

volume delivered [6], it did facilitate faster weaning when compared with PSV [7]. However, it could be argued that COPD patients are usually difficult to wean and should be carefully managed to prevent any iatrogenic harms such as air leaks which might occur as a result due to their highly compliant lung. And although the mode minimizes clinician's intervention which might minimize errors and prevent delay in weaning, their intervention might be needed when the ventilator provides more/less support needed when it is used as an initial mode of ventilation. Acute Respiratory Distress Syndrome (ARDS) and Acute Lung Injury (ALI) hence, one research indicated that ASV could provide more than 10ml/kg in such case [8] which does not follow lung protective strategies currently recommended for such lung abnormality [9]. The patient is weaned from sedation, oriented with adequate level of consciousness. Comparison with Other Weaning Modes A literature search on comparative studies between ASV and other weaning modes were conducted, for the aim of identifying the advantages of ASV over any of them if any. And although this time the ASV mode showed no superiority over SIMV followed by PS in the length of tracheal intubation, ICU stay, and amounts of postoperative sedation, the advantages of less clinician intervention needed might be considered as an advantage for the ASV mode. However, the major concern within the weaning protocol was edited; by depending on the normalization of the PaCO<sub>2</sub> value instead of taking extra 6 spontaneous breaths, which might be considered as a more reliable indicator for the patients allocated to the SIMV group to be eligible for the next phase of weaning. Interestingly, they stated that ASV delivered significantly higher tidal volumes, which might be beneficial for post open heart surgery patients who are prone to derecruitment, but it might be against the current recommendation about protective lung strategies using less volume. And although, their protocol for the PC group stated that once there was detected spontaneous breaths it was their indicator to switch the patients to PSV, the mandatory breaths on PC was set at 12–15 BPM which might be satisfactory for stable post-operative patients. In one study compared between ASV and Synchronised Intermittent Mandatory Ventilation (SIMV) followed by Pressure Support (PS) following a three phases protocol ASV group were extubated faster than SIMV followed by PS group [10]. Furthermore, it would be interesting to investigate the differences between ASV mode and SIMV+PS mode, since most of the current ventilators provide SIMV + PS as a single mode. When the targeted ABG values is reached which includes acceptable oxygenation PaO<sub>2</sub>>60 on FiO<sub>2</sub>