Hypercapnia and extracorporeal carbon dioxide removal (ECCO$_2$R) in the acute respiratory distress syndrome

Luis Morales-Quinteros$^{1,2,3,*}$, Jordi Mancebo$^1$, Lorenzo Del Sorbo$^{4,5}$

Abstract

As a result of technical improvements, extracorporeal techniques for carbon dioxide removal have become an attractive option in managing adults with acute respiratory failure. However, evidence to support its use is scarce, and several questions regarding the best way to implement this therapy remain unanswered, which can be associated with severe side effects. In this review, we will present the currently available knowledge on (1) ECCO$_2$R as an adjuvant treatment to invasive mechanical ventilation, (2) the impact of hypercapnia in patients with acute respiratory distress syndrome (ARDS), (3) the pathophysiological rationale and evidence of ECCO$_2$R in patients with ARDS.

Keywords

Acute respiratory distress syndrome; Extracorporeal carbon dioxide removal; Carbon dioxide; Lung-protective ventilation; Ventilator-associated lung injury

1. Background

Acute hypoxemic respiratory failure, and its most severe form, acute respiratory distress syndrome (ARDS), is a leading cause of admission to the intensive care unit (ICU). It is associated with significant mortality and long-term morbidity for survivors and considerable resource utilization for health care systems [1].

In critically ill patients with acute hypoxemic respiratory failure, mechanical ventilation is a life-saving treatment [2]. At the same time, this therapy can cause ventilator-induced lung injury (VILI), a lung injury condition inflicted or aggravated by mechanical ventilation during treatment. Multiple evidence demonstrated that excessive lung stress and strain, induced by excessive transpulmonary pressure, results in regional alveolar overdistension or cyclic opening and closing of distal airways, which cause lung injury [3]. In recent years, much effort has been invested in understanding the pathophysiology of VILI, which has led to notable changes in ventilation management and remarkable improvement in patient outcomes. For instance, while it was common practice to use “unphysiological large” tidal volumes to prevent atelectasis and target normal gas exchange, it is now widely accepted to use low pressures and low tidal volumes to protect the lungs against VILI [2, 4]. In a seminal study, the ARDSNet investigators showed significantly higher mortality with a high tidal volume ($V_T$) strategy of 12 mL/kg of predicted body weight (PBW), as compared to a low $V_T$ strategy of 6 mL/kg PBW and limiting end-inspiratory plateau pressure ($P_{PLAT}$) to $\leq$ 30 cmH$_2$O [5]. However, the reduction in tidal volume and inspiratory pressures results in the development of respiratory acidosis, which is tolerated within certain safe limits, according to the notion of “permissive hypercapnia”.

Nonetheless, in some patients, even lung-protective ventilation (LPV) settings may not be fully protective [6, 7]. Up to one-third of patients receiving lung-protective ventilation had evidence of tidal hyperinflation and, hence, risk of VILI [6]. Moreover, data from large observational studies suggest that there might not be a safe threshold for tidal volume or driving pressure due to the heterogeneity of lung injury [8, 9]. These data prompted the hypothesis that further reducing tidal volume and driving pressure could result in less VILI and patient-centered outcome improvement [10].

This strategy would potentially entail an unacceptably high risk of life-threatening respiratory acidosis [11] due to significantly reducing alveolar ventilation with tidal volumes equal to or inferior to physiologic dead space. To overcome this issue and facilitate “ultra” protective strategies of mechanical ventilation to minimize VILI, increasing interest has been focused on extracorporeal carbon dioxide removal (ECCO$_2$R) since the first reports in the 1980s [12–14].

2. Pathophysiological rationale of ECCO$_2$R in ARDS

One of the major clinical challenges in ARDS and hyperoxemia is carbon dioxide (CO$_2$) clearance and the strategy to best achieve it. However, the optimal physiologic and metabolic
targets to provide adequate homeostasis without inducing VILI are not yet defined, as highlighted above, suggesting a potential role for ECCO₂R.

In patients with ARDS, hypercapnia develops due to decreased alveolar ventilation, determined by the variable combination of alveolar collapse/infiltrate and increased alveolar dead space. Alveolar infiltrates, and collapse is unevenly distributed throughout the lung, with smaller preserved aerated zones, defined as “baby lung” [15]. Physiological dead space (V₅/V₇) is the sum of the anatomical and alveolar dead spaces and is defined as all parts of the tidal volume that do not participate in gas exchange. V₅/V₇ comes from respiratory units that receive disproportionately low perfusion compared with ventilation (Q < V₅), resulting in an increasing “West Zone I” physiology [16]. High alveolar dead space (VD₄₅L/V₄₅L) may result from endothelial injury, microvascular thrombi, and overdistention of alveoli during mechanical ventilation [17, 18]. V₅/V₇ during the first seven days after ARDS diagnosis is an independent lung-specific physiological variable associated with increased mortality [19, 20]. However, dead space measurements are not routinely performed in clinical practice to guide patient management due to the challenges of the various measurement strategies [21]. Other methods for estimating V₅/V₇, which do not require quantitative assessment of exhaled carbon dioxide, are easier to use at the bedside. Recently, the ventilatory ratio and end-tidal-to-arterial Partial pressure of carbon dioxide (PCO₂) ratio have been described as surrogates for V₅/V₇ in ARDS patients [22–25].

2.1 Hypercapnia in ARDS

The effects of hypercapnia have been extensively studied in clinical and experimental investigations, but the results are conflicting. Thus, the definition of adequate CO₂ and pH clinical targets remains challenging.

Hickling et al. [26] were the first to propose protective ventilation strategies as the rescue therapy for patients with severe ARDS to limit VILI. These strategies include the following measures: (1) low peak inspiratory pressure and low V̇₅ ventilation; (2) use of positive end-expiratory pressure (PEEP); and (3) acceptance of higher partial pressure of arterial carbon dioxide (PaCO₂) levels. Despite its limitations, this study showed significantly lowered hospital mortality by adapting the protective ventilation strategies. This finding led to a series of clinical investigations in patients with ARDS, including the potential protective role of permissive hypercapnia [5, 8, 27–29]. Regrettfully, important limitations of these studies, such non-randomization of patients to receive normocapnia or hypercapnia, have precluded the conclusive demonstration of a direct protective effect of high CO₂ in these patients.

To advance the knowledge on this issue, several experimental studies have also investigated the potential protective effect of hypercapnia on mechanisms of acute lung injury [30]. In an experimental model of rabbit lungs ventilated ex vivo with high pressures, hypercapnia decreased microvascular permeability, lung edema formation, and protein concentration in the bronchoalveolar lavage fluid [31]. The plausible mechanisms are (1) the CO₂ action, through nuclear factor-kappa (NFκB) pathway activation, preventing p65 translocation and thereby reducing inflammation [32, 33]; (2) CO₂ inhibition of the ADAM-17 (a disintegrin and metalloprotease domain enzyme), which prevents the activation of the p44/p42 MAPK (mitogen-activated protein kinases pathway) [34].

Hypercapnia has also been shown to reduce apoptosis in rat lungs exposed to high-pressure ventilation by inhibiting the activation of the MAPKinase and stress-activated protein kinases (SAPK)/Jun amino-terminal kinases (JNK) pathways in alveolar epithelial cells [35]. In contrast to its beneficial effects, the potentially detrimental effects of hypercapnia on mechanisms of injury have also been studied. It has been observed that high levels of CO₂ impaired the phagocytic activity of neutrophils in rat models [36]. Furthermore, hypercapnia decreased alveolar cell proliferation and delayed wound repair in different types of human lung cells in pH-independent and dose-dependent ways [37]. Hypercapnic acidosis impairs membrane wound revealing [38, 39] in ex-vivo and in-vitro rat models of VILI. High CO₂ levels have been found to decrease the clearance of alveolar edema through inhibition of the Na⁺–K⁺-ATPase pump through an endocytosis process [40] that is pH independent [41]. Lastly, hypercapnia may modulate innate immunity and host defense via pH-independent or dependent mechanisms [42, 43]. High CO₂ levels suppress innate immunity by inhibiting mRNA and the expressions of inflammatory cytokines (IL-6 and TNF-α) and autophagy in alveolar macrophages in rats [43, 44]. The biological actions of CO₂ are depicted in Fig. 1.

Although progressively adopted or tolerated in patients with ARDS to facilitate protective mechanical ventilation settings, permissive hypercapnia has considerable pathophysiological effects, which need to be considered. Hypercapnic acidosis can increase pulmonary vascular resistance and worsen pulmonary hypertension, potentially increasing right ventricular afterload and triggering acute cor pulmonale. It also impairs diaphragmatic function through afferent transmission or integrity with short-term exposure to moderate hypercapnia in preclinical models [45, 46]. Hypercapnia causes precapillary cerebral arteriole dilation, increasing cerebral blood flow, a clear concern in the setting of reduced intracranial compliance, in which increased global cerebral blood flow may critically elevate intracranial pressure. Moreover, hypercapnic acidosis directly reduces the contractility of cardiac and vascular smooth muscle [47, 48]. However, this is counterbalanced by the hypercapnia-mediated sympathoadrenal effects, including increased preload and heart rate, increased myocardial contractility, and decreased afterload, leading to a net increase in cardiac output [48, 49].

A recent secondary analysis of three international studies on patients with ARDS showed that severe hypercapnia, defined as PaCO₂ 50 mmHg, was independently associated with higher ICU mortality and multiorgan failure [50]. Interestingly, the number of patients with severe hypercapnia progressively increased from 1998 to 2010, mirroring the progressively higher adoption of lung protective ventilation, which may reflect the belief of the beneficial effect of hypercapnia.

In another retrospective analysis of mechanically ventilated patients, it was observed that patients who developed respiratory acidosis (pH < 7.35 and PaCO₂ > 65 mmHg) during the first 24 hours of ventilation had a worse prognosis compared
to those who had normocapnia or compensated hypercapnia [51].

The “Large observational study to UNderstand the Global impact of Severe Acute respiratory FailurE” (LUNG SAFE) study, a worldwide multicenter observational investigation in ventilation practice in patients with ARDS [52], reported the prevalence and impact of changes in CO₂ on ventilation management and outcomes in patients with early ARDS. This observational study showed that hypocapnia and hypercapnia are commonly present, and in approximately half of the patients, CO₂ derangements are sustained over the first two days of ventilation. Interestingly, there was no mortality difference between normocapnic and hypercapnic patients, concluding that there is no evidence for hypercapnia to be considered beneficial or harmful. Of note, the LUNG SAFE investigators also show ICU mortality to be higher in hypocapnia compared to normocapnic patients with mild-to-moderate ARDS, suggesting the need for caution with sustained hypocapnia.

The above-discussed evidence suggests that the application of ECCO₂R could be beneficial to improving metabolic homeostasis and minimizing VILI, which is achieved by allowing the delivery of ultra-protective mechanical ventilation settings and avoiding the potentially detrimental hemodynamic and neurological consequences of hypercapnia. It is increasingly recognized that CO₂ is more than just a product of cellular metabolism and that hypercapnia can regulate several critical biological functions in the lung, which could be detrimentally altered by inadequate ECCO₂R application.

3. Principles and technical aspects of ECCO₂R

3.1 Principles

The ECCO₂R devices consist of a drainage cannula placed in a large central vein or artery (the latter if an arterio-venous configuration is used, which is not often), a pump, and a gas exchanger (artificial membrane lung), and a return cannula into the venous system. Gas exchange is achieved through an extracorporeal artificial lung unit containing a diffusion membrane. In this unit, blood is passed through hollow plastic fibers with a mesh-like pattern that increase the surface area for membrane-to-blood contact and gas exchange efficiency. Via the surface of the membrane fibers, the exchange of oxygen and CO₂ occurs by diffusion. The efficiency of each device (i.e., the volume of CO₂ removed per minute, adjusted to blood flow) should be an important consideration for clinicians since it determines the blood flow rate and hence the catheter size needed for adequate CO₂ removal. To obtain an efficient membrane lung with the lowest necessary amount of membrane surface, a design incorporating short fibers that allows a maximal sweep gas ratio is required to keep the gradient over the entire length of the fiber at its highest possible level. This is in contrast to extracorporeal membrane oxygenation (ECMO), which requires high flow rates to increase arterial blood oxygenation. ECCO₂R needs considerably lower blood flow rates as the gas dissociation curves in blood for oxygen and CO₂ are significantly different.

Theoretically, due to the higher diffusion coefficient of CO₂,
3.2 Technique

Due to the much higher diffusion capacity of CO$_2$ than O$_2$, different configurations of extracorporeal CO$_2$ elimination are possible. The system’s configuration depends on the selection of the vascular access (arterial or venous) and the type of cannulas that will be used. A distinction is made between pump-driven vs. arterio-venous pumpless systems (Fig. 2).

3.2.1 Arterio-venous ECCO$_2$R (AV-ECCO$_2$R)

ECCO$_2$R with arterio-venous configuration utilizes the patient’s arterio-venous pressure gradient to pump blood through the artificial lung. Vascular access is most commonly obtained by cannulating the femoral artery and vein using the percutaneous technique. Mean arterial pressure greater than 60 mmHg and a cardiac index >3 L/min/m$^2$ provide flow rates ranging between 0.5 and 1.2 L/min. This configuration is unsuitable for hemodynamically unstable or heart failure patients [61, 62].

The major advantage of the system is the absence of blood trauma due to a pumpless system and thus pump-associated complications. However, this benefit is outbalanced by the risk of distal ischemia, which can occur on the side of the arterial cannulation. The pumpless arterio-venous system introduces a new vascular bed to the patient, which adds an additional burden to the heart that already has to pump blood through the brain, liver, kidneys, and other organs. Given the complications associated with cannulation, its use has fallen out of interest.

3.2.2 Veno-venous ECCO$_2$R (VV-ECCO$_2$R)

Veno-venous ECCO$_2$R systems utilize a pump to generate flow across a membrane. To date, pump-driven systems are by far the more used systems. They enable a jugular or femoral double lumen cannula of a size between 20 and 23–24 Fr, allowing blood flows around 500–1000 mL/min. Smaller cannulas can also be considered for lower blood flow, decreasing the cannulation risk. A hemodialysis catheter with 11.5 or 13.5 Fr can generate blood flows of up to 300 mL/min but has a relatively high recirculation rate [63], thus reducing the system’s efficiency.
The pumps can be roller (peristaltic) or rotary (centrifugal). The latter has a rotating impeller which creates a suction vortex that draws blood into the center of the pump and propels it outwards from the outlet. The system, which evolved from ECMO, is driven by roller pumps and uses 200 to 450 mL/min of corresponding blood flows. In contrast, the systems developed from ECMO often have flow rates of 0.5 to a maximum of 2.0 L/min using a centrifugal pump [64].

Compared to the AV configuration, one of the gains of VV-ECCO₂R is that it is less invasive as arterial cannulation is avoided and that patients can potentially be mobilized earlier. We recommend VV-ECCO₂R over AV-ECCO₂R in most circumstances unless the centers are already familiar with this technology.

4. Evidence of ECCO₂R in ARDS

ECCO₂R was first proposed in the 1980s when the detrimental effect of VILI was still vastly unrecognized and ignored. The evolving conceptual paradigm of ECCO₂R clinical application was to use extracorporeal support to rest the lung and avoid VILI from high volume and pressure ventilation [14]. Interestingly, in small clinical series, the application of ECCO₂R was reported to decrease barotrauma in patients with ARDS [13, 14] before large clinical trials could demonstrate the benefit of lung-protective ventilation. However, to date, no high-quality evidence has shown the efficacy of ECCO₂R in improving patient outcomes.

A recent meta-analysis of 14 studies with pumpless and pump-driven ECCO₂R [65] has shown that the technique can achieve a sustained reduced partial pressure of arterial CO₂ to 40–50 mmHg and increased blood pH to 7.30–7.45 and a significant increased PaO₂/FiO₂ ratios; these while decreasing Vₜ~3 mL/kg/IBW (ideal body weight), and P_{PLAT} by at least 5 cmH₂O, maintaining a PEEP level of around 15 cmH₂O. The device duration was between 7 to 14 days. However, there was no effect on mortality or clinically relevant outcome measures.

The SUPERNOVA study investigated the role of ultra-protective ventilation in patients with early moderate ARDS under invasive mechanical ventilation [66]. Ultra-protective ventilation consisted in targeting tidal volumes of 4 mL/kg and P_{PLAT} ≤ 25 cmH₂O. The main outcome was the proportion of patients achieving ultra-protective ventilation without developing respiratory acidosis (pH <7.30 while maintaining PaCO₂ around 20% of baseline values with Vt 6 mL/kg IBW). Devices with different CO₂ extraction rates were used. ECCO₂R was kept for 3–8 days. ECCO₂R was able to significantly reduce P_{PLAT} from 26 ± 5 cmH₂O to 23 ± 3 cmH₂O in 73% of patients, with a reduction of driving pressure from 13 ± 5 to 9 ± 4 cmH₂O. Few adverse effects were related to the use of ECCO₂R. These findings showed that in this study, ECCO₂R was feasible and safe. A secondary analysis of the data from the SUPERNOVA study demonstrated that the magnitude of reduction in VT, driving pressure, and mechanical power permitted by ECCO₂R is significantly higher in ARDS patients with higher dead space (determined by a ventilator ratio (VR) >2) or lower compliance of the respiratory system (Crs) or treated with a higher CO₂ extraction rate device [67].

Finally, although these data confirmed the technique’s feasibility with consistent physiological effects, the lack of patient-centered outcomes warranted further investigation.

Several studies have shown the feasibility and efficiency of ECCO₂R in removing significant amounts of CO₂ to facilitate very low tidal volume mechanical ventilation strategies [66, 68]. However, these studies were not designed to investigate the efficacy of this technique in improving patient-centered outcomes.

Recently a large, randomized, controlled, open, phase 3 pragmatic clinical and cost-effectiveness trial led by experienced clinical trials group [57] tried to respond to the clinical question of whether ECCO₂R improves day 90 all-cause mortality in mechanically ventilated patients with acute hypoxemic respiratory failure. The original plan was for an interim analysis of 360 patients. However, this was moved forwards to 412 patients after the trial was paused to investigate an intracranial hemorrhage in the intervention arm. At this time point, the Data and Safety Monitoring Board (DSMB) performed a conditional power analysis and found that ongoing recruitment was unlikely to show benefit. 202 patients were randomized to the experimental arm and 210 to the control arm. Tidal volumes, inspiratory plateau pressure, and driving pressure were lower in patients randomized to the intervention arm than controls, as per the study design. However, although mean ventilator-free days were significantly lower in the ECCO₂R group (mean difference, −2.1 (95% CI, −3.8 to −0.3); p = 0.02), no difference was found in the primary outcome of day 90 all-cause mortality, 41.5% in the lower tidal volume ventilation with ECCO₂R group vs. 39.5% in the standard care group (Risk Ratio, 1.05 (95% CI, 0.83–1.33); difference, 2.0% (95% CI, −7.6% to 11.5%); p = 0.68). This was unchanged after adjusting for age, Sequential Organ Failure Assessment (SOFA) score, and baseline PaO₂/FiO₂. Higher rates of adverse events were observed in the intervention arm: 168 (52% of patients) vs. 61 (23% of patients), including higher rates of intracranial hemorrhage and infectious complications.

Moreover, several issues may have affected the outcome in the ECCO₂R group. In fact, in the intervention arm of the trial, there were higher rates of mandatory modes of mechanical ventilation and neuromuscular blockade and less use of prone positioning than in the control arm. In addition, several participating centers had little experience with the clinical application of ECCO₂R. Furthermore, although driving pressure in the ECCO₂R group was 2–3 cmH₂O lower than in controls, with the expected significant decrease of mechanical load, in both groups, driving pressure was maintained below 14 cmH₂O, which has been suggested as a protective threshold to minimize VILI [69]. Future studies will need to investigate whether targeting a lower respiratory rate by study design with ECCO₂R results in improved outcomes, as demonstrated in an elegant experimental large animal model [70].

Overall, the data presented in this study confirmed that achieving lower tidal volumes using ECCO₂R is possible and highlighted how translating this physiologic effect into clinical benefit is challenging due to the complex and not fully revealed pathophysiology of VILI.

Other relevant studies on ECCO₂R in ARDS are summarized in Table 1.
**TABLE 1. Relevant studies of ECCO$_2$R in ARDS.**

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of patients</th>
<th>Configuration</th>
<th>ECCO$_2$R Characteristics</th>
<th>Time on ECCO$_2$R</th>
<th>Major Results</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blood flow (mL/min)</td>
<td>Sweep flow (L/min)</td>
<td>Membrane (material); surface in m$^2$</td>
</tr>
<tr>
<td>Terragni <em>et al.</em> [77]</td>
<td>32</td>
<td>RRT platform adapted to ECCO$_2$R and a double lumen catheter (femoral)</td>
<td>191–422</td>
<td>8</td>
<td>PLP* (Decap®, Hemodec, Salerno, Italy); 0.33</td>
</tr>
<tr>
<td>Bein <em>et al.</em> [68]</td>
<td>79</td>
<td>Femoral AV PECLA</td>
<td>1300</td>
<td>Not reported</td>
<td>PMP** (iLA AV, Novalung, Heilbronn, Germany); 1.3</td>
</tr>
<tr>
<td>Fanelli <em>et al.</em> [56]</td>
<td>15</td>
<td>VV system and single double lumen catheter with femoral or jugular approach</td>
<td>435</td>
<td>10</td>
<td>PLP* based on siloxane layer (ALung Hemolung RAS); 0.59</td>
</tr>
<tr>
<td>Augy <em>et al.</em> [78]</td>
<td>70</td>
<td>VV system and a double-lumen catheter</td>
<td>430</td>
<td>Not reported</td>
<td>PLP* based on siloxane layer (ALung Hemolung RAS) or PMP; 1.3 (Novalung iLA active); 0.59</td>
</tr>
<tr>
<td>Schmidt <em>et al.</em> [79]</td>
<td>20</td>
<td>VV system managed with RRT platform via a 15.5-Fr single dual lumen catheter (femoral or jugular)</td>
<td>420</td>
<td>10</td>
<td>PMP** (PrismaLung®; Gambro-Baxter); 0.32</td>
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### TABLE 1. Continued.

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of patients</th>
<th>ECCO$_2$R Characteristics</th>
<th>Time on ECCO$_2$R</th>
<th>Major Results</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Configuration</td>
<td>Blood flow (mL/min)</td>
<td>Sweep flow (L/min)</td>
<td>Membrane (material); surface in m$^2$</td>
</tr>
<tr>
<td>Ding X et al. [80]</td>
<td>12</td>
<td>VV configuration with two 12-Fr two lumen hemodialysis into the right jugular vein and one of the femoral veins</td>
<td>342</td>
<td>10</td>
</tr>
<tr>
<td>Combes et al. [66]</td>
<td>95</td>
<td>VV configuration with a double-lumen catheter</td>
<td>300–500 vs. 800–1000</td>
<td>6–10</td>
</tr>
<tr>
<td>McNamee JJ et al. [57]</td>
<td>405</td>
<td>VV configuration with a dual-lumen catheter inserted percutaneously into a central vein</td>
<td>350–450</td>
<td>10</td>
</tr>
</tbody>
</table>

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*PLP: polypropylene; **PMP: poly-4-methyl-1-pentene; AE: adverse effects; ARDS: acute respiratory distress syndrome; COPD: chronic obstructive pulmonary disease; LPV: lung protective ventilation; PECLA: pumpless extracorporeal lung assist; PEEP: positive end-expiratory pressure; $P_{PLAT}$: Plateau pressure; RRT: renal replacement therapy; $V_T$: tidal volume; SAE: serious adverse effects; IMV: invasive mechanical ventilation; PBW: predicted body weight; AV: arterio-venous; iLA: interventional lung assist; VFDs: ventilator free days; VV: veno-venous; RAS: Respiratory Assist System; HLS: Heart-Lung Support; ECMO: extracorporeal membrane oxygenation; DP: driving pressure.
5. Complications

Although ECCO$_2$R seems to improve or correct hypercapnic acidosis, its use is associated with a range of vascular, hematological, and other complications (Table 2). In a recent international feasibility trial, ECCO$_2$R-related adverse events such as catheter displacement or infectious complications were observed in 2% and membrane lung clotting or bleeding in 14% of patients, highlighting the coagulation/anticoagulation balance as a key issue [56].

Table 2. Complications associated with ECCO$_2$R.

<table>
<thead>
<tr>
<th>Therapy-related</th>
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<tr>
<td>• Worsening of hypoxemia at the onset of low tidal ventilation</td>
</tr>
<tr>
<td>• Bleeding (pulmonary, gastrointestinal, cerebral)</td>
</tr>
<tr>
<td>• Hemolysis</td>
</tr>
<tr>
<td>• Consumption coagulopathy</td>
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<tr>
<td>• Thrombocytopenia/thrombopathy</td>
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<tr>
<td>• Air embolism</td>
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<tr>
<td>• Vascular injury (bleeding)</td>
</tr>
<tr>
<td>• Catheter infection</td>
</tr>
<tr>
<td>• Thrombosis</td>
</tr>
<tr>
<td>• Hematoma, aneurism, pseudoaneurysm</td>
</tr>
<tr>
<td>• Distal limb ischemia (AV-ECCO$_2$R)</td>
</tr>
<tr>
<td>• Catheter malposition, dislodgement or kinking</td>
</tr>
<tr>
<td>• Compartment syndrome</td>
</tr>
<tr>
<td>• Accidental arterial insertion (AV-ECCO$_2$R system)</td>
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<tr>
<td>• Recirculation</td>
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<table>
<thead>
<tr>
<th>Device-related</th>
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<tbody>
<tr>
<td>• Pump malfunction</td>
</tr>
<tr>
<td>• Oxygenator malfunction</td>
</tr>
<tr>
<td>• Heat exchanger failure</td>
</tr>
<tr>
<td>• Clot plugging</td>
</tr>
</tbody>
</table>

AV-ECCO$_2$R: arterio-venous extracorporeal carbon dioxide removal.

ECCO$_2$R can worsen hypoxemia and increase FiO$_2$ requirements due to derecruitment, which can be counteracted by applying higher levels of PEEP. Lower partial alveolar oxygen pressure can also result from a reduced lung respiratory quotient [71–73].

One of the most important differences between AV and VV configurations is the risk of complications related to the femoral artery catheterization with partial obstruction of blood flow and the potential occurrence of limb ischemia.

Hemorrhagic events related to vascular access and anticoagulation are the most frequent complications of ECCO$_2$R. The low flow makes systemic anticoagulation necessary, increasing significant bleeding risk, including cerebral, gastrointestinal, and nasopharyngeal bleeding. The contact between blood and the artificial surfaces of the circuit at very low flows can lead to a secondary consumption of clotting factors and associated bleeding complications. Clinically significant hemorrhagic complications are reported in the range between 2% and 50% [65, 74].

Although most systems are also coated with heparin to minimize thrombogenicity of the surface as little as possible, thrombus formation may build-up due to increased exposure time of the blood in contact with the artificial membrane lung and circuit due to lower flow rates. Clotting in the system may reduce or compromise the membrane efficiency or completely obstruct the circuit if anticoagulation is not achieved. This may reduce the membrane efficiency and consequently increase CO$_2$ levels rapidly. Membrane thrombosis must be considered a life-threatening event, requiring the immediate substitution of the circuit.

Heparin-induced thrombocytopenia is rarely observed. In this case, an albumin or phosphorylcholine/phosphatidylcholine coating can be requested [75].

The careful choice of adequate vascular access is critical in preventing thrombosis and detecting catheter kinking, precluding the achievement of target blood flow rates [56]. Catheter displacement or kinking may also result in pump malfunction and membrane thrombosis. Hence, subclavian or jugular vein cannulation is preferred over the femoral vein access when a high body mass index or intraabdominal hypertension is present. Intravascular hemolysis also has been reported.

6. Future perspectives

ECCO$_2$R effectively allows the implementation of protective or ultra-protective ventilation in patients with ARDS. However, current data do not demonstrate efficacy in improving patient-centered outcomes. Further investigations, warranted to establish the overall clinical effect of ECCO$_2$R in patients with ARDS, will need to address several important issues regarding, among others, the definition of optimal blood flow and hence circuit configuration, the definition of optimal target of pH, CO$_2$, tidal volumes and alveolar distending pressures, and the definition of optimal anticoagulation strategies. These advancements will also clarify whether ECCO$_2$R should be applied in all patients with ARDS, only in specific subphenotypes, or whether a personalized mechanical ventilation strategy, including ECCO$_2$R, should be delivered to each patient based on specific disease characteristics and risk factors.

7. Summary and recommendations

ECCO$_2$R may be a promising adjuvant therapeutic strategy to reduce the injury induced by mechanical ventilation.

In a recent European consensus on using ECCO$_2$R for ultra-protective ventilation in ARDS patients, driving pressure with plateau pressure optimization was the main criteria for commencement of the technique. The clinical targets were pH >7.30, respiratory rate <20–25 breaths/min, P$_{FLAT}$ <25 cmH$_2$O and driving pressure <14 cmH$_2$O [76]. At the moment, ECCO$_2$R in patients with ARDS should not be used in patients outside clinical trials.

Future studies that harness the potential benefits of ECCO$_2$R
without increasing the risk of other complications are needed to progress this technology.

AUTHOR CONTRIBUTIONS
LMQ and LDS—designed the study, wrote original draft, reviewed and edited. LDS and JM—reviewed, edited and corrected English. JM—supervised and reviewed.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE
Not applicable.

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CONFLICT OF INTEREST
The authors declare no conflict of interest.

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