Pediatric Acute Respiratory Distress Syndrome: Consensus Recommendations From the Pediatric Acute Lung Injury Consensus Conference

PARDS Definition, Etiology, & Pathophysiology

1. No age criteria
2. Exclusionary criteria: prematurity-related lung disease, perinatal lung injury, other congenital anomalies
3. In the first 24 hours, respiratory indices and biomarkers should be serially measured

Ventilatory Support

1. Oxygen therapy should be titrated between 88%-97% S_{pO2}
2. PEEP levels of 10-15 cm H_2O should be titrated to oxygenation and hemodynamic markers specific for patient; monitor specific levels as PEEP increases

Outpatient Support

1. Screen pulmonary function tests within the first year after discharge
2. Physical, neurocognitive, emotional, family, and social function should be measured 3 months after hospital discharge

Adjunctive Treatment

1. Surfactant therapy, prone positioning, use of corticosteroids, and anticoagulants are currently inconclusive
2. Maintain a clear airway
3. Minimal sedation that potentiates maximal oxygen delivery, consumption, and respiratory efforts
4. Titrate respiratory and general hemodynamic support as needed when patients' levels show improvement
5. Use enteral nutrition over parenteral nutrition when tolerated
6. Provide RBC transfusion if Hgb concentration falls below 7 g/dL
7. Monitor F_{IO2}, S_{po2}, and/or P_{ao2}, P_{aw}, PEEP, pH and P_{aCO2} to detect severity of PARDS

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