

REVIEW

Bench to bedside review: Extracorporeal carbon dioxide removal, past present and future

Matthew E Cove¹, Graeme MacLaren^{2,3}, William J Federspiel^{1,4,5} and John A Kellum^{1,4,*}

Abstract

Acute respiratory distress syndrome (ARDS) has a substantial mortality rate and annually affects more than 140,000 people in the USA alone. Standard management includes lung protective ventilation but this impairs carbon dioxide clearance and may lead to right heart dysfunction or increased intracranial pressure. Extracorporeal carbon dioxide removal has the potential to optimize lung protective ventilation by uncoupling oxygenation and carbon dioxide clearance. The aim of this article is to review the carbon dioxide removal strategies that are likely to be widely available in the near future. Relevant published literature was identified using PubMed and Medline searches. Queries were performed by using the search terms ECCOR, AVCO2R, VVCO2R, respiratory dialysis, and by combining carbon dioxide removal and ARDS. The only search limitation imposed was English language. Additional articles were identified from reference lists in the studies that were reviewed. Several novel strategies to achieve carbon dioxide removal were identified, some of which are already commercially available whereas others are in advanced stages of development.

Introduction

The reported incidence of acute respiratory distress syndrome (ARDS) ranges from 7 to 59 per 100,000 people [1,2], and is associated with a mortality rate of 40 to 45%. This rate remains unacceptably high despite the introduction of lung protective ventilation and, although hospital mortality may be slowly decreasing, ICU and 28 day mortality have remained constant [1,3]. Failure to

implement lung protective ventilation (LPV) may be one of the reasons ICU mortality rates have remained unchanged [4-6]. When surveyed, health care providers reported that hypercapnia or its related effects were significant barriers to achieving LPV [7]. Hypercapnia complicated 14% of patients in the large ARDS network on the use of LPV [8]. However, patients with a high risk of death were excluded. In a study of severe ARDS, where tidal volumes were adjusted to target a mean airway pressure less than 28 cmH₂O, all patients experienced hypercapnia [9]. As evidence emerges that tidal volumes <6 ml.kg⁻¹ might further reduce mortality [9,10], alternative strategies to manage the inevitable hypercapnia must be considered.

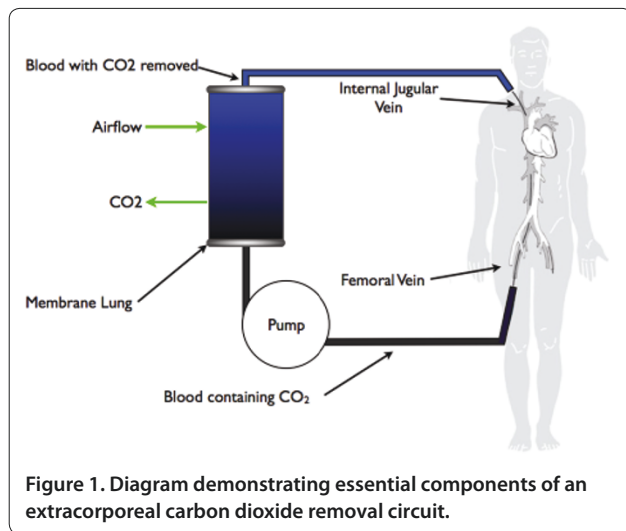
Permissive hypercapnia is one approach, but it only improves mortality when patients are ventilated with high tidal volumes [8]. Such volumes should no longer be used since 6 ml.kg⁻¹ is superior to 12 ml.kg⁻¹ and <4 ml.kg⁻¹ might be superior to 6 ml.kg⁻¹ [9-11]. Although hypercapnia might have beneficial effects on oxygen delivery and attenuation of inflammation [12], it also harms injured lung through immunosuppression and impaired pulmonary epithelial repair [13,14]. Furthermore, hypercapnia perpetuates right heart failure [15] and is undesirable in patients with elevated intracranial pressure. An alternative strategy to manage hypercapnia is extracorporeal carbon dioxide removal (ECCOR), a technology pioneered four decades ago [16] but only recently readily accessible through commercialization of several novel devices. ECCOR therefore deserves a fresh look and this review aims to provide an overview of devices currently available and those that may be available in the near future.

ECCOR in principle

ECCOR is designed to remove carbon dioxide (CO₂) and, unlike extracorporeal membrane oxygen (ECMO), does not provide significant oxygenation. A discussion of ECMO is beyond the scope of this article but is well reviewed elsewhere [17,18]. In its simplest form, ECCOR consists of a drainage cannula placed in a large central vein, a pump, a membrane lung and a return cannula (Figure 1). Blood is pumped through the membrane

*Correspondence: kellumja@upmc.edu

¹Clinical Research, Research, Investigation and Systems Modeling of Acute Illness (CRISMA) Center, Department of Crit Care Med, University of Pittsburgh School of Medicine, 603 Scaife Hall, 3550 Terrace Street, Pittsburgh, PA 15261, USA
Full list of author information is available at the end of the article



'lung' and CO₂ is removed by diffusion. Membrane lungs are permeable to gases but not liquids. A flow of gas containing little or no CO₂ runs along the other side of the membrane, ensuring the diffusion gradient favors CO₂ removal.

In contrast to ECMO, where the need for oxygenation requires high blood flow rates, ECCOR allows much lower blood flow rates, a result of major differences in CO₂ and oxygen (O₂) kinetics. First, almost all the O₂ in blood is carried by hemoglobin, which displays sigmoidal saturation kinetics. Assuming normal hemoglobin and venous O₂, each liter of venous blood can only carry an extra 40 to 60 ml of O₂ before the hemoglobin is saturated. Blood flows of 5 to 7 L·minute⁻¹ are therefore required to supply enough O₂ for an average adult (250 ml·minute⁻¹). Conversely, most CO₂ is transported as dissolved bicarbonate, displaying linear kinetics without saturation. Thus, 1 L of blood is capable of carrying more CO₂ than O₂, and 250 ml of CO₂ can be removed from <1 L of blood. Second, CO₂ diffuses more readily than O₂ across extracorporeal membranes because of greater solubility [17].

The membrane lung

The membrane lung made long-term extracorporeal gas exchange feasible. Before membrane lungs, extracorporeal circuits achieved gas exchange by creating a direct air-blood interface, either bubbling air through blood or creating a thin film of blood on the surface of a rotating cylinder/disc. However, blood-air interfaces denature proteins, activate clotting and inflammatory pathways, and damage circulating cells [19]. Consequently, devices relying on blood-air interfaces cannot be used more than a few hours without serious complications.

The concept of placing a barrier between blood and air began with the observation that gas exchange occurred

across cellophane tubing in hemodialysis machines [20]. This led to the development of membrane lungs consisting of gas permeable silicone-rubber mounted on a nylon mesh [21]. The nylon mesh provided structural strength and decreased leakage from random pinhole defects, which occur during the manufacture of thin silicone-rubber membranes [19]. Three major factors determine the amount of gas crossing membranes: the diffusion gradient, the membrane-blood contact time and the membrane diffusion characteristics.

The CO₂ diffusion gradient is determined by the CO₂ content of the blood and the air passing through the membrane lung, as well as the speed of the airflow. Membrane-blood contact time is determined by membrane geometry. In early devices, Theodore Kolobow arranged the membrane into a coil [22] and used a fabric with an irregular surface, increasing the surface area [23]. Hollow fiber membranes have now replaced coiled silicon-rubber membranes. Early fibers were constructed with microporous polypropylene. Micropores create microscopic blood-gas interfaces allowing efficient gas exchange, but also cause plasma leak. Recently, non-microporous poly-4-methyl-1-pentene (PMP) has been used; it provides superior gas exchange, better biocompatibility and is less susceptible to plasma leak [24-26]. Adding covalently bound heparin to membrane surfaces enhances biocompatibility, and gas exchange has been improved by arranging fibers into a complex mat and running blood on the outside [27] (Figure 2). This arrangement allows perpendicular blood flow to the fibers, improving mass transfer by reducing the diffusion path length compared to parallel flow. Modern membrane lungs achieve adequate gas exchange with surface areas of 1 to 3 m² (Table 1).

The pump

Blood flow through ECCOR circuits can be achieved in one of two ways. In patients with sufficient arterial pressure, a pumpless system can be used where blood is driven out of an arterial cannula by high arterial pressures and returned through a venous cannula, often called arteriovenous CO₂ removal (AVCO2R). Pumpless systems result in less blood trauma, but require large bore arterial cannulas and an adequate cardiac output. The alternative is to use a mechanical pump.

Early devices used roller or peristaltic pumps. Although cheap and reliable, these pumps were prone to blood trauma - for example, hemolysis - from compression and heating of blood components. Blood trauma is less of a problem at lower blood flow rates - for example, those used in dialysis. The introduction of rotary pumps has resulted in simpler yet effective systems that cause less blood trauma. Two main types of rotary pumps are used in ECCOR devices, centrifugal and diagonal flow pumps.

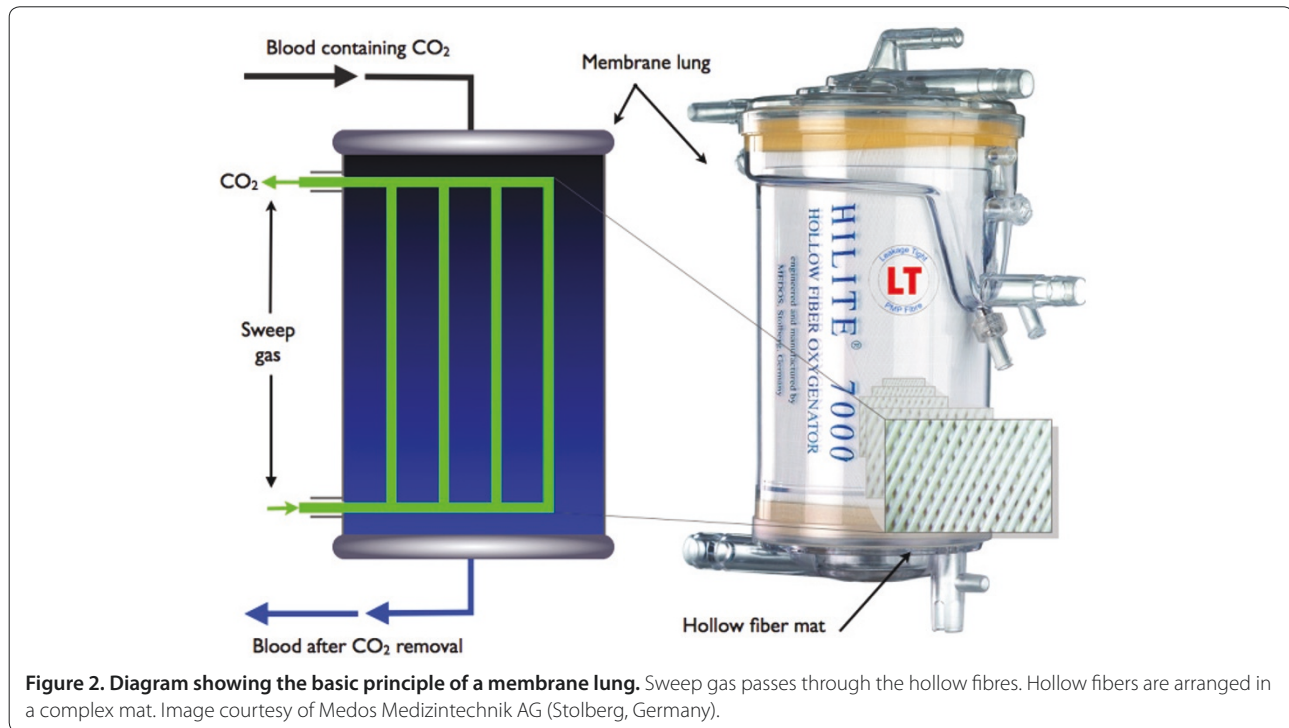


Figure 2. Diagram showing the basic principle of a membrane lung. Sweep gas passes through the hollow fibres. Hollow fibres are arranged in a complex mat. Image courtesy of Medos Medizintechnik AG (Stolberg, Germany).

Centrifugal pumps use a radial rotating impeller to create a suction vortex that draws blood into the center of the pump and spins it outwards, imparting centrifugal momentum, which is converted into driving pressure. In diagonal flow pumps, impeller design is a mix of radial and axial geometry. Centrifugal pumps tend to generate high pressures and low flows, whereas diagonal pumps produce both high flows and high pressures [28]. Impellers are connected to a drive shaft, requiring bearings to support the rotational movement. Exposure of blood to typical bearings promotes clotting, causing deposition of coagulation debris that can seize the bearing. Some pumps use seals to protect the bearings, but these can wear out; other designs use biocompatible materials to construct the bearings. In the most advanced centrifugal pumps impellers are completely suspended in an electromagnetic field, eliminating the need for a drive shaft or bearings and reducing heating, minimizing blood trauma and lowering the incidence of mechanical failure.

Access cannula

Early clinical trials placed separate drainage and return cannulas in the saphenous veins [29,30]. Modern cannulas are placed percutaneously in a femoral-femoral or femoral-jugular orientation. To maintain flow and minimize blood trauma, heparin-coated wire-reinforced cannulas are used. Recently, a high flow, wire-reinforced double-lumen catheter has been developed. It is placed via the right internal jugular vein and the drainage port (tip of the cannula) is advanced into the intra-hepatic inferior

vena cava using ultrasound guidance [31]. In this orientation the return port aligns with the right atrium, minimizing recirculation. New ECCOR devices with flow rates comparable to those in dialysis use double-lumen cannulas similar to dialysis catheters [32,33].

ECCOR in practice

The first clinical trial of extracorporeal respiratory support was published in 1979, and used the Kolobow spiral-coil membrane lung, a roller pump and veno-arterial access to provide ECCOR [34]. This trial found no difference between conventional treatment and ECCOR. At about the same time Gattinoni and coworkers introduced ECCOR [35], but did not publish the first clinical trial until 1986, where patients with severe ARDS were selected for LPV combined with ECCOR (Kolobow spiral-coil membrane lung, and a roller pump). Observed mortality was 51% using this technique [29]. Subsequent work was initially encouraging [36] but a randomized controlled study in 1994 concluded that ECCOR conferred no survival advantage [30]. Importantly, complication rates were high with ECCOR, being discontinued in 33% of cases owing to bleeding, and 20% experiencing circuit clotting. Recently, new devices with lower complication rates have demonstrated improved survival when combined with ultra-protective ventilation [9]; some are already available whilst others are in advanced development. They can be broadly categorized into i) arteriovenous devices, ii) venovenous devices, iii) gas exchange catheters and iv) respiratory dialysis.

Table 1. Extracorporeal carbon dioxide removal circuit components

Component	Name	Special features	Manufacturer
Pump	Centrimag	Impeller elevated in electromagnetic field	Levotronic LLC Waltham, MA, USA
	RotaFlow	Impeller driven by electromagnetic field and has single sapphire bearing	Maquet, Rastatt, Germany
	Biomedicus	Impeller drive shaft supported by sealed bearings	Medtronic, Eden Prairie, MN, USA
	Deltastream	Diagonally streamed impeller, sealed bearings	Medos Medizintechnik AG, Stolberg, Germany
Membrane lung	Quadrox D	1.8 m ² surface area, 250 ml priming volume	Maquet, Rastatt, Germany
	iLA membrane ventilator	1.3 m ² surface area, 175 ml priming volume	Novalung GmbH, Heilbronn, Germany
	hilite 7000LT	1.9 m ² surface area, 275 ml priming volume	Medos Medizintechnik AG, Stolberg, Germany
	Affinity NT	2.5 m ² surface area, 270 ml priming volume	Medtronic, Eden Prairie, MN, USA

This list is not exhaustive, but demonstrates the range of products available. iLA, interventional lung assist.

Arteriovenous carbon dioxide removal

AVCO2R is commercially available through Novalung (GmbH, Hechingen, Germany) and marketed as the interventional lung assist (iLA) membrane ventilator (Figure 3). The membrane lung, frequently called the 'Novalung', utilizes a low resistance design allowing blood flow using the patient's own arteriovenous pressure gradient. Cannulas are placed percutaneously in the femoral artery and vein [37,38]. A similar system has been developed in the United States using the Affinity NT (Medtronic, Minneapolis, MN) [39,40].

Pumpless systems require an arteriovenous pressure gradient ≥ 60 mmHg, which is unsuitable for hemodynamically unstable patients. Further, cannulation of a major artery can result in distal ischemia [37], although measuring the artery diameter with ultrasound and selecting a cannula that occupies no more than 70% of the lumen reduces this risk [38]. AVCO2R has been successfully used to facilitate LPV in patients with ARDS [41-43], severe asthma [44] and as a bridge to lung transplantation [45].

Venovenous carbon dioxide removal

Venovenous carbon dioxide removal (VVCO2R) requires a mechanical pump to propel blood through the circuit and can be broadly divided depending on whether the pump and membrane lung are separate components or incorporated into a single console. When separate components are used, the circuit is set up as described in Figure 1. Table 1 shows some of the different components that can be used. These circuits are more complicated to operate, often need flow rates >1 L \cdot minute⁻¹ and may need multidisciplinary support. The growth of programs in more general settings has provided impetus to simplify ECCOR, resulting in several devices where the pump and membrane lung are combined into one console.

iLA Active

The iLA Active mounts the Novalung and a diagonal flow pump together in one device. At higher blood flow

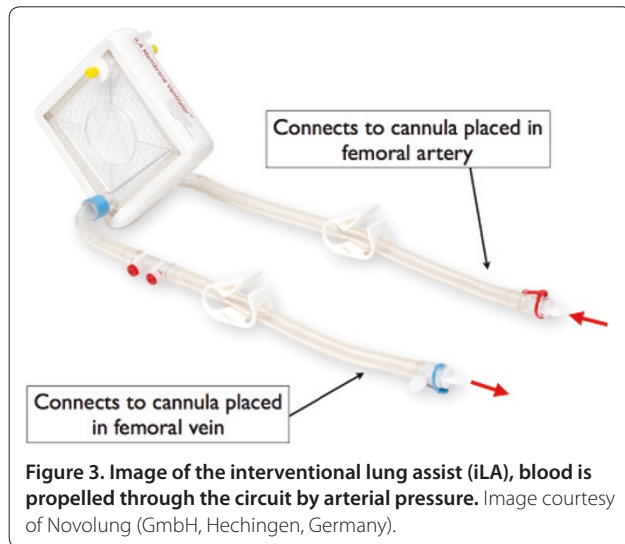
rates this device can provide venovenous ECMO. Conceptually, this is the simplest method of providing ECCOR via a console, and although it does not provide any special benefits over separate components, the pump is designed to provide reliable flows throughout a large range of flow rates.

Decap/Decapsmart

The Decap system (Hemodec, Salerno, Italy) uses a membrane lung in series with a hemodialysis filter and roller pump (Figure 4). The hemodialysis filter serves two purposes with regard to CO₂ removal. First, it reduces the chance of bubble formation by increasing resistance within the membrane lung. Second, ultrafiltrate from the filter is returned to the blood stream prior to the membrane lung inflow. Since ultrafiltrate contains dissolved CO₂, recirculating in this way allows additional CO₂ removal by creating a greater flow rate through the membrane lung than the flow from the patient. Consequently, smaller membrane lungs can be used (0.3 to 1.35 m²) with lower flow rates (<500 ml \cdot minute⁻¹) than conventional ECCOR [33], resulting in similar anticoagulation requirements to continuous venovenous hemodialysis [46]. The Decap has been successfully used in adults and children [9,47,48].

Hemolung

The Hemolung (Alung Technologies, Pittsburgh, USA) is the latest device to enter the ECCOR arena. In this device the membrane lung and centrifugal pump are combined together, acting as one unit (Figure 5). Blood is drawn into the unit via a rotating impeller. The center contains a rotating core that accelerates blood towards a surrounding stationary fiber bundle. This is called active mixing; the rotating core generates disturbed blood flow patterns subjacent to the fiber membrane, reducing diffusional resistance and increasing gas exchange. As a result, CO₂ removal is more efficient and achieved with a smaller membrane surface area and flows of 400 to 600 ml \cdot minute⁻¹,



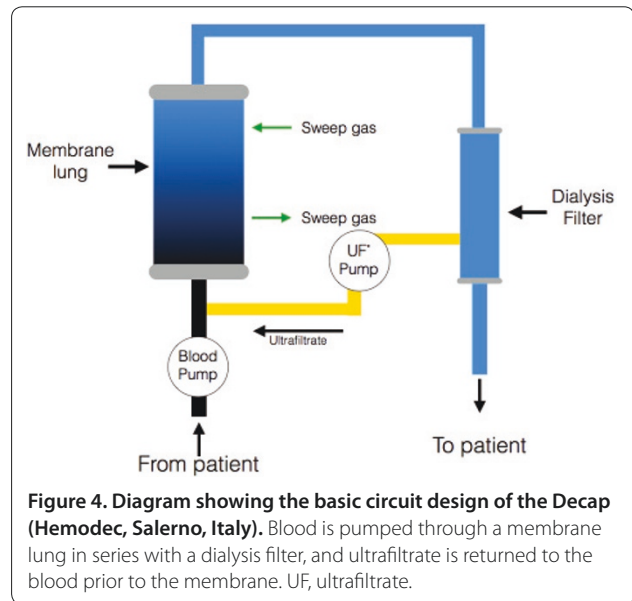
which allows use of smaller double-lumen catheters. The smaller membrane surface area, siloxane coating for plasma resistance and covalently bound heparin result in lower anticoagulation requirements [32]. Gas flow through the membrane lung is supplied under negative pressure, a safety feature preventing air embolism if the membrane is disrupted. The Hemolung enabled a 50% reduction in minute ventilation in animal trials and was recently successfully used in a clinical case series of five adults [49].

Gas-exchange catheters

Several gas-exchange catheters have been developed but only one, the intravenocaval oxygenator and carbon dioxide removal device (IVOX), has been used clinically. These devices package hollow fiber membrane lungs into a catheter that is small enough to be placed in the vena cava, that is, <15 mm in diameter. Intracorporeal catheters are conceptually attractive because they are exposed to 2 to 3 L·minute⁻¹ of blood flow and therefore CO₂ removal is not flow limited.

The IVOX was designed for both oxygenation and CO₂ removal. Orienting 'crimped' membrane fibers in a spiral arrangement maximized gas exchange by increasing surface area and creating disturbed blood flow patterns over the membrane [50]. Disturbed blood flow provides convection velocity towards the fiber surfaces, reducing diffusional resistance. The membrane surface of the IVOX ranged from 0.2 to 0.5 m² [51] and gas flow was applied under negative pressure; an important safety feature in intracorporeal devices since there is no other opportunity to prevent air embolism if the membrane is disrupted.

In animal trials the IVOX consistently removed 40 ml·minute⁻¹ of CO₂, but oxygen delivery was less



reliable. Clinical experience was mixed; the IVOX facilitated lower ventilator settings in some studies [52], but made no difference in others [53,54]. On the whole, gas exchange was too limited and placement associated with high complication rates from bleeding and thrombosis [52]. Commercial development has subsequently ceased.

Future directions and devices in development

Several of the above devices are undergoing clinical trials, often in combination with LPV (Table 2). Other promising approaches are still in development, in particular more efficient gas exchange catheters and respiratory dialysis. Novel methods to maximize CO₂ removal, such as blood acidification, are also under investigation [55].

Gas-exchange catheters in development

Following the IVOX, attention has focused on developing a catheter that meets 50% of adult gas exchange requirement. Several ingenious approaches are being studied. The first approach is generation of active mixing within the catheter. This was initially attempted using an intra-aortic balloon pump close to the shaft of the IVOX catheter [56]. However, the membrane fibers were not fixed and fiber movement opposed active mixing. The Hattler catheter solved this using a rigid fiber mat constructed around a central balloon [57] (Figure 6). Rapid pulsation of the balloon directed blood flow over the membrane fibers, causing active mixing. In this design membrane fibers do not occupy the whole lumen of the vein, causing less fiber drag on blood flow. In animal trials the Hattler catheter exchanged CO₂ at 305 ml·minute⁻¹·m⁻², almost double the IVOX rate at similar CO₂ concentrations [58,59].

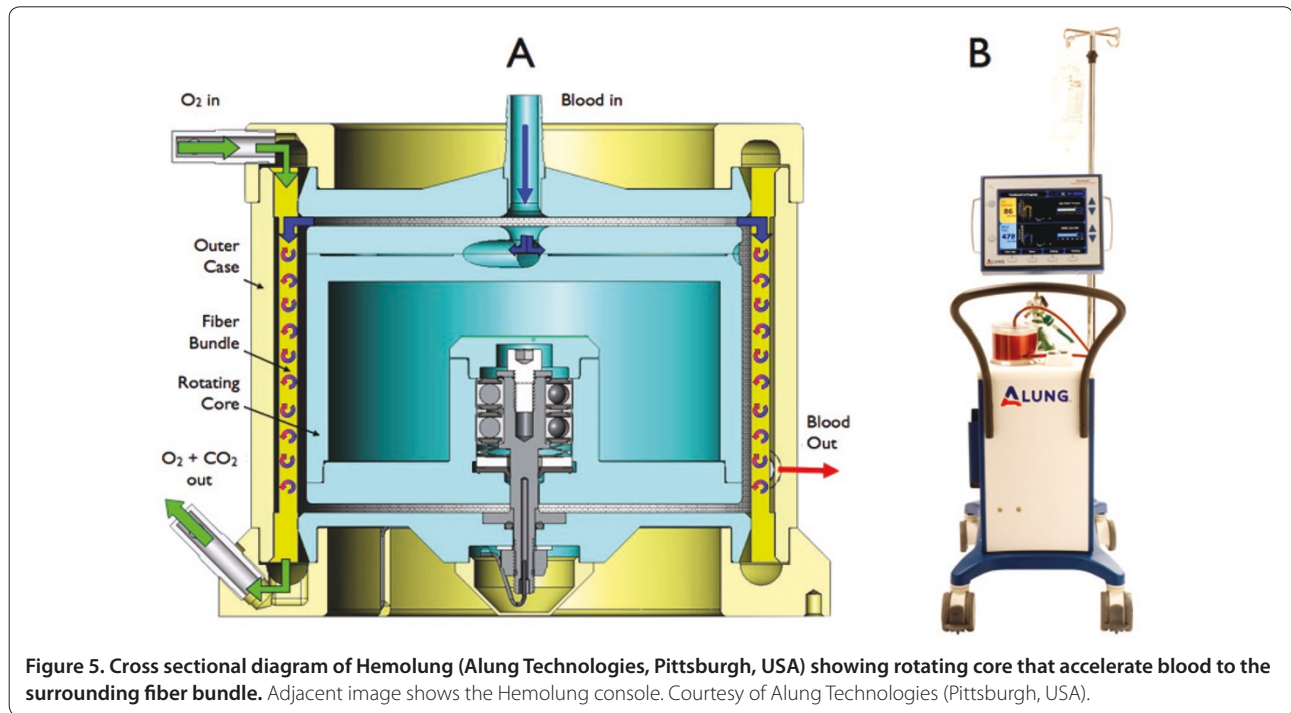


Figure 5. Cross sectional diagram of Hemolung (Alung Technologies, Pittsburgh, USA) showing rotating core that accelerate blood to the surrounding fiber bundle. Adjacent image shows the Hemolung console. Courtesy of Alung Technologies (Pittsburgh, USA).

Table 2. Current active trials from clinicaltrials.gov accessed April 2012

Study title	Device	Sponsor	Status
Extracorporeal CO ₂ removal in COPD (DECOPD)	Decap Smart	University of Turin, Italy	Recruiting
Pulmonary and Renal Support during Acute Respiratory Distress Syndrome (PARSA)	Neonatal membrane lung (HiLite 800 LT, Medos) within dialysis circuit (Multifiltrate kit 7, CVVH 1000, Fresenius)	Hopital Ambroise Pare, France	Recruiting
Low-flow ECCO2-R and 4 ml/kg Tidal Volume vs. 6 ml/kg Tidal Volume to Enhance Protection From Ventilator Induced Lung Injury in Acute Lung Injury (ELP)	Not specified	University of Turin, Italy	Not yet recruiting

Active mixing can also be achieved by rotating the fiber bundle; a strategy used in the dynamic intravascular lung assist device (D-ILAD) [60]. Although the D-ILAD was almost twice as efficient as balloon-pulsating catheters, rotating fibers could damage vessel walls upon contact. Recently, the Hattler catheter has been modified by replacing the balloon with a series of small impellers. It has been successfully used in animals and has CO₂ exchange rates similar to the D-ILAD [61].

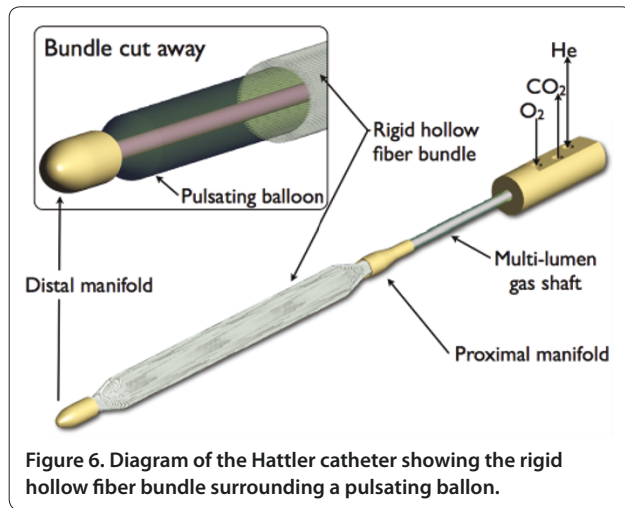
Finally, in addition to active mixing, CO₂ exchange has been improved by covalent immobilization of carbonic anhydrase to the surface of the hollow fiber membrane [62]. As a result, CO₂ is more rapidly generated from bicarbonate, facilitating removal.

Respiratory dialysis

In the 1980s, several groups reported the results of animal experiments using dialysis to remove CO₂ in the

form of bicarbonate. This approach is appealing because CO₂ is transported in the form of bicarbonate, which moves freely across dialysis membranes. Conventional hemodialysis uses bicarbonate-containing dialysates to correct the metabolic acidosis accompanying renal failure, but bicarbonate-free dialysates can remove enough CO₂ to replace pulmonary ventilation in dog models [63]. Currently, respiratory dialysis is limited by the inability to maintain electrolyte concentrations and pH whilst removing bicarbonate. Several approaches to replace bicarbonate have been attempted using sodium hydroxide, tromethamine (THAM), and organic anions. However, fluid gain, hyperchloremic acidosis, hemolysis, cardiac arrhythmias and acid-base derangements have prevented successful long-term use [64,65].

Recently, hemofiltration has been used to remove bicarbonate. One group used sodium hydroxide in a post-filter replacement fluid and maintained pH and CO₂



within physiological range for 18 hours in hypoventilated sheep. However, hyperchloremic acidosis developed and blood flow rates exceeding 500 ml·minute⁻¹ would be needed to remove sufficient CO₂ in humans [66]. Another group removed bicarbonate by using pre-filter replacement fluid containing THAM. Physiologic CO₂ levels and pH were maintained for 1.5 hours, but it was not determined whether THAM had the same long-term problems seen in the hemodialysis models [67]. Nonetheless, respiratory dialysis holds much promise if the problems of electrolyte and acid-base disturbances can be solved.

Conclusion

Several modalities of providing ECCOR are now either available or in development. As evidence favoring low-volume, low-pressure ventilation in ARDS accumulates, the argument for applying these ventilation strategies in all critically ill patients will gather momentum. However, successful application is dependent upon a safe, reliable approach for CO₂ removal.

Simpler more efficient ECCOR devices requiring lower blood flow rates and smaller access cannulas promise to improve safety and ease of use. Novel designs, such as the Decap, can serve the dual purpose of renal support and ECCOR. However, other solutions currently in development, gas exchange catheters and respiratory dialysis, promise to be minimally invasive, easy to initiate and well tolerated. They may even eliminate the need for intubation in some forms of respiratory failure, where CO₂ is the primary problem [68]. Familiarity with devices already available can change our approach to ARDS and prime the ICU for the arrival of devices that may revolutionize our approach to respiratory failure.

Abbreviations

ARDS, acute respiratory distress syndrome; AVCO₂R, arteriovenous CO₂ removal; D-ILAD, dynamic intravascular lung assist device; ECCOR,

extracorporeal carbon dioxide removal; ECMO, extracorporeal membrane oxygenation; iLA, interventional lung assist; LPV, lung protective ventilation; THAM, tromethamine; VVCO₂R, venovenous carbon dioxide removal.

Competing Interests

MEC and GM have no competing interests to declare. WJF is head of the scientific advisory board at ALUNG Technologies, and has an equity interest in this company. JAK is a paid consultant for ALUNG Technologies.

Acknowledgements

MEC acknowledges support from NIH grant HL07820. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Heart, Lung, and Blood Institute or the National Institutes of Health. The authors acknowledge Marquet (Rastatt, Germany) Medos (Medizintechnik AG, Stolberg, Germany), Novalung GmbH (Heilbronn, Germany) and Hemolung (ALUNG Technologies, Pittsburgh, USA) for their assistance in producing the figures.

Author details

¹Clinical Research, Research, Investigation and Systems Modeling of Acute Illness (CRISMA) Center, Department of Crit Care Med, University of Pittsburgh School of Medicine, 603 Scaife Hall, 3550 Terrace Street, Pittsburgh, PA 15261, USA. ²Cardiothoracic Intensive Care Unit, National University Health System, 5 Lower Kent Ridge Road, Singapore, 119074. ³Paediatric Intensive Care Unit, Royal Children's Hospital, Flemington Rd, Melbourne, VIC 3052, Australia. ⁴McGowan Institute of Regenerative Medicine, University of Pittsburgh, Room 218, McGowan Building, 3025 East Carson Street, Pittsburgh, PA 15203, USA. ⁵Department of Bioengineering and Department of Chemical Engineering, University of Pittsburgh, 3700 O'Hara Street, Pittsburgh, PA 15261, USA.

Published: 21 September 2012

References

1. Villar J, Blanco J, Anon JM, Santos-Bouza A, Blanch L, Ambros A, Gandia F, Carriedo D, Mosteiro F, Basaldua S, Fernandez RL, Kacmarek RM: **The ALIEN study: incidence and outcome of acute respiratory distress syndrome in the era of lung protective ventilation.** *Intensive Care Med* 2011, **37**:1932-1941.
2. Rubenfeld GD, Caldwell E, Peabody E, Weaver J, Martin DP, Neff M, Stern EJ, Hudson LD: **Incidence and outcomes of acute lung injury.** *N Engl J Med* 2005, **353**:1685-1693.
3. Phua J, Badia JR, Adhikari NK, Friedrich JO, Fowler RA, Singh JM, Scales DC, Stather DR, Li A, Jones A, Gattas DJ, Hallett D, Tomlinson G, Stewart TE, Ferguson ND: **Has mortality from acute respiratory distress syndrome decreased over time?: A systematic review.** *Am J Respir Crit Care Med* 2009, **179**:220-227.
4. Weinert CR, Gross CR, Marinelli WA: **Impact of randomized trial results on acute lung injury ventilator therapy in teaching hospitals.** *Am J Respir Crit Care Med* 2003, **167**:1304-1309.
5. Young MP, Manning HL, Wilson DL, Mette SA, Riker RR, Leiter JC, Liu SK, Bates JT, Parsons PE: **Ventilation of patients with acute lung injury and acute respiratory distress syndrome: Has new evidence changed clinical practice?** *Crit Care Med* 2004, **32**:1260-1265.
6. Kalhan R, Mikkelsen M, Dedhiya P, Christie J, Gaughan C, Lanken PN, Finkel B, Gallop R, Fuchs BD: **Underuse of lung protective ventilation: Analysis of potential factors to explain physician behavior.** *Crit Care Med* 2006, **34**:300-306.
7. Rubenfeld GD, Cooper C, Carter G, Thompson BT, Hudson LD: **Barriers to providing lung-protective ventilation to patients with acute lung injury.** *Crit Care Med* 2004, **32**:1289-1293.
8. Kregenow DA, Rubenfeld GD, Hudson LD, Swenson ER: **Hypercapnic acidosis and mortality in acute lung injury.** *Crit Care Med* 2006, **34**:1-7.
9. Terragni PP, Del Sorbo L, Mascia L, Urbino R, Martin EL, Birocchio A, Faggiano C, Quintel M, Gattinoni L, Ranieri VM: **Tidal volume lower than 6 ml/kg enhances lung protection: role of extracorporeal carbon dioxide removal.** *Anesthesiology* 2009, **111**:826-835.
10. Hager DN, Krishnan JA, Hayden DL, Brower RG: **Tidal volume reduction in patients with acute lung injury when plateau pressures are not high.** *Am J Respir Crit Care Med* 2005, **172**:1241-1245.
11. Network TARDS: **Ventilation with lower tidal volumes as compared with traditional tidal volumes for acute lung injury and the acute respiratory**

- distress syndrome. The Acute Respiratory Distress Syndrome Network. *N Engl J Med* 2000, **342**:1301-1308.
12. Curley G, Laffey JG, Kavanagh BP: **Bench-to-bedside review: carbon dioxide.** *Crit Care* 2010, **14**:220.
 13. O'Crainin DF, Nichol AD, Hopkins N, Boylan J, O'Brien S, O'Connor C, Laffey JG, McLoughlin P: **Sustained hypercapnic acidosis during pulmonary infection increases bacterial load and worsens lung injury.** *Crit Care Med* 2008, **36**:2128-2135.
 14. O'Toole D, Hassett P, Contreras M, Higgins BD, McKeown ST, McAuley DF, O'Brien T, Laffey JG: **Hypercapnic acidosis attenuates pulmonary epithelial wound repair by an NF-kappaB dependent mechanism.** *Thorax* 2009, **64**:976-982.
 15. Mekontso Dessap A, Charron C, Devaquet J, Aboab J, Jardin F, Brochard L, Vieillard-Baron A: **Impact of acute hypercapnia and augmented positive end-expiratory pressure on right ventricle function in severe acute respiratory distress syndrome.** *Intensive Care Med* 2009, **35**:1850-1858.
 16. Kolobow T, Gattinoni L, Tomlinson TA, Pierce JE: **Control of breathing using an extracorporeal membrane lung.** *Anesthesiology* 1977, **46**:138-141.
 17. Maclaren G, Combes A, Bartlett RH: **Contemporary extracorporeal membrane oxygenation for adult respiratory failure: life support in the new era.** *Intensive Care Med* 2011, **38**:210-220.
 18. Gattinoni L, Carlesso E, Langer T: **Clinical review: Extracorporeal membrane oxygenation.** *Crit Care* 2011, **15**:243.
 19. Lim MW: **The history of extracorporeal oxygenators.** *Anaesthesia* 2006, **61**:984-995.
 20. Kolff WJ, Berk HT, ter Welle M, van der LEYAJ, van Dijk EC, van Noordwijk J: **The artificial kidney: a dialyser with a great area.** 1944. *J Am Soc Nephrol* 1997, **8**:1959-1965.
 21. Bramson ML, Osborn JJ, Main FB, O'Brien MF, Wright JS, Gerbode F: **A new disposable membrane oxygenator with integral heat exchange.** *J Thorac Cardiovasc Surg* 1965, **50**:391-400.
 22. Kolobow T, Bowman RL: **Construction and evaluation of an alveolar membrane artificial heart-lung.** *Trans Am Soc Artif Intern Organs* 1963, **9**:238-243.
 23. Kolobow T, Spragg RG, Pierce JE, Zapol WM: **Extended term (to 16 days) partial extracorporeal blood gas exchange with the spiral membrane lung in unanesthetized lambs.** *Trans Am Soc Artif Intern Organs* 1971, **17**:350-354.
 24. Peek GJ, Killer HM, Reeves R, Sosnowski AW, Firmin RK: **Early experience with a polymethyl pentene oxygenator for adult extracorporeal life support.** *ASAIO J* 2002, **48**:480-482.
 25. Khoshbin E, Roberts N, Harvey C, Machin D, Killer H, Peek GJ, Sosnowski AW, Firmin RK: **Poly-methyl pentene oxygenators have improved gas exchange capability and reduced transfusion requirements in adult extracorporeal membrane oxygenation.** *ASAIO J* 2005, **51**:281-287.
 26. Toomasian JM, Schreiner RJ, Meyer DE, Schmidt ME, Hagan SE, Griffith GW, Bartlett RH, Cook KE: **A polymethylpentene fiber gas exchanger for long-term extracorporeal life support.** *ASAIO J* 2005, **51**:390-397.
 27. Gaylor JD: **Membrane oxygenators: current developments in design and application.** *J Biomed Eng* 1988, **10**:541-547.
 28. Reul HM, Akdis M: **Blood pumps for circulatory support.** *Perfusion* 2000, **15**:295-311.
 29. Gattinoni L, Pesenti A, Mascheroni D, Marcolin R, Fumagalli R, Rossi F, Iapichino G, Romagnoli G, Uziel L, Agostoni A, et al.: **Low-frequency positive-pressure ventilation with extracorporeal CO₂ removal in severe acute respiratory failure.** *JAMA* 1986, **256**:881-886.
 30. Morris AH, Wallace CJ, Menlove RL, Clemmer TP, Orme JFJ, Weaver LK, Dean NC, Thomas F, East TD, Pace NL, Suchyta MR, Beck E, Bombino M, Sittig DF, Bohm S, Hoffmann B, Becks H, Butler S, Pearl J, Rasmussen B: **Randomized clinical trial of pressure-controlled inverse ratio ventilation and extracorporeal CO₂ removal for adult respiratory distress syndrome.** *Am J Respir Crit Care Med* 1994, **149**:295-305.
 31. Wang D, Zhou X, Liu X, Sidor B, Lynch J, Zwischenberger JB: **Wang-Zwische double lumen cannula-toward a percutaneous and ambulatory paracorporeal artificial lung.** *ASAIO J* 2008, **54**:606-611.
 32. Batchinsky AI, Jordan BS, Regn D, Necsoiu C, Federspiel WJ, Morris MJ, Cancio LC: **Respiratory dialysis: reduction in dependence on mechanical ventilation by venovenous extracorporeal CO₂ removal.** *Crit Care Med* 2011, **39**:1382-1387.
 33. Gramaticopolo S, Chronopoulos A, Piccinni P, Nalesso F, Brendolan A, Zanella M, Cruz DN, Ronco C: **Extracorporeal CO₂ removal - a way to achieve ultraprotective mechanical ventilation and lung support: the missing piece of multiple organ support therapy.** *Contrib Nephrol* 2010, **165**:174-184.
 34. Zapol WM, Snider MT, Hill JD, Fallat RJ, Bartlett RH, Edmunds LH, Morris AH, Peirce EC 2nd, Thomas AN, Proctor HJ, Drinker PA, Pratt PC, Bagniewski A, Miller RG Jr: **Extracorporeal membrane oxygenation in severe acute respiratory failure. A randomized prospective study.** *JAMA* 1979, **242**:2193-2196.
 35. Gattinoni L, Kolobow T, Tomlinson T, Iapichino G, Samaja M, White D, Pierce J: **Low-frequency positive pressure ventilation with extracorporeal carbon dioxide removal (LFPPV-ECCO2R): an experimental study.** *Anesth Analg* 1978, **57**:470-477.
 36. Brunet F, Mira JP, Belghith M, Monchi M, Renaud B, Fierobe L, Hamy I, Dhainaut JF, Dall'ava-Santucci J: **Extracorporeal carbon dioxide removal technique improves oxygenation without causing overinflation.** *Am J Respir Crit Care Med* 1994, **149**:1557-1562.
 37. Bein T, Weber F, Philipp A, Prasser C, Pfeifer M, Schmid FX, Butz B, Birnbaum D, Taeger K, Schlitt HJ: **A new pumpless extracorporeal interventional lung assist in critical hypoxemia/hypercapnia.** *Crit Care Med* 2006, **34**:1372-1377.
 38. Zimmermann M, Bein T, Arlt M, Philipp A, Rupperecht L, Mueller T, Lubnow M, Graf BM, Schlitt HJ: **Pumpless extracorporeal interventional lung assist in patients with acute respiratory distress syndrome: a prospective pilot study.** *Crit Care* 2009, **13**:R10.
 39. Conrad S, Zwischenberger J, Grier L, Alpard S, Bidani A: **Total extracorporeal arteriovenous carbon dioxide removal in acute respiratory failure: a phase I clinical study.** *Intensive Care Med* 2001, **27**:1340-1351.
 40. Conrad SA, Green R, Scott LK: **Near-fatal pediatric asthma managed with pumpless arteriovenous carbon dioxide removal.** *Crit Care Med* 2007, **35**:2624-2629.
 41. Iglesias M, Martinez E, Badia JR, Macchiarini P: **Extrapulmonary ventilation for unresponsive severe acute respiratory distress syndrome after pulmonary resection.** *Ann Thorac Surg* 2008, **85**:237-244; discussion 244.
 42. Bein T, Zimmermann M, Hergeth K, Rammig M, Rupperecht L, Schlitt HJ, Slutsky AS: **Pumpless extracorporeal removal of carbon dioxide combined with ventilation using low tidal volume and high positive end-expiratory pressure in a patient with severe acute respiratory distress syndrome.** *Anaesthesia* 2009, **64**:195-198.
 43. Johnson P, Frohlich S, Westbrook A: **Use of extracorporeal membrane lung assist device (Novalung) in H1N1 patients.** *J Card Surg* 2011, **26**:449-452.
 44. Elliot SC, Paramasivam K, Oram J, Bodenham AR, Howell SJ, Mallick A: **Pumpless extracorporeal carbon dioxide removal for life-threatening asthma.** *Crit Care Med* 2007, **35**:945-948.
 45. Bartosik W, Egan JJ, Wood AE: **The Novalung interventional lung assist as bridge to lung transplantation for self-ventilating patients - initial experience.** *Interact Cardiovasc Thorac Surg* 2011, **13**:198-200.
 46. Livigni S, Maio M, Ferretti E, Longobardo A, Potenza R, Rivalta L, Selvaggi P, Vergano M, Bertolini G: **Efficacy and safety of a low-flow veno-venous carbon dioxide removal device: results of an experimental study in adult sheep.** *Crit Care* 2006, **10**:R151.
 47. Ruberto F, Pugliese F, D'Alio A, Perrella S, D'Auria B, Ianni S, Anile M, Venuta F, Coloni GF, Pietropaoli P: **Extracorporeal removal CO₂ using a venovenous, low-flow system (Decapsmart) in a lung transplanted patient: a case report.** *Transplant Proc* 2009, **41**:1412-1414.
 48. Moscatelli A, Ottonello G, Nahum L, Lampugnani E, Puncuh F, Simonini A, Tumolo M, Tuo P: **Noninvasive ventilation and low-flow veno-venous extracorporeal carbon dioxide removal as a bridge to lung transplantation in a child with refractory hypercapnic respiratory failure due to bronchiolitis obliterans.** *Pediatr Crit Care Med* 2010, **11**:e8-12.
 49. Burki N, Mani R, Herth F, Schmidt w, Teschler H, Bonin F: **A novel extracorporeal CO₂ removal system: application of the hemolung in patients with hypercapnic respiratory failure.** *Am J Respir Crit Care Med* 2011, **183**:A1697.
 50. Mortensen JD, Berry G: **Conceptual and design features of a practical, clinically effective intravenous mechanical blood oxygen/carbon dioxide exchange device (IVOX).** *Int J Artif Organs* 1989, **12**:384-389.
 51. Cox CSJ, Zwischenberger JB, Kurusz M: **Development and current status of a new intracorporeal membrane oxygenator (IVOX).** *Perfusion* 1991, **6**:291-296.
 52. Conrad SA, Eggerstedt JM, Grier LR, Morris VF, Romero MD: **Intravenacaval membrane oxygenation and carbon dioxide removal in severe acute respiratory failure.** *Chest* 1995, **107**:1689-1697.
 53. Gentilello LM, Jurkovich GJ, Gubler KD, Anardi DM, Heiskell R: **The**

- intravascular oxygenator (IVOX): preliminary results of a new means of performing extrapulmonary gas exchange. *J Trauma* 1993, **35**:399-404.
54. Murdoch LJ, Boyd OF, Mackay J, Bennett ED, Grounds RM: **The peri-operative management of surgical insertion and removal of the intravenous oxygenator device (IVOX). A report of nine cases.** *Anaesthesia* 1993, **48**:845-848.
 55. Zanella A, Patroniti N, Isgro S, Albertini M, Costanzi M, Pirrone F, Scaravilli V, Vergnano B, Pesenti A: **Blood acidification enhances carbon dioxide removal of membrane lung: an experimental study.** *Intensive Care Med* 2009, **35**:1484-1487.
 56. Tao W, Schroeder T, Bidani A, Cardenas VJJ, Nguyen PD, Bradford DW, Traber DL, Zwischenberger JB: **Improved gas exchange performance of the intravascular oxygenator by active blood mixing.** *ASAIO J* 1994, **40**:M527-32.
 57. Federspiel WJ, Hout MS, Hewitt TJ, Lund LW, Heinrich SA, Litwak P, Walters FR, Reeder GD, Borovetz HS, Hattler BG: **Development of a low flow resistance intravenous oxygenator.** *ASAIO J* 1997, **43**:M725-730.
 58. Hattler BG, Lund LW, Golob J, Russian H, Lann MF, Merrill TL, Frankowski B, Federspiel WJ: **A respiratory gas exchange catheter: In vitro and in vivo tests in large animals.** *J Thoracic Cardiovasc Surg* 2002, **124**:520-530.
 59. Zwischenberger JB, Nguyen TT, Tao W, Bush PE, Cox CS, Traber DL, Herndon DN, Bidani A: **IVOX with gradual permissive hypercapnia: a new management technique for respiratory failure.** *J Surg Res* 1994, **57**:99-105.
 60. Makarewicz AJ, Mockros LF, Anderson RW: **A dynamic intravascular artificial lung.** *ASAIO J* 1994, **40**:M747-750.
 61. Mihelc KM, Frankowski BJ, Lieber SC, Moore ND, Hattler BG, Federspiel WJ: **Evaluation of a respiratory assist catheter that uses an impeller within a hollow fiber membrane bundle.** *ASAIO J* 2009, **55**:569-574.
 62. Kaar JL, Oh HI, Russell AJ, Federspiel WJ: **Towards improved artificial lungs through biocatalysis.** *Biomaterials* 2007, **28**:3131-3139.
 63. Chang BS, Garella S: **Complete extracorporeal removal of metabolic carbon dioxide by alkali administration and dialysis in apnea.** *Int J Artif Organs* 1983, **6**:295-298.
 64. Gille JP, Saunier C, Schrijen F, Hartemann D, Tousseul B: **Metabolic CO₂ removal by dialysis: THAM vs NaOH infusion.** *Int J Artif Organs* 1989, **12**:720-727.
 65. Nolte SH, Benfer RH, Grau J: **Extracorporeal CO₂ removal with hemodialysis (ECBicCO₂R): how to make up for the bicarbonate loss?** *Int J Artif Organs* 1991, **14**:759-764.
 66. Cressoni M, Zanella A, Epp M, Corti I, Patroniti N, Kolobow T, Pesenti A: **Decreasing pulmonary ventilation through bicarbonate ultrafiltration: an experimental study.** *Crit Care Med* 2009, **37**:2612-2618.
 67. Russ M, Deja M, Ott S, Bedarf J, Keckel T, Hiebl B, Wagner JJ, Unger JK: **Experimental high-volume hemofiltration with predilutional tris-hydroxymethylaminomethane for correction of low tidal volume ventilation-induced acidosis.** *Artif Organs* 2011, **35**:E108-118.
 68. Pesenti A, Patroniti N, Fumagalli R: **Carbon dioxide dialysis will save the lung.** *Crit Care Med* 2010, **38**:S549-S554.

doi:10.1186/cc11356

Cite this article as: Cove ME, et al.: Bench to bedside review: Extracorporeal carbon dioxide removal, past present and future. *Critical Care* 2012, **16**:232.

LETTER

Open Access

Veno-venous extracorporeal CO₂ removal for the treatment of severe respiratory acidosis

Matthew E Cove^{1*} and William J Federspiel²

See related research by Karagiannidis *et al.* <http://ccforum.com/content/18/3/R124>

We read with interest the article by Karagiannidis and colleagues reporting the effects of extracorporeal CO₂ removal (ECCO₂R) in a pig model of severe respiratory acidosis [1]. However, their conclusion that blood flow rates between 750 and 1,000 ml/minute are necessary to correct severe acidosis using ECCO₂R may have been biased by limitations in experimental methodology.

Firstly, the authors report CO₂ removal rates for various blood flow rates using 19Fr and 14Fr catheters. However, the data clearly demonstrated blood recirculation using the 14Fr catheter, reducing CO₂ removal efficiency. Although the authors mention this limitation, it is curious why the 14Fr data were presented at all, since recirculation confounds meaningful interpretation.

Secondly, a 15-minute equilibration time was used between experimental set points, but no evidence is provided that equilibrium was achieved. It is reasonable to

expect equilibration within 15 minutes when the entire cardiac output participates in gas exchange, but in this study blood flow rates of only 200 to 1,000 ml/minute passed through the gas exchanger. Longer equilibration times may have resulted in continued pH correction, as demonstrated in a human ECCO₂R pilot study using approximately 450 ml/minute blood flows [2].

Finally, this study demonstrates reductions of partial pressure of CO₂ from 107.9 to 76.9 mmHg with blood flows of 500 ml/minute. In clinical practice this may be sufficient, a reduction from 80-85 to 60-65 mmHg in chronic obstructive pulmonary disease patients with respiratory acidosis normalized pH, allowing intubation to be avoided [2].

Although ECCO₂R with higher blood flows clearly increases CO₂ removal, lower flows with appropriately designed catheters may provide sufficient support for severe hypercapnic respiratory failure.

Authors' response

Christian Karagiannidis, Wolfram Windisch and Thomas Mueller

We are grateful for the comments to our recent manuscript [1] provided by Cove and Federspiel and we very much appreciate their effort in further elucidating the concept of ECCO₂R. We are happy to respond to their comments as follows.

Cove and Federspiel are correct in stating that ECCO₂R was insufficient using 14.5Fr catheters and that this was also attributable to recirculation. It was one of the intentions of our study to explicitly show this [1]. However, ECCO₂R was insufficient in our experimental setting, too, when using 19Fr catheters at blood flow rates of 500 ml/minute while recirculation was negligible. This indicates

that lower blood rates *per se* contributed to insufficient ECCO₂R.

We agree that equilibrium for CO₂ may not have been completed after 15 minutes, because bicarbonate is stored in slow compartments. However, in addition to the information already given in the methods section we observed that CO₂ measures at the exhaust outlet were very stable after 15 minutes, supporting the assumption that equilibrium for CO₂ was largely achieved.

Finally, we acknowledge the existing, albeit small scientific evidence for the clinical application of ECCO₂R in patients. The patients in the study mentioned were far less acidotic, were mostly breathing spontaneously and were in a fairly stable condition [2]. Therefore, the results of our study setting with severely acidotic pigs are not transferrable to these conditions. To normalize severe respiratory acidosis, blood flows in the range of

* Correspondence: mdecme@nus.edu.sg

¹Department of Respiratory and Critical Care Medicine, National University Hospital Singapore, NUHS Tower Block Level 10, Singapore 119228, Singapore

Full list of author information is available at the end of the article

750 to 1,000 ml/minute are necessary; less may be sufficient to avoid intubation in non-invasive ventilation failure under certain conditions.

Abbreviation

ECCO₂R: Extracorporeal CO₂ removal.

Competing interests

MEC has no competing interests to declare. WJF is head of the scientific advisory board at ALung Technologies, and has an equity interest in this company. CK received travel grants and lecture fees from Maquet, Rastatt, Germany. WW received fees for advisory board meetings and lectures from Maquet, Rastatt, Germany. TM received travel grants from Maquet, Rastatt, Germany.

Acknowledgements

This work was supported in part by new clinician scientist program (MEC) and NMRC TA grant NMRC/TA/0015/2013 (MEC).

Author details

¹Department of Respiratory and Critical Care Medicine, National University Hospital Singapore, NUHS Tower Block Level 10, Singapore 119228, Singapore. ²Departments of Bioengineering and Critical Care Medicine, McGowan Institute for Regenerative Medicine, University of Pittsburgh, 3025 East Carson Street, Pittsburgh, PA 15203, USA.

Published online: 17 April 2015

References

1. Karagiannidis C, Kampe KA, Sipmann FS, Larsson A, Hedenstierna G, Windisch W, et al. Venovenous extracorporeal CO₂ removal for the treatment of severe respiratory acidosis: pathophysiological and technical considerations. *Crit Care*. 2014;18:R124.
2. Burki NK, Mani RK, Herth FJ, Schmidt W, Teschler H, Bonin F, et al. A novel extracorporeal CO₂ removal system: results of a pilot study of hypercapnic respiratory failure in patients with COPD. *Chest*. 2013;143:678–86.