

In Critical Care

1. Most ETTs have an identifiable mark 1 to 2 cm from the cuff. Maintaining the video view of the glottic opening during ETT insertion and placing this mark at the vocal cords will guard against main stem intubation (and virtually guarantee against esophageal intubation).
2. Upper airway obstruction can be addressed with humidified air followed by racemic epinephrine, heliox, and, ultimately, surgical airway placement if airway patency cannot be secured via the laryngeal route.
3. Bleeding from a tracheostomy site 48 hours after procedure should always prompt investigation for tracheoarterial fistula formation.
4. Bronchoalveolar lavage should be considered when there is a suspected atypical pneumonia or nonresolving infiltrate.
5. Bronchoscopy has limited value in the diagnosis of idiopathic interstitial pneumonias.
6. Exercise therapy has significant benefits in both the acute and chronic setting for patients with COPD. It can be started in the ICU and continued on an outpatient basis in a formal pulmonary rehabilitation program.
7. Many patients with COPD and acute respiratory failure can be supported with noninvasive ventilatory support; however, intubation when needed is relatively well tolerated.
8. The five causes of hypoxemia are:
 - V/Q (ventilation/perfusion) mismatch
 - Alveolar hypoventilation
 - Shunt: physiologic (alveolar level) and anatomic (proximal to lung)
 - Diffusion limitation
 - Low inspired oxygen fraction
9. Two therapies proven to reduce mortality in patients with ARDS are:
 - Low tidal volume ventilation (6mL/kg predicted body weight)
 - Prone positioning
10. Death from massive hemoptysis is more commonly due to asphyxiation than exsanguination.