, equations (1) and (3) can be combined to get the following drive pressure equation:

$$Pdrive = Rrs\ QLUNG + 1/Crs \int QLUNGdt, \qquad EQ\ \#4.$$

If equation #4 above is evaluated at the end of the inspiratory phase, and QLUNG is assumed to be zero (e.g., at the transition point between inspiration and exhalation), the integral of QLUNG is the tidal volume, Vt. Based on these assumptions, a static drive pressure is calculated by the drive pressure module **118** of control **110** by utilizing the following equation:

$$Pdrive = 1/Crs\ Vt = Vt/Crs, \qquad EQ\ \#5.$$

In further aspects, a dynamic drive pressure is calculated by the drive pressure module **118** of control **110** by utilizing the following equation:

$$Pmus = Pwye - Pend\ exp - (RTUBE + Rrs)\ QLUNG - 1/Crs \int QLUNGdt, \qquad EQ\ \#6$$

where:

Pmus = respiratory muscle pressure;

Pwye = pressure at the patient wye;

Pend exp = pressure at the end of the expiratory phase;

RTUBE = resistance of the artificial airway;

Rrs = patient respiratory resistance;

QLUNG = lung flow; and

Crs = compliance of the respiratory system.

As can be seen from the above equations, at the end of the inspiratory phase where QLUNG = 0 and $\int QLUNGdt$ = tidal volume, dynamic and static drive pressure are the same. However, when the lung flow is non-zero, the driving pressure includes a

component related to the resistance of the patient respiratory system. Under some conditions, this can result in the maximum driving pressure being higher than the driving pressure at the end of the inspiratory phase. In these situations, the use of the driving pressure at the end of inspiration (or static drive pressure) may not fully represent the impact of the ventilator **100** on lung injury. As such, the dynamic drive pressure measurement is a better or more accurate measurement for determining and/or preventing lung injury than the static drive pressure measurement.

The drive pressure module **118** measures the drive pressure repeatedly throughout a breath. In some aspects, the drive pressure module **118** measures drive pressure every servo cycle, such as every 2 milliseconds, 5 millisecond, or 10 milliseconds. The servo cycle is the amount of time required by the processor **116** or controller **110** of the ventilator **100** to perform a calculation in response to a received measured pressure or flow. In some aspects, the sensors **107** send output or measurements every servo cycle.

The drive pressure module **118** communicates the drive pressure to other modules, such as the treatment module **119** and condition module **117**, controller **110**, the pneumatic system **102**, and/or the display **122**.

The treatment module **119** performs an action in response to receiving the drive pressure. The action may include generating a display of the drive pressure, evaluating the drive pressure, generating an alert based on the drive pressure, providing a recommendation based on the drive pressure, and/or changing ventilator parameters based on the drive pressure. For example, the treatment module **119** may send instruction to the display to display **122** a determined drive pressure. In other aspects, the treatment module may generate a graph of the drive pressure, such as a waveform or bar graph of the drive pressure. For instance, the treatment module **119** may generate a graph or waveform of drive pressure versus time.

In some aspects, the treatment module **119** evaluates the drive pressure by comparing the drive pressure to a threshold. If the treatment module **119** determines that the drive pressure breaches the threshold, the treatment module **119** performs an action in response to this determination. As discussed above, the action may include a display of the drive pressure and/or the breach, generating an alert based on the breach, providing a recommendation based on the breach, and/or changing ventilator parameters based on the breach. If the treatment module **119** determines that the drive pressure does not breach the threshold, the treatment module **119** continues to evaluate the received drive pressures from the drive pressure module **118**. In further aspects, if the treatment module **119**

determines that the drive pressure does not breach the threshold, the treatment module **119** may also provide a recommendation to the clinician based on the drive pressure meeting the threshold.

The drive pressure threshold may be a drive pressure of 15 cm of H_2O or less, a drive pressure of 10 cm of H_2O or less, or a drive pressure of 5 cm of H_2O to 15 cm of H_2O. This list is exemplary and is not meant to be limiting. Any suitable drive pressure range for optimal patient ventilation may be utilized by the treatment module **119**, controller **110**, and/or ventilator **100**. The threshold may be predetermined, selected by the ventilator based on other patient information, or selected or input by a clinician.

In response to a drive pressure or a breach of a threshold by the drive pressure, the treatment module **119** may generate an alert. The alert may be a visual, audio, or any other type of sensory notification that notifies a clinician that the patient's drive pressure has breached a predetermined threshold. In response to a drive pressure meeting a threshold, or a breach of a threshold, the treatment module **119** may provide a recommendation. The recommendation may be changes to ventilator parameters, such as target settings, other ventilator settings, changes in breath type, changes in breath subtype, and/or changes in ventilator mode. For example, if the drive pressure exceeds a threshold, such as is greater than 15 cm of H_2O, the treatment module **119** may recommend a decrease in tidal volume, a decrease in flow, a decrease in pressure, an increase in PEEP, and/or a decrease in PEEP to try and bring the drive pressure within the desired levels. For example, if the drive pressure exceeds a threshold, such as is less than 2 cm of H_2O, the treatment module **119** may recommend an increase in tidal volume, an increase in flow, an increase in pressure, and/or a increase in PEEP because such changes may be beneficial for the patient and have no or very low risk of causing lung injury. Alternatively, the treatment module **119** may automatically modify the ventilation parameters listed above based on drive pressure or the result of a comparison of drive pressure to a threshold. The ventilation parameter may include a target setting, oxygen percentage, rise time, trigger sensitivity, peak flow rate, peak inspiratory pressure, tidal volume, and/or PEEP. In some aspects, the treatment module **119** may adjust ventilation parameters to maintain the drive pressure within a target range, such as the threshold. An automatic change in ventilation parameter may be sent by treatment module **119** to the display **122** or other modules to notify the clinician of the change.

As discussed above, method **200** illustrates a method for drive pressure ventilation of a patient with a ventilator. Accordingly, method **200** ventilates a patient with a DP

breath type. Method **200** provides a spontaneous breath type that allows for the calculation of dynamic drive pressure and does not require invasive monitoring. To accomplish this goal, the method **200** briefly interrupts and smoothly transitions from a base spontaneous breath subtype, other than a PA breath subtype, into the PA breath subtype in response to a condition and then smoothly transitions back into the base spontaneous breath subtype when a patient respiratory system compliance and/or resistance has been calculated. Method **200** accomplishes the smooth transition by determining a percent support setting for the PA breath subtype. As such, method **200** may adjust ventilator parameters and/or perform other actions based on a monitored dynamic drive pressure.

As illustrated, method **200** includes a spontaneous ventilation operation **201**. During the spontaneous ventilation operation **201**, the ventilator ventilates the patient utilizing a spontaneous breath subtype. The spontaneous breath subtype is any spontaneous breath type other than a PA breath type.

As illustrated, method **200** includes a spontaneous collection operation **202**. During the spontaneous collection operation **202**, the ventilator collects and analyzes non-invasive sensor output during the spontaneous breath subtype. In other words, during spontaneous collection operation **202**, the ventilator non-invasively monitors respiratory data of the patient. Non-invasive sensor output or respiratory data refers to the output or measurements generated by non-invasive sensors. As such, in some aspects, during spontaneous collection operation **202**, the ventilator collects flow rate, tidal volume, and/or pressure measurements from non-invasive sensors located in the ventilator **100** and/or ventilation tubing system **130**. In some aspects during spontaneous collection operation **202**, the ventilator **100** estimates a pressure or flow at the wye **170** based on an analysis of the non-invasive sensor output. In other aspects, other parameters are derived by the ventilator **100** during spontaneous collection operation **202** based on analysis of the of the non-invasive sensor output.

During operations **201** and **202**, the ventilator analyzes the non-invasive sensor output or respiratory data to detect a patient effort. During operations **201** and **202**, the ventilator delivers inspiratory gas to the patient with the ventilator in response to a detected patient effort. The inspiratory gas is delivered according to the spontaneous breath subtype.

At DP operation **204**, a drive pressure of the patient is calculated or estimated during the spontaneous breath subtype utilizing a calculated or estimated compliance

measurement and/or resistance measurement determined during the last PA breath subtype and the output from the sensors during the spontaneous breath subtype. The calculation and/or estimation of the compliance measurement and/or resistance measurement is discussed in more detail below and performed during operations **212** and **214**. In some aspects, the ventilator during DP operation **204** may calculate or estimate the muscle pressure of the patient during the spontaneous breath subtype based on the compliance measurement and/or resistance measurement. During DP operation **204**, the ventilator calculates or estimates a dynamic drive pressure. For example, as discussed above, the ventilator during DP operation **204** may calculate or estimate the dynamic drive pressure by utilizing Equation # 6 listed above. In some aspects, the ventilator during DP operation **204** is also capable of calculating or estimating static drive pressure by utilizing Equation # 5 listed above.

Method **200** also includes a determination operation **206**. At determination operation **206**, the ventilator determines if a condition occurred. In some aspects, the ventilator during determination operation **206** monitors the non-invasive sensor output to determine if the condition has occurred. In other aspects, the ventilator during determination operation **206** monitors the number of delivered breath or the passage of time to determine if a condition has occurred. If the ventilator determines that the condition occurred at determination operation **206**, the ventilator selects to perform support setting operation **208**. If the ventilator determines that the condition did not occur during determination operation **206**, the ventilator selects to perform action operation **220**. The condition may be the expiration of a predetermined amount of time, the delivery of a predetermined number of breaths, and/or a change in one or more monitored parameters that indicates that a change in patient respiratory system compliance and/or resistance has occurred. In some aspects, the condition is a change in monitored pressure, monitored tidal volume, or monitored flow of at least 25%. In other aspects, the condition is expiration of 1 hour from the last use of the PA breath subtype without a change in monitored pressure, monitored tidal volume, or monitored flow of at least 25% since the last PA breath subtype. In further aspects, the condition is the delivery of 200 breaths from the last use of the PA breath subtype without a change in monitored pressure, monitored tidal volume, or monitored flow of at least 25% since the last PA breath subtype.

As illustrated, method **200** includes support setting operation **208**. At support setting operation **208** the ventilator determines a percent support setting for a PA breath

subtype. In some aspects, at support setting operation **208**, the ventilator utilizes a predetermined support setting. In other aspects, at support setting operation **208** the ventilator selects a support setting based on at least one of a target setting from the spontaneous breath subtype or the non-invasively measured respiratory data collected during the spontaneous breath subtype. In further aspects, the ventilator during support setting operation **208** determines other settings for the PA breath subtype. For example, a PEEP level for the PA breath subtype may be set based on a PEEP level utilized in the spontaneous breath subtype.

Next, switch operation **210** is performed by the ventilator. At switch operation **210** the ventilator automatically and temporarily switches from the spontaneous breath subtype into the PA breath subtype for at least one breath utilizing the determined or calculated percent support setting. In some aspects, at switch operation **210** the ventilator automatically and temporarily switches from the spontaneous breath subtype into the PA breath subtype for at least three breaths utilizing the determined or calculated percent support setting. The PA breath subtype is performed for at least one breath, at least two breaths, or at least three breaths. In some aspects, the PA breath subtype is delivered by the ventilator during switch operation **210** until at least one patient respiratory system compliance and/or resistance measurement has been obtained. In some aspects, the PA breath subtype is delivered by the ventilator during switch operation **210** until at least two different patient respiratory system compliance and/or resistance measurements have been obtained. In some aspects, the PA breath subtype is delivered by the ventilator during the switch operation **210** until 5, 4, 3, or 2 patient respiratory system compliance and/or resistance measurements have been obtained. As such, the ventilator may deliver ventilation utilizing the PA breath subtype for at most 4 breaths, 8 breaths, 10 breaths, 12 breaths, 15 breaths, 20 breaths, 30 breaths, 40 breaths, or 50 breaths.

Accordingly, method **200** also includes PA collect and analyze operation **212**. The ventilator during the PA collect and analyze operation **212**, collects and analyzes the non-invasively measured respiratory data during the PA breath subtype. Next, a compliance operation **214** is performed by the ventilator. During the compliance operation **214**, the ventilator calculates or estimates the patient respiratory system compliance and/or resistance based on the non-invasively measured respiratory data taken during the PA breath subtype during the PA collect and analyze operation **212**. If multiple patient respiratory system compliance and/or resistance measurements are taken by the ventilator during compliance operation **214**, the ventilator determines a compliance measurement

and/or a resistance measurement based on these multiple measurements. For example, if multiple patient respiratory system compliance measurements are taken, the ventilator may average the measurements or select the middle or last obtained measurement to be utilized as the PA breath subtype calculated compliance measurement for use during DP operation **204**.

Method **200** also includes a return operation **216**. At return operation **216** the ventilator switches from the PA breath subtype back to the previously utilized spontaneous breath subtype. As discussed above, the ventilator returns the spontaneous breath subtype after a predetermined number of patient respiratory system compliance or resistance measurements have been obtained during the PA breath subtype, after a predetermined number of breaths, or after a predetermined amount of time. Next, spontaneous ventilation operation **201** is performed again.

Method **200** also includes action operation **220**. At action operation **220**, the ventilator performs an action based on drive pressure. The action may include generating a display of the drive pressure, evaluating the drive pressure, generating an alert based on the drive pressure, providing a recommendation based on the drive pressure, and/or changing ventilator parameters based on the drive pressure. In some aspects, the ventilator may generate a graph of the drive pressure for display during action operation **220**, such as a waveform or bar graph of the drive pressure. In some aspects, the ventilator evaluates the drive pressure by comparing the drive pressure to threshold during action operation **220**. If the ventilator determines that the drive pressure breaches the threshold during action operation **220**, ventilator performs an action in response to this determination. As discussed above the action may include a display of the drive pressure and/or the breach, generating an alert based on the breach, providing a recommendation based on the breach, and/or changing ventilator parameters based on the breach. If the ventilator determines that the drive pressure does not breach the threshold during action operation **220**, the ventilator continues to evaluate the calculated or estimated drive pressure. In further aspects, if the ventilator during action operation **220** determines that the drive pressure does not breach the threshold, the ventilator may also provide a recommendation to the clinician based on the drive pressure meeting the threshold.

In response to a drive pressure or a breach of a threshold by the drive pressure, the ventilator may generate an alert during action operation **220**. In response to a drive pressure meeting a threshold, or a breach of a threshold, the ventilator may provide a recommendation. Alternatively, the ventilator during action operation **220** may

automatically modify the ventilation parameters listed above based on drive pressure or the result of a comparison of drive pressure to a threshold.

In some embodiments, a microprocessor-based ventilator that accesses a computer-readable medium having computer-executable instructions for performing the method of ventilating a patient with a medical ventilator is disclosed. This method includes repeatedly performing the steps disclosed in method **200** above and/or as illustrated in FIG. 2. In some aspects, method **200** is performed by the ventilator system **100** described above with reference to FIG. 1.

In another example, FIG. 3 is a chart illustrating a normalized respiratory mechanics plane (R-M Plane). FIG. 3 depicts the relationship between tidal volume (ml) and distending pressure (ΔP in cmH2O). Distending pressure is calculated by subtracting the Positive End Expiratory Pressure (PEEP) from Plateau Pressure (P_{PLAT}), as illustrated by the X-axis of FIG 3. In the context of patient ventilation, the following equation would operationalize the relationship: $V_T = \Delta P * C_L$, where C_L represents the compliance (elasticity) of the patient lung-thorax system. The units of C_L for FIGS. 3 and 4 are volume/pressure or ml/cmH_2O. Thus, if C_L is known, the volume (ml) is found by multiplying C_L by ΔP. An examination of the equation $V_T = \Delta P * C_L$ reveals that C_L becomes a constant with the units of $V_T/\Delta P$. i.e., C_L is visualized as the positive slope of a line originating at 0,0, rising linearly up and to the right (should a separate slide be made). With a simple transformation of the units for the Y-axis, volume/predicted body weight (PBW) (the volume units for lung protective ventilation (ml/kg) and likewise expressing C_L as C_L/kg provides the chart illustrated in FIG. 3. FIG. 3 assumes the following:

1) The term ml/kg applied to all patients is valid and
2) The term C_L/kg applied to all patients is also valid.

As such, the following can be stated (where V_L is lung volume):

1) If V_L/kg and ΔP are known, C_L/kg = (V_L/kg)/ ΔP;
2) If V_L/kg and C_L/kg are known, ΔP = (V_L/kg)/(C_L/kg); and
3) If ΔP and C_L/kg are known, V_L/kg = ΔP * C_L/kg.

Accordingly, any matched pair of coordinates for ml/kg and ΔP on FIG. 3 locates a unique point on the R-M Plane and that point lies on a line whose slope is $\approx C_L$/kg. Furthermore, all such matched coordinates whose ratio is equivalent ($\approx$) will also lie on that C_L/kg slope. Recognizing that valid estimates for ΔP and V_L/kg are available, the intersection of orthogonal projections of these two values identifies a probable estimate of the patient's

current C_L/kg. A current estimate of a patient's actual C_L is found by multiplying the normalized value by the patient's estimated PBW.

Given the structure of the R-M Plane, it's now possible to indicate how the patient's status can be monitored and identified, either by a software algorithm or by using boundary conditions set by the clinician. If the clinician were interested in maintaining lung-protective ventilation, upper and lower, horizontal boundaries would alert when V_T/kg were too low or too high. Ventilator notifications could identify key changes and suggest corrections. A patient with ARDS might be decompensating with ever worsening compliance. Boundary violations could notify the clinician of this occurring.

In another aspect, a feature of the recurring points could be utilized with FIG. 3, to indicate the trajectory the patient's change as illustrated in FIG. 4. FIG. 4 is a chart illustrating a normalized respiratory mechanics plane with provided patient temporal status. The connection between sequential points would indicate rate of change and a notification could be provided by the ventilator to the clinician based on this rate of change. In FIG. 4 the repeated values for V_T/kg, ΔP and C_L/kg are captured and processed every 5 minutes or so. At the end of each interval, software analyzes the patient's sensor data and indicates the patient's location on the R-M Plane. Identical sets of values would produce equivalent points. However, as shown in FIG. 4, if a new point differed by X from the last one, a new point whose structure/identity would differ from the last one is plotted on the chart. In some aspects, each point is time stamped on the chart. The three vertical array points, illustrated in FIG. 4, indicate that the insufflation pressure remained constant but the patient's C_L was increasing coincident with increasing V_T. Given that the sequential values for V_T/kg, ΔP and C_L/kg could change in any of several logical trajectories, a temporal indicator on the R-M plane can apprise a clinician of the patient's status.

FIG. 5 is a chart illustrating a normalized respiratory mechanics plane with provided boundaries. Similar to FIG. 3, FIG. 5 depicts the relationship between tidal volume (ml) and distending pressure (ΔP in cmH2O) and provides boundaries that show better and worse ventilation areas on the chart. In some aspects, FIG. 5 could be displayed at each start-up on request. FIG. 5 reinforces in the clinician's mind the areas of better or worse ventilation. In some aspects, once the patient's PBW is known, the depiction of FIG. 5 is converted to the given patient or defaulted to the normalized patient as shown in FIG. 3.

In some embodiments, the ventilator system includes: means for ventilating a patient with the ventilator in a spontaneous breath subtype; means for non-invasively monitoring respiratory data of the patient with at least one of a pressure sensor and a flow sensor operatively coupled to at least one of a patient circuit or a pressure generating system; means for analyzing the respiratory data to detect a patient effort; means for delivering inspiratory gas to the patient with the ventilator in response to a detected patient effort; means for determining an occurrence of a condition by the ventilator based on information gathered by the ventilator; in response to the condition, means for determining a percent support setting for a PA breath subtype based on a target setting or the respiratory data from the spontaneous breath subtype; means for automatically and temporarily switching from the spontaneous breath subtype into the PA breath subtype for at least one breath in response to calculating the percent support setting; means for estimating a respiratory system compliance and/or respiratory system resistance of the patient during the PA breath subtype based on the respiratory data; means for returning to the spontaneous breath subtype after the at least three breaths; means for calculating a drive pressure of the patient during the spontaneous breath subtype utilizing the respiratory system compliance and/or the respiratory system resistance and the respiratory data; and means for performing an action based on the drive pressure. The spontaneous breath subtype does not include a proportional assist (PA) breath type.

Those skilled in the art will recognize that the methods and systems of the present disclosure may be implemented in many manners and as such are not to be limited by the foregoing exemplary embodiments and examples. In other words, functional elements being performed by a single or multiple components, in various combinations of hardware and software or firmware, and individual functions, can be distributed among software applications at either the client or server level or both. In this regard, any number of the features of the different embodiments described herein may be combined into single or multiple embodiments, and alternate embodiments having fewer than or more than all of the features herein described are possible. Functionality may also be, in whole or in part, distributed among multiple components, in manners now known or to become known. Thus, myriad software/hardware/firmware combinations are possible in achieving the functions, features, interfaces and preferences described herein. Moreover, the scope of the present disclosure covers conventionally known manners for carrying out the described features and functions and interfaces, and those variations and modifications that may be

made to the hardware or software firmware components described herein as would be understood by those skilled in the art now and hereafter.

While specific embodiments have been described and illustrated, such embodiments should be considered illustrative of the subject matter described herein and not as limiting the claims as construed in accordance with the relevant jurisprudence.

EMBODIMENTS IN WHICH AN EXCLUSIVE PROPERTY OR PRIVILEGE IS CLAIMED ARE DEFINED AS FOLLOWS:

1. A ventilator system for delivering drive pressure ventilation to a patient, the ventilator system comprising:

a pressure generating system that generates a flow of breathing gas;

a ventilation tubing system including a patient interface for connecting the pressure generating system to the patient;

one or more non-invasive sensors operatively coupled to at least one of the pressure generating system or the ventilation tubing system, wherein the one or more non-invasive sensors generate output indicative of at least one of flow, volume or pressure;

a controller that collects and analyzes the output to determine a condition, wherein the controller is configured to:

in response to the condition, temporarily switch the ventilator system from a spontaneous breath subtype into a proportional assist (PA) breath subtype for at least one breath,

estimate a respiratory system compliance of the patient during the PA breath subtype based on the output collected during the PA breath subtype;

after the at least one breath, switch the ventilator system from the PA breath subtype back to the spontaneous breath subtype,

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after a return to the spontaneous breath subtype, calculate a drive pressure of the patient based on the respiratory system compliance and the output after the return, the drive pressure being a pressure represented in cmH_2O that is applied within the patient's lungs to cause inflation; and

a display for displaying the drive pressure.

2. The ventilator system of claim **1**, wherein:

the controller compares the drive pressure to a threshold to form a comparison;

the controller determines that the drive pressure breaches the threshold based on the comparison to form a determination; and

in response to the determination, the controller provides an alert.

3. The ventilator system of claim **2**, wherein in further response to the determination, the controller adjusts a ventilation parameter for the ventilator system.

4. The ventilator system of claim **3**, wherein the ventilation parameter is at least one of oxygen percentage, rise time, trigger sensitivity, peak flow rate, peak inspiratory pressure, tidal volume, PEEP, or a target setting.

5. The ventilator system of claim **1**, wherein the controller utilizes a predetermined percent support setting for the PA breath subtype.

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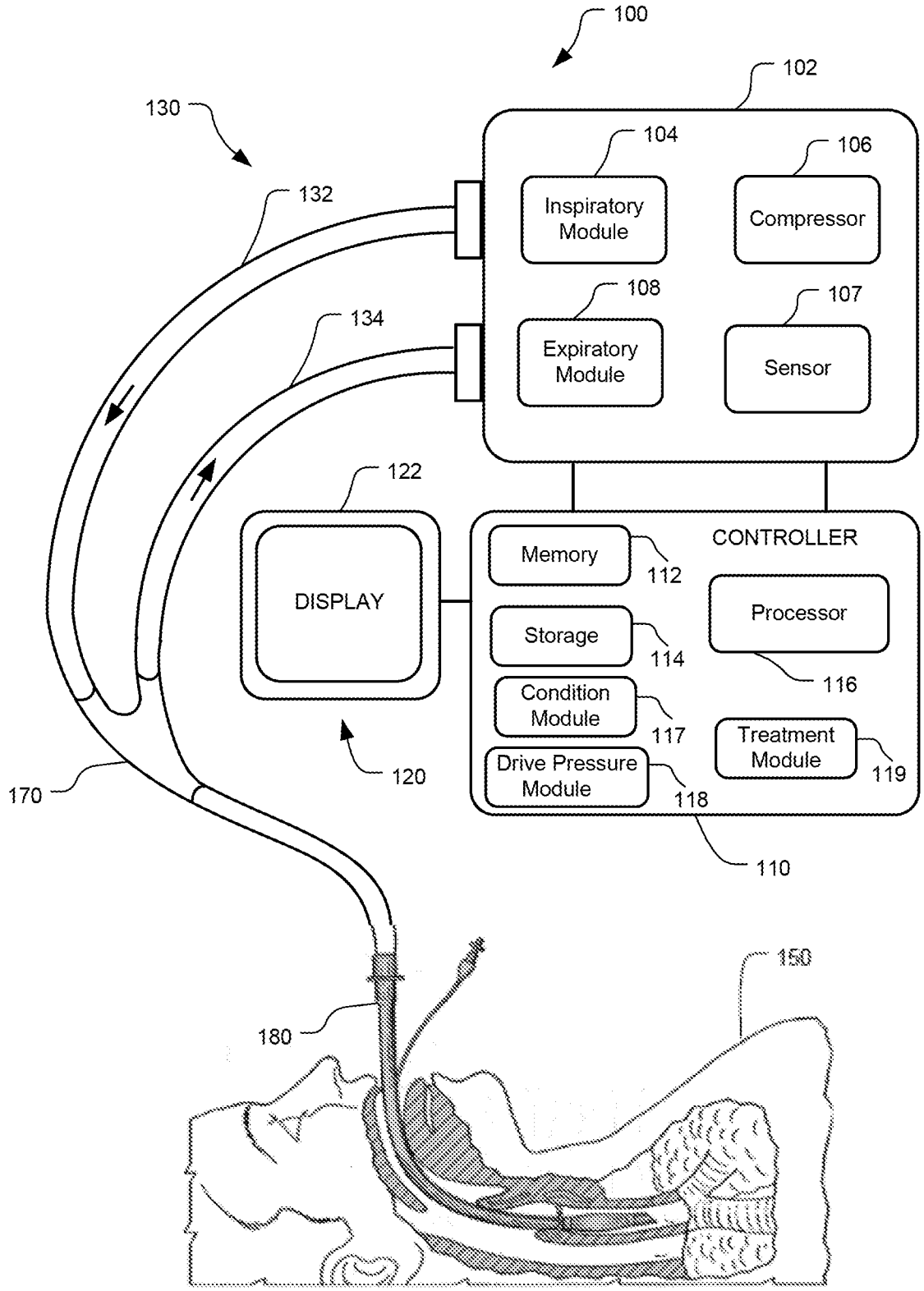

100
102
130
104
106
132
Inspiratory Module
Compressor
108
107
134
Expiratory Module
Sensor
122
DISPLAY
CONTROLLER
Memory
112
Processor
Storage
114
116
Condition Module
117
Treatment Module
119
Drive Pressure Module
118
120
170
110
150
180

FIG. 1

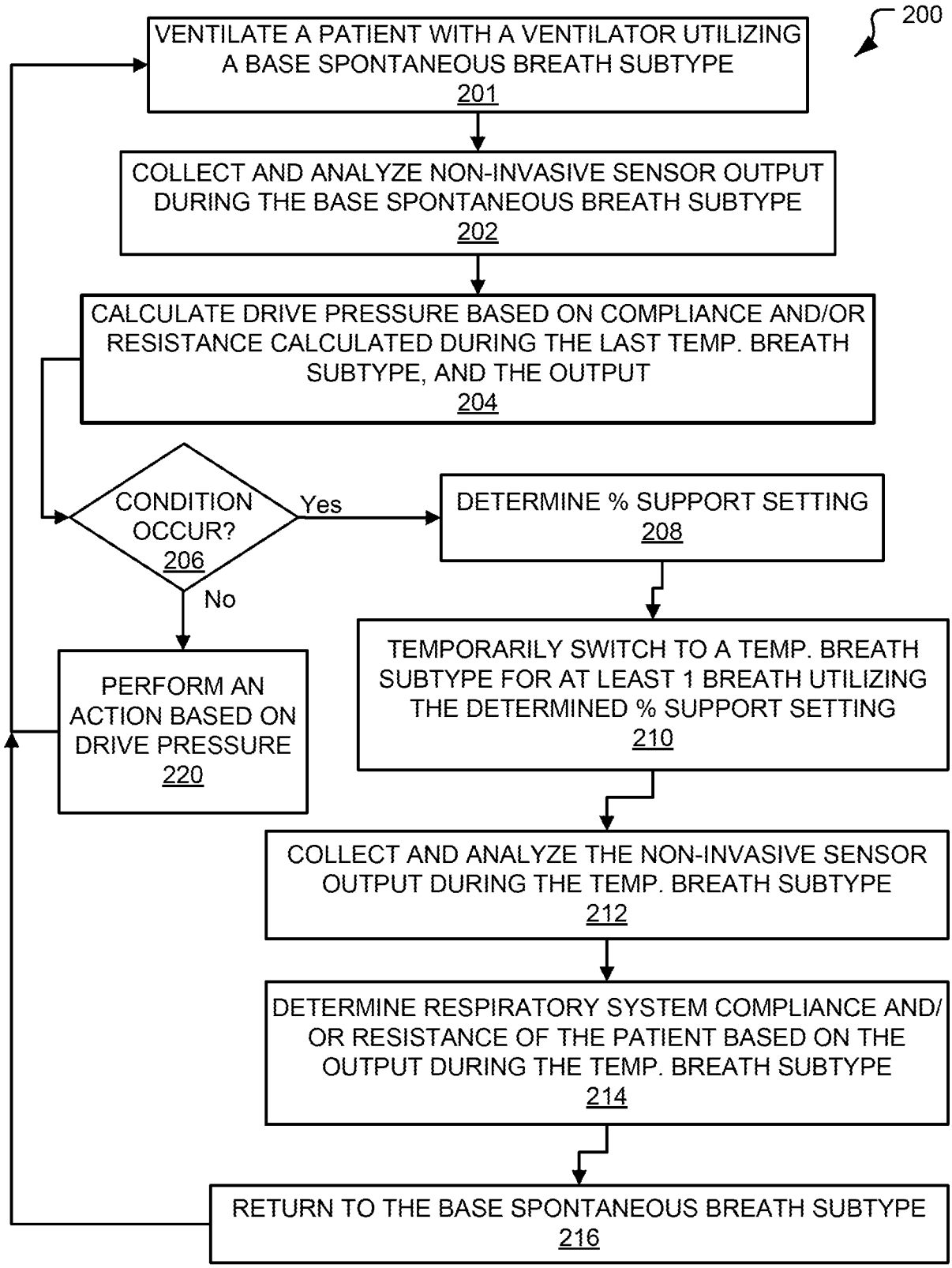

200
VENTILATE A PATIENT WITH A VENTILATOR UTILIZING A BASE SPONTANEOUS BREATH SUBTYPE
201
COLLECT AND ANALYZE NON-INVASIVE SENSOR OUTPUT DURING THE BASE SPONTANEOUS BREATH SUBTYPE
202
CALCULATE DRIVE PRESSURE BASED ON COMPLIANCE AND/OR RESISTANCE CALCULATED DURING THE LAST TEMP. BREATH SUBTYPE, AND THE OUTPUT
204
CONDITION OCCUR?
206
Yes
No
DETERMINE % SUPPORT SETTING
208
TEMPORARILY SWITCH TO A TEMP. BREATH SUBTYPE FOR AT LEAST 1 BREATH UTILIZING THE DETERMINED % SUPPORT SETTING
210
COLLECT AND ANALYZE THE NON-INVASIVE SENSOR OUTPUT DURING THE TEMP. BREATH SUBTYPE
212
DETERMINE RESPIRATORY SYSTEM COMPLIANCE AND/OR RESISTANCE OF THE PATIENT BASED ON THE OUTPUT DURING THE TEMP. BREATH SUBTYPE
214
RETURN TO THE BASE SPONTANEOUS BREATH SUBTYPE
216
PERFORM AN ACTION BASED ON DRIVE PRESSURE
220

FIG. 2

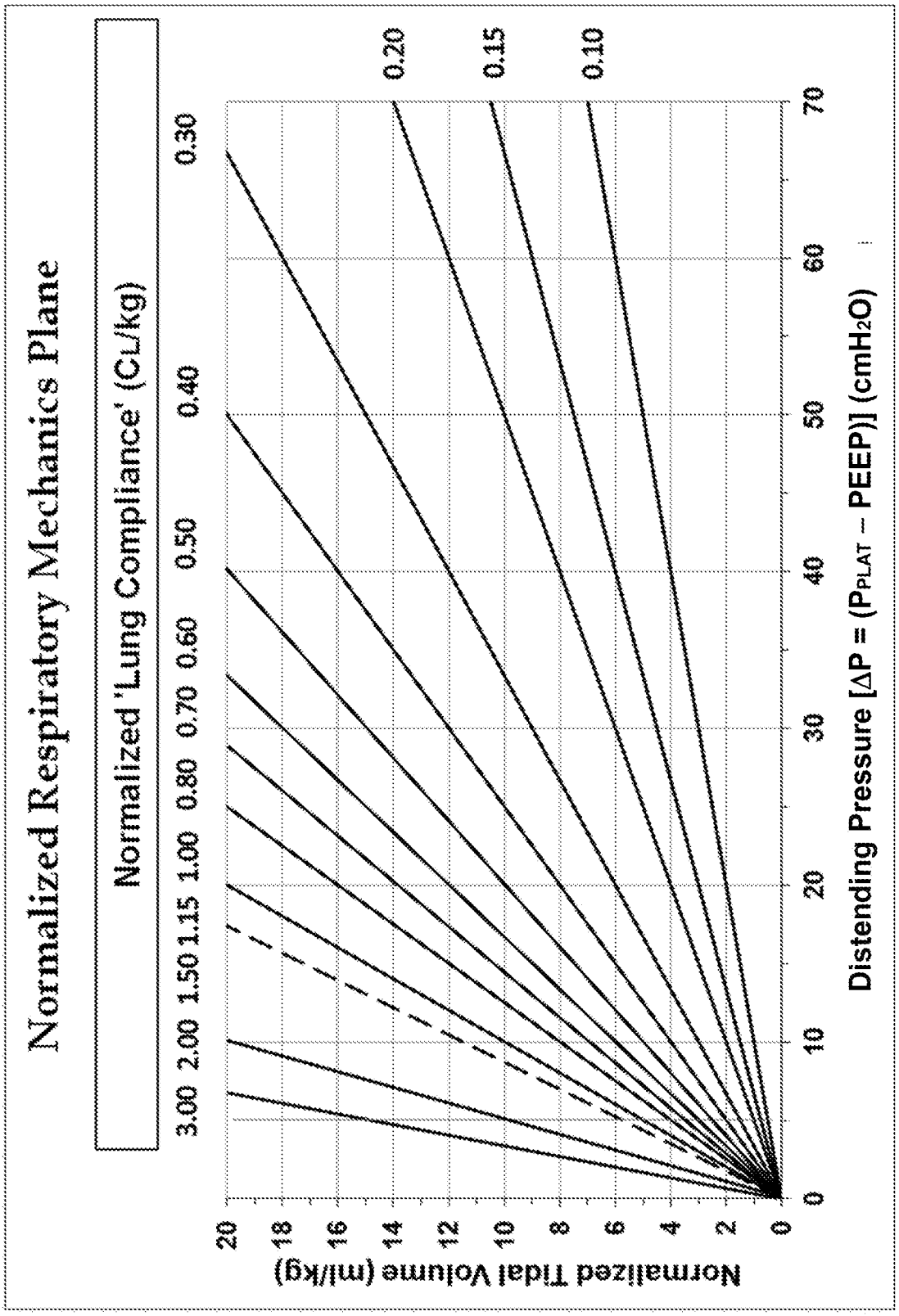

Normalized Respiratory Mechanics Plane
Normalized 'Lung Compliance' (CL/kg)
3.00 2.00 1.50 1.15 1.00 0.80 0.70 0.60 0.50 0.40 0.30
0.20
0.15
0.10
Normalized Tidal Volume (ml/kg)
0 2 4 6 8 10 12 14 16 18 20
0 10 20 30 40 50 60 70
Distending Pressure [ΔP = (PPLAT – PEEP)] (cmH2O)

FIG. 3

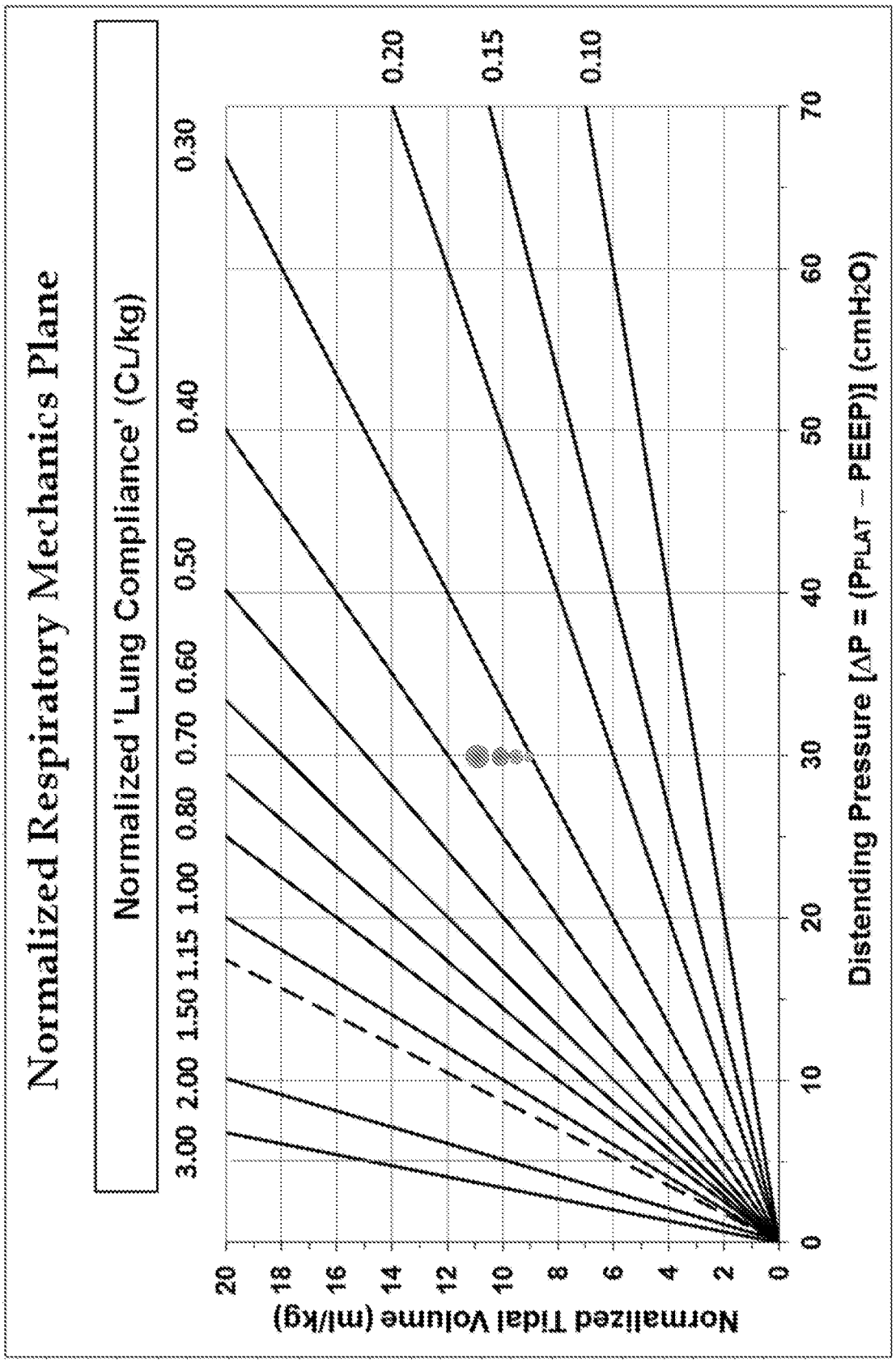

Normalized Respiratory Mechanics Plane
Normalized 'Lung Compliance' (CL/kg)
3.00 2.00 1.50 1.15 1.00 0.80 0.70 0.60 0.50 0.40 0.30
0.20
0.15
0.10
Normalized Tidal Volume (ml/kg)
0 2 4 6 8 10 12 14 16 18 20
0 10 20 30 40 50 60 70
Distending Pressure [ΔP = (PPLAT – PEEP)] (cmH2O)

FIG. 4

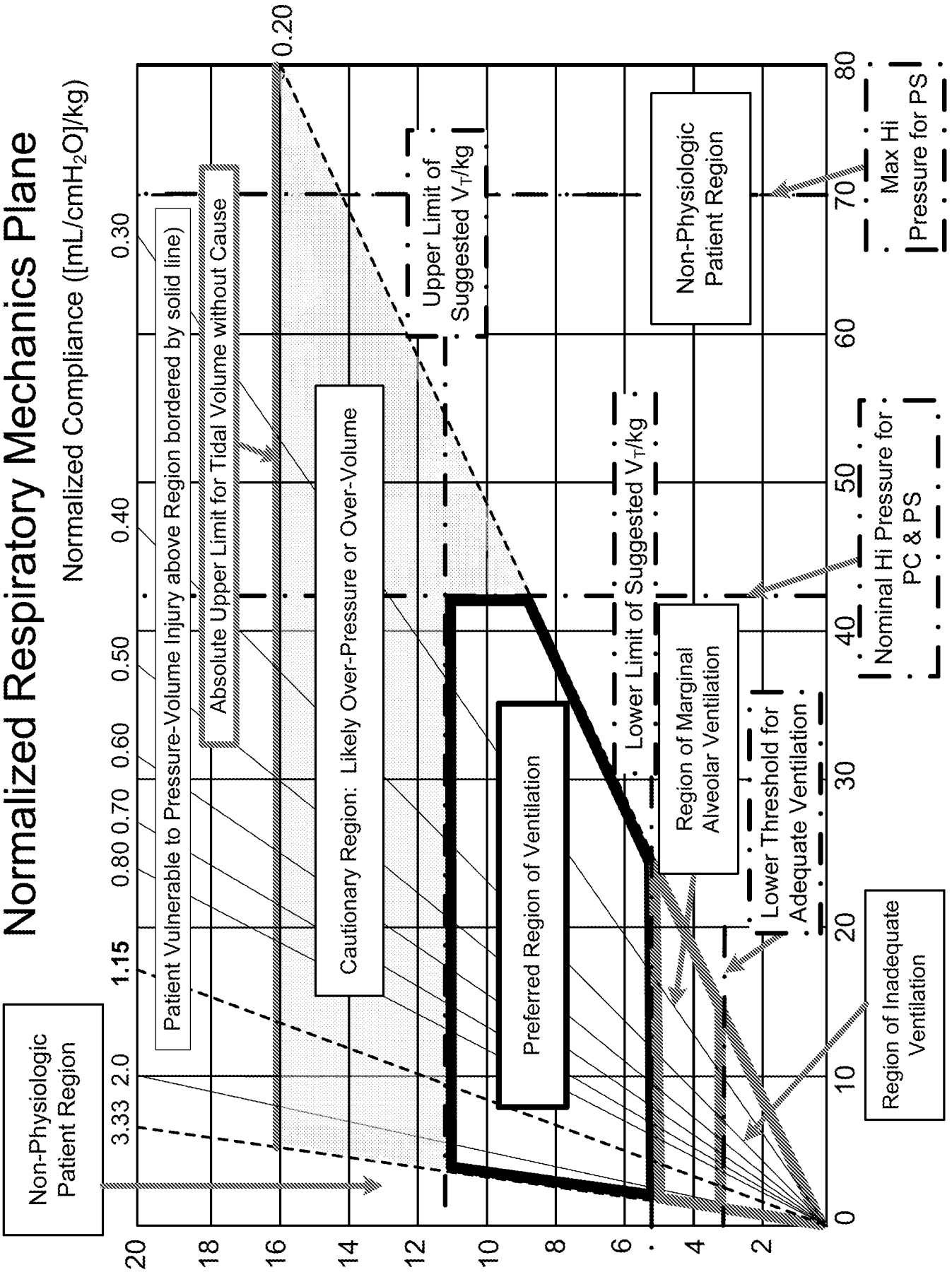
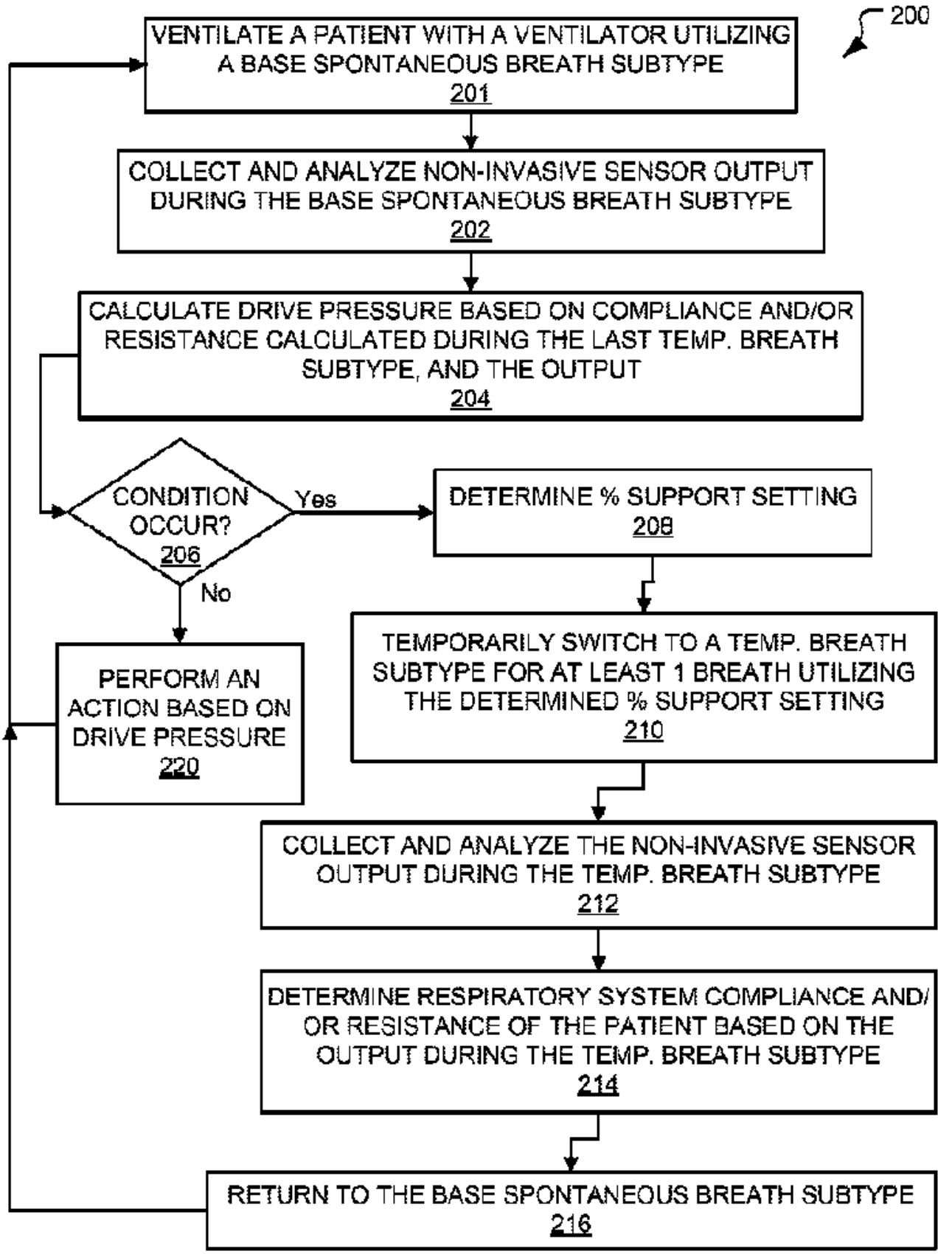

Normalized Respiratory Mechanics Plane
Normalized Compliance ([mL/cmH2O]/kg)
Non-Physiologic Patient Region
Patient Vulnerable to Pressure-Volume Injury above Region bordered by solid line)
Absolute Upper Limit for Tidal Volume without Cause
Cautionary Region: Likely Over-Pressure or Over-Volume
Preferred Region of Ventilation
Region of Marginal Alveolar Ventilation
Region of Inadequate Ventilation
Upper Limit of Suggested VT/kg
Lower Limit of Suggested VT/kg
Lower Threshold for Adequate Ventilation
Nominal Hi Pressure for PC & PS
Max Hi Pressure for PS
Non-Physiologic Patient Region
3.33
2.0
1.15
0.80
0.70
0.60
0.50
0.40
0.30
0.20
20
18
16
14
12
10
8
6
4
2
0
10
20
30
40
50
60
70
80

FIG. 5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214
RETURN TO THE BASE SPONTANEOUS BREATH SUBTYPE
216