We would like to bring up some critical points regarding these scales. First, the CPOT and the BPS do not have a specific item for patients who are in a coma (Glasgow Coma Scale ≤8), with artificial airways (eg, tracheostomy tube), who are breathing spontaneously without receiving mechanical ventilation.3

Other important concerns are items that evaluate patients’ compliance with ventilators. When patients cough we expect to hear the sound of ventilator alarms, which occurs only if alarms have been adequately set up. Consequently, the evaluation of this item is dependent on the variability of clinical settings and health care professionals.4

Another element that can make it difficult to recognize a patient “fighting with the ventilator” is the use of ventilation modes based on active expiration valves (eg, BIPAP, Dräger; DuoPAP, Hamilton; BiVent, Siemens; Bi-Level, Puritan Bennett-Covidien). These ventilation modes let the patients breathe spontaneously, without activating the ventilator alarms. The identification of patient-ventilator asynchronies is made by the direct observation of patients and the interpretation of ventilator waveforms.5

A recent European survey6 has shown a wide variability in ventilator education provided to ICU nurses. Unfortunately we do not know how many nurses are “comfortable” with ventilator graph interpretation, even if 83% consider waveform analysis education “important” or “very important.” Presently, there is a lack of papers published about this issue.

Finally, some clinical conditions, not necessarily related to pain, can determine the activation of ventilator alarms due to patients’ dyssynchronies: hiccup and seizures. These conditions can determine false positive results. We hope that our observations can be helpful to improve these pain assessment tools for critically ill patients. CCN

References

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Letters to the Editor

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Pain assessment scales in nonverbal critically ill adult patients: ventilator-related issues
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