RESPIRATION AND THE AIRWAY

Delivery of tidal volume from four anaesthesia ventilators during volume-controlled ventilation: a bench study†

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Editor’s key points
• This study investigated the accuracy of delivered tidal volume in four new ventilators under different conditions.
• Set and delivered tidal volumes differed when compliance and resistance were changed, although the effect of fresh gas flow was less.
• Some of the new ventilators tested were more accurate than others.
• The clinical significance of these findings is uncertain, but anaesthetists should be aware of the potential for imprecision.

Background. Tidal volume (VT) must be accurately delivered by anaesthesia ventilators in the volume-controlled ventilation mode in order for lung protective ventilation to be effective. However, the impact of fresh gas flow (FGF) and lung mechanics on delivery of VT by the newest anaesthesia ventilators has not been reported.

Methods. We measured delivered VT (V̇T) from four anaesthesia ventilators (Aisys™, Flow-i™, Primus™, and Zeus™) on a pneumatic test lung set with three combinations of lung compliance (C, ml cm H2O⁻¹) and resistance (R, cm H2O litre⁻¹ s⁻²): C60R5, C30R5, C60R20. For each CR, three FGF rates (0.5, 3, 10 litre min⁻¹) were investigated at three set VTs (300, 500, 800 ml) and two values of PEEP (0 and 10 cm H2O). The volume error = [(V̇T - V̇Tset)/V̇Tset] × 100 was computed in body temperature and pressure-saturated conditions and compared using analysis of variance.

Results. For each CR and each set VT, the absolute value of the volume error significantly declined from Aisys™ to Flow-i™, Zeus™, and Primus™. For C60R5, these values were 12.5% for Aisys™, 5% for Flow-i™ and Zeus™, and 0% for Primus™. With an increase in FGF, absolute values of the volume error increased only for Aisys™ and Zeus™. However, in C30R5, the volume error was minimal at mid-FGF for Aisys™. The results were similar at PEEP 10 cm H2O.

Conclusions. Under experimental conditions, the volume error differed significantly between the four new anaesthesia ventilators tested and was influenced by FGF, although this effect may not be clinically relevant.

Keywords: measurement techniques, ventilation volumes; model, ventilatory mechanics; ventilation, fresh gas flow; ventilation, mechanical; ventilators

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Anaesthesia ventilators must adapt to various lung mechanics and maintain the same ventilatory settings as those often selected for patients in intensive care unit (ICU), such as PEEP or tidal volume (VT). In the volume-controlled ventilation (VCV) mode, gas compression and hygrometric conditions should be properly managed by the ventilators.1,2

Dry (0% relative humidity) and cold (15°C) gas must be conditioned to enter the lung as water-saturated (47 mm Hg and 100% relative humidity) and warmed (temperature close to 37°C). Humidifying and heating the inspired gas mixture increases the gas volume. Therefore, gas compression and thermal expansion act in opposite ways. The situation is further complicated depending on whether the gas volume is expressed as ambient temperature–pressure-saturated (ATPD) or body temperature–pressure-saturated (BTPS) in the ventilator. By simply changing the scale, the amount of volume would change by an average of 10%.2 When a ventilator is switched on, the units of gas volume are set by default on the ATPD, BTPS, or body temperature pressure dry (BTPD) scale. It has been shown that the actual VT may significantly differ from the set VT in modern ICU ventilators.2,3 One reason for this is that algorithms differ between different ventilators.

Anaesthesia ventilators have specific features. Fresh gas flow (FGF) is used to deliver oxygen and anaesthetic gases and to remove CO2. The product of FGF and inspiratory time gives the fresh gas volume to be added to the set VT for ventilators that are not FGF decoupled. Varying FGF would result in
variations of the total delivered \( V_T \). In order to render the delivered \( V_T \) equal to the set \( V_T \), ventilators use an FGF decoupling system that diverts FGF or modulates the set \( V_T \) depending on the set FGF. Automatic compensation for gas compression improves the \( V_T \) accuracy of ventilators without this type of algorithm.4–7 Because the effect of FGF on \( V_T \) has not been widely investigated and algorithm and software versions regularly improve anaesthesia ventilators, we launched a bench study to measure the delivered \( V_T \) from four anaesthesia ventilators. We aimed to investigate the impact of the FGF rate on \( V_T \) during VCV with the primary hypothesis being that the FGF rate did not influence it.

### Methods

#### Equipment

The set-up comprised: (i) brand new ventilators, fully checked by the manufacturer: Aisys™ (GE Datex-Ohmeda, München, Germany), Flow-i™ (Maquet, Solna, Sweden), and Primus™ and Zeus™ (Dräger, Lübeck, Germany) (Table 1); (ii) one-lung configuration test lung (TTL, Michigan Instruments, Grand Rapids, MI, USA) with adjustable compliance (\( C \)) configuration test lung (TTL, Michigan Instruments, Grand Rapids, MI, USA) with adjustable compliance (\( C \), cm \( \text{ml} \cdot \text{cm}^{-1} \cdot \text{H}_2\text{O} \)) and parabolic resistors (\( R \), cm \( \text{H}_2\text{O} \) litre \( \text{s}^{-1} \)); (iii) a double-limb ventilatory circuit (Smoothbore breathing system, 1.6 m limb, Intersurgical, Workingham, UK); (iv) a data acquisition system containing a pneumotachograph (Fleish 4 pneumotachograph, Fleish, Lausanne, Switzerland) for airflow (\( V \)) measurement, and a straight connector (VBM Medizintechnik GmbH, Sulz a. N., Germany) as a port for airway opening pressure (Pao) measurement. The pneumotachograph was inserted between the Y-piece of the ventilatory circuit and the Pao port. \( R \) is between the Pao port and the TTL. Pneumotachograph was linear over the –10 to +10 litre \( \text{s}^{-1} \) \( V \) range. \( V \) and Pao ports were connected to piezoresistive transducers (BD Gabarith™, Vogt Medical Vertrieb GmbH, Karlsruhe, Germany). Signals were amplified, sent to an analogue–digital hardware (Biopac MP150, BIOPAC Systems, Inc., Goleta, CA, USA), and recorded at 400 Hz (AcqKnowledge™ 3.8.2, BIOPAC Systems, Inc.).

#### Protocol

The experiment was conducted over a 1 day period for each ventilator. Room temperature, barometric pressure, and hygrometry were measured on the day of investigation [DPM4 (QA-PT), Fluke Corporation, Everett, WA, USA]. Before the experiment, a complete automated check was performed on the ventilator before use, followed by a 30 min stabilization period. Piezoresistive transducers were calibrated before measurements.

#### Procedure

Each ventilator was set to VCV with constant inflation flow, inspired oxygen fraction 40%, insufflation time 1 s, insufflation to exsufflation time ratio 1/3, and a respiratory rate of 14 cycles min \( ^{-1} \). Zeus™ sets a 0.2 s inspiratory pause by default.

First, three combinations of \( C \) and \( R \) were applied in a random order: C60R5 (normal lung), C30R5 (reduction in lung compliance), and C60R20 (increased airway resistance). Then, for each CR combination, PEEP 0 cm \( \text{H}_2\text{O} \) (ZEEP) (except for Zeus™ which provided 2–3 cm \( \text{H}_2\text{O} \) PEEP by default) was applied. On ZEEP, low (0.5 litre \( \text{min}^{-1} \) except for Zeus™ in which the lowest FGF was 0.65 litre \( \text{min}^{-1} \)), middle (3 litre \( \text{min}^{-1} \)), and high (10 litre \( \text{min}^{-1} \)) FGF rates were administered. At each FGF rate, \( V_T \)s of 300, 500, and 800 ml were delivered. Each \( V_T \) was tested with and without a 1 s end-inspiratory pause. With pause, the insufflation to exsufflation time ratio went to 1/2. Zeus™ was not tested without pause as mentioned above. Each \( V_T \) and pause combination was administered randomly at each FGF rate. The same steps were repeated at PEEP 10 cm \( \text{H}_2\text{O} \) (PEEP10). At each step, a 5 min stabilization period was followed by a 1 min continuous recording of Pao and \( V \). Each recording started with a 5 s end-

### Table 1: Main characteristics of the four anaesthesia ventilators investigated and physical ambient conditions at the time of present investigation. FGF, fresh gas flow; ATPD, ambient temperature pressure dry; BTPD, body temperature pressure dry; BTPS, body temperature–pressure-saturated; \( V_T \), tidal volume

<table>
<thead>
<tr>
<th></th>
<th>Aisys™</th>
<th>Flow-i™</th>
<th>Primus™</th>
<th>Zeus™</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturer</td>
<td>GE</td>
<td>Maquet</td>
<td>Dräger</td>
<td>Dräger</td>
</tr>
<tr>
<td>Software version</td>
<td>7.01</td>
<td>1.02</td>
<td>4.3</td>
<td>4.01</td>
</tr>
<tr>
<td>Gas delivery system</td>
<td>Ascending bellows-in-box</td>
<td>Volume reflector</td>
<td>Piston-driven</td>
<td>Turbine</td>
</tr>
<tr>
<td>FGF decoupling system</td>
<td>No (fresh gas compensation)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Set gas conditions</td>
<td>ATPD</td>
<td>BTPD</td>
<td>BTPS</td>
<td>BTPS</td>
</tr>
<tr>
<td>Built-in flow meter</td>
<td>Variable orifice flow sensors</td>
<td>Hot wire</td>
<td>Hot wire</td>
<td>Hot wire</td>
</tr>
<tr>
<td>Accuracy on ( V_T ) measurement provided by the manufacturer in the ( V_T ) range presently investigated</td>
<td>(&lt;7%)</td>
<td>(15%)</td>
<td>(5–10%)</td>
<td>(10%)</td>
</tr>
<tr>
<td>Circuit compliance (( \text{ml} \cdot \text{cm}^{-1} \cdot \text{H}_2\text{O} ))</td>
<td>1.28</td>
<td>1.54</td>
<td>1.60</td>
<td>1.91</td>
</tr>
<tr>
<td>Circuit temperature (°C)</td>
<td>22.8</td>
<td>20.9</td>
<td>21.1</td>
<td>24.0</td>
</tr>
<tr>
<td>Room temperature (°C)</td>
<td>23.2</td>
<td>20.9</td>
<td>21.1</td>
<td>25.3</td>
</tr>
<tr>
<td>Room air pressure (mm Hg)</td>
<td>755</td>
<td>741</td>
<td>741</td>
<td>742</td>
</tr>
<tr>
<td>Room relative humidity (%)</td>
<td>50</td>
<td>Missing</td>
<td>50</td>
<td>46</td>
</tr>
</tbody>
</table>
inspiratory pause in order to check for leaks in the experimental set-up. At the end of the last step for each CR, condition zero $V'$ was recorded for 30 s. The last three respiratory cycles of each record were analysed. At the end of the experiment, the temperature was measured at the Y-piece.

Data analysis

Data were analysed offline (AcqKnowledge® 3.8.2, BIOPAC Systems, Inc.). $V_T$ was measured during insufflation ($V_{TI}$) from the numerical integration of the $V'$ signal after subtracting the zero $V'$ reference value. $V_{TI}$ was normalized in BTPS conditions as follows:

$$V_{TI}(\text{BTPS}) = \frac{V_{TI}(\text{ATPD}) \times (P_B - P_{H_2O})}{P_B} \times 310 - \frac{273}{273 + T(\text{°C})}$$

where $P_B$ is the ambient pressure, $P_{H_2O}$ the partial pressure of water in saturated air at circuit temperature, and $T$ the circuit temperature.

$V_{TI}$ was expressed as the volume error according to:

$$\text{Volume error} = \left[ \frac{V_{TI} - V_{Tset}}{V_{Tset}} \right] \times 100$$

The primary endpoint was the effect of FGF on the volume error between the ventilators in each CR condition at each PEEP level and set $V_T$. Lung mechanics conditions, PEEP, and $V_T$ were analysed separately. For each CR–PEEP–set $V_T$ combination, with end-inspiratory pause, the ventilator effect, the FGF effect, and their interaction on the volume error were tested using analysis of variance (ANOVA). Multiple pairwise comparisons were performed using Tukey’s HSD procedure.8

We wanted to know which pressure, among the peak and plateau $P_{AaO}$, was used by the algorithm to compensate for the compliance of the ventilator circuit. For that, we decided to analyse the effect of end-inspiratory pause in the C60R20 condition only because the latter would be most likely to enhance the difference between the peak and plateau $P_{AaO}$. In order to take into account the number of tests, we applied the Bonferroni correction.9 One hundred and eight combinations were generated (3 CR×2 PEEP×2 inspiratory pause×3 $V_T$×3 FGF). The level of statistical significance set in ANOVA was computed by dividing 0.05 by the square root of 108, which is 0.005. Post hoc comparisons were 324 with an end-inspiratory pause (3 CR×2 PEEP×3 $V_T$×3 FGF×6 ventilator comparisons) and 162 without an end-inspiratory pause (only three ventilators) resulting in a total of 486 comparisons. The level of statistical significance for each comparison was computed as 0.05 divided by the square root of 486, which is 0.002.

The distribution of the volume error was compared using the $\chi^2$ test.

Values are expressed as mean (SD) unless otherwise stated. Statistical analysis was carried out using R software-version 2.9.0 (R Development Core Team. R: A Language and Environment for Statistical Computing. Vienna, Austria: R Foundation for Statistical Computing; 2009).

Results

Unfortunately, the files pertaining to the PEEP 10 experiment with a pause for the lowest FGF rate at $V_T$ 300 for Zeus™ and $V_T$ 800 for Flow-i™ were unreadable on the hard disk drives of our computers, and hence, data are lacking. The physical ambient conditions at the time of the experiments are shown in Table 1.

Overall volume error

Across all ventilators and all conditions, the actual $V_T$ varied between 279 and 347 ml for set $V_T$ 300, 464 and 588 for set $V_T$ 500, and 736 and 891 for set $V_T$ 800. The mean (SD) volume error was +9.1 (2.5)% for Aisys™, +6.7 (1.4)% for Flow-i™, −1.1 (1.6)% for Primus™, and −3.1% (2.6) % for Zeus™.

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**Fig 1** Effect of FGF on the volume error across four anaesthesia ventilators for a set tidal volume of 500 ml (with end-inspiratory pause) and compliance of 60 ml cm$^{-1}$ H$_2$O. Resistance 5 cm$^{-1}$ H$_2$O litre$^{-2}$ on ZEEP (blue bars) and PEEP (green striped bars) 10 cm H$_2$O. For each ventilator, the left vertical bar is for low FGF, the middle vertical bar for medium FGF, and the right vertical bar for high FGF. The bars represent the mean values. †$P < 0.05$ vs the three other ventilators at a given FGF rate. *$P < 0.05$. 

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$V_T$ delivery by anaesthesia ventilators
Volume error in ZEEP with pause

In the C60R5 condition set $V_T$ 500 (Fig. 1), the volume error was significantly different between ventilators with no FGF effect. The same was true for $V_T$ 300 and $V_T$ 800, except that the latter FGF rate had a statistical effect (Supplementary Table S1).

For the C60R20 mechanical condition, the results were similar to C60R5. The volume error was significantly different between Primus™ and Zeus™ for the highest FGF (0% vs -4%) for $V_T$ 300 and 500.

For the C30R5 mechanical condition, the ventilator, FGF rate, and their interaction had significant effect on the volume error at each set $V_T$. Contrary to the two previous mechanical conditions, the volume error behaved differently for Aisys™. It was significantly and systematically lower in the middle than at two other FGF rates (Supplementary Table S1). As a result, the volume error was significantly lower at the middle FGF rate with Aisys™ than with Flow-i™.

A summary of the volume error values averaged for the three FGFs is displayed in Table 2 in terms of ventilator, CR, and PEEP level.

**Effect of FGF on volume error in PEEP 10 with pause**

With PEEP 10, the most striking feature was the FGF effect in Aisys™. The volume error was significantly lower with mid-FGF than for the two other FGF rates in the C60R5 condition set $V_T$ 500 (Fig. 1). The same was true for all other conditions (Supplementary Table S2) except for set $V_T$ 300 C60R20 and C30R5 and set $V_T$ 500 C60R20 (Supplementary Table S2).

**Effect of FGF on volume error in each ventilator**

For Flow-i™ and Primus™, the volume error did not change with FGF in almost all conditions (Supplementary Tables S1 and S2). For Zeus™, when the FGF increased, the mean (sd) absolute volume error increased on ZEEP and PEEP 10 by 4.5 (0.8)% ($P<0.05$) and 4.4 (1.0)% ($P<0.05$) (Supplementary Tables S1 and S2), respectively. The differences in the volume error between the lowest and highest FGF on ZEEP and PEEP 10 were 1.4 (1.3)% and 1.3 (2.1)% ($P<0.05$).

**Effect of pause on volume error in the C60R20 condition**

There were significant effects on the volume error of the ventilator, FGF, pause, and their corresponding interactions (Fig. 2). Furthermore, adding a pause had opposite effects on the volume error depending on the ventilator (Fig. 2). For Aisys™ and Primus™ ventilators, the volume error significantly decreased with pause when compared with without pause regardless of the $V_T$. The opposite was found for the Flow-i™ ventilator (Fig. 2).

**Accuracy of anaesthesia ventilators**

Table 3 displays the distribution of the volume error classified into three categories over all the conditions for each ventilator. As shown, Primus™ had the highest rate in the low range of volume error and Aisys™ had the lowest rate.

**Discussion**

We found significant statistical differences in the volume error: (i) between ventilators, (ii) from FGF rate across ventilators, and (iii) from end-inspiratory pause.

**Methodological issues**

Gas volume was normalized in BTPS condition for all ventilators. None of the previous studies of anaesthesia ventilators performed this normalization and, therefore, the comparisons between ventilators were performed with different gas physical conditions. In the present study, the BTPS correction for Aisys™ and Flow-i™ resulted in an average increase in $V_T$ by 8.4% and 3.7%, respectively. No correction was made for the other two ventilators (Table 1).

### Table 2 Volume error in four anaesthesia ventilators set with end-inspiratory pause at three nominal set tidal volumes and two levels of PEEP, for three conditions of lung resistance and compliance. Values are mean (standard deviation) in percentage; C, compliance; R, resistance; $V_T$, tidal volume; ZEEP, zero end-expiratory pressure; NA, not available. All pairwise differences between ventilators for each level of CR, set $V_T$, and ZEEP are statistically significant except those indicated by the symbols. * vs Zeus, † vs Flow-i

<table>
<thead>
<tr>
<th>Ventilator</th>
<th>CR</th>
<th>$V_T$ 300</th>
<th>$V_T$ 500</th>
<th>$V_T$ 800</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aisys™</td>
<td>C60R5</td>
<td>11.4 (1.4)</td>
<td>9.5 (1.9)</td>
<td>12.0 (0.8)</td>
</tr>
<tr>
<td></td>
<td>C60R20</td>
<td>9.6 (0.8)</td>
<td>9.0 (0.5)</td>
<td>10.2 (0.6)</td>
</tr>
<tr>
<td></td>
<td>C30R5</td>
<td>8.0 (2.6)*</td>
<td>9.7 (0.3)</td>
<td>9.1 (1.1)</td>
</tr>
<tr>
<td>Flow-i™</td>
<td>C60R5</td>
<td>8.0 (0.2)</td>
<td>5.5 (0.3)</td>
<td>7.6 (0.5)</td>
</tr>
<tr>
<td></td>
<td>C60R20</td>
<td>8.4 (0.2)</td>
<td>6.4 (0.4)</td>
<td>6.7 (0.1)</td>
</tr>
<tr>
<td></td>
<td>C30R5</td>
<td>9.7 (0.4)</td>
<td>8.5 (0.5)</td>
<td>8.4 (0.2)</td>
</tr>
<tr>
<td>Primus™</td>
<td>C60R5</td>
<td>0.7 (0.4)</td>
<td>-0.4 (0.2)</td>
<td>-0.1 (0.2)</td>
</tr>
<tr>
<td></td>
<td>C60R20</td>
<td>-0.1 (0.2)</td>
<td>-1.6 (0.2)</td>
<td>-1.6 (0.2)</td>
</tr>
<tr>
<td></td>
<td>C30R5</td>
<td>0.8 (0.3)</td>
<td>1.4 (0.3)</td>
<td>-0.1 (0.5)</td>
</tr>
<tr>
<td>Zeus™</td>
<td>C60R5</td>
<td>-5.2 (1.6)</td>
<td>-4.9 (1.7)</td>
<td>-4.9 (1.8)</td>
</tr>
<tr>
<td></td>
<td>C60R20</td>
<td>-1.4 (2.0)</td>
<td>NA</td>
<td>-2.4 (1.8)</td>
</tr>
<tr>
<td></td>
<td>C30R5</td>
<td>0.1 (2.1)</td>
<td>-0.9 (2.5)</td>
<td>-1.1 (2.3)</td>
</tr>
</tbody>
</table>
We used the Bonferroni correction to correct for multiple comparisons in our data analysis. The manner in which the data are handled has been criticized. It is too conservative and can miss significant differences. However, in the present experiment, virtually all differences were statistically significant. This was due to the very low standard deviations resulting from the very low variability between measurements for a given variable for this type of in vitro experiment. So, our goal was to minimize the number of positive tests.

**Difference in the engineering system and the present findings**

The difference in the magnitude of the volume error across ventilators may be explained by differences in the engineering system used (Table 1). However, it is unclear which element, among the electronic system, algorithm, FGF decoupling system, accuracy and position of the flow meters, and type of gas delivery system, would determine the accuracy of VT delivery. In bench studies, the precision in delivered VT was greater with a piston than with a turbine or a bellows-in-box, owing to a low-compliance system, leak compensation, and rigid piston design.

Aisys™ is a pneumatically driven ventilator in which the gas delivery unit is an ascending bellows-in-box with fresh gas compensation. The closer the volume delivered per
minute and FGF, the smaller the volume error. FGF is not decoupled, that is, fresh gas is primarily delivered to the inspiratory circuit, and then the ventilator electronically computes the required volume to be added to the fresh gas in order to get the set \( V_T \). Even though electronic devices are increasingly accurate, they may be challenged in extreme conditions, as Aisys\textsuperscript{TM} had the highest volume error in the present study. This result is in disagreement with that of a previous bench study in which the average volume error ranged between −5% and +6%.\textsuperscript{12} One explanation for this inconsistency could be the gas volume expression, which was not provided.\textsuperscript{12} With Flow-i\textsuperscript{TM}, the gas delivery system, referred to as the volume reflector, is a circle system with a non-compliant tank of gas of about 1.2 litres. Exhaled gases are recycled in the volume reflector and pure oxygen is used to push expired gas into the inspired flow. Its rigidity means that overflows are avoided and ensures that the tank is always filled, even in the event of a leak. In fact, the volume error magnitude was lower than in Aisys\textsuperscript{TM} but higher than in Primus\textsuperscript{TM} and Zeus\textsuperscript{TM}. Primus\textsuperscript{TM} is a piston ventilator with a fresh gas decoupling system. Piston pitch is about 5 μl. This accuracy is consistent with our observations showing that volume error is very low (about 1%) with Primus\textsuperscript{TM}. Zeus\textsuperscript{TM} is a turbine ventilator. It works with a closed-circuit system, which delivers the adequate gas mixture at the lowest FGF. The turbine system works as a pressure source whose accuracy fully depends on flow-meter precision. Indeed, the volume error with Zeus\textsuperscript{TM} was in-between that with Flow-i\textsuperscript{TM} and Primus\textsuperscript{TM}, about 3%.

The absolute volume error value exhibited two distinct patterns with increasing FGF. It increased in Aisys\textsuperscript{TM} and Zeus\textsuperscript{TM} but did not change in Primus\textsuperscript{TM} and Flow-i\textsuperscript{TM}. With Aisys\textsuperscript{TM}, the overestimation of \( V_T \) went up with the increase in FGF. The underestimation of \( V_T \) with Zeus\textsuperscript{TM} with increasing FGF could be explained by the Venturi effect in the circuit as shown in turbine-driven transport ventilators.\textsuperscript{13}

**Effect of pause set at the ventilator at end-inspiration**

The pause effect on \( V_T \) has not been previously investigated with anaesthesia ventilators. With pause, the following points are expected to change in actual \( V_T \): (i) no change, if the algorithm of compensation for ventilator circuit compliance targets peak Pao and if inspiratory flow does not change; (ii) increase, if the algorithm targets plateau Pao; (iii) reduction, if inspiratory flow diminishes as a result of pause, or if pause impairs the working of the algorithm. With Aisys\textsuperscript{TM} and Primus\textsuperscript{TM}, we found that \( V_T \) decreased with pause. The fact that inspiratory flow did not change with and without pause suggests no such algorithm in these ventilators or specific functioning of the algorithm that does not follow the above rules. Another explanation would be that the increase in the mean Pao we found (by 70%, not shown), resulting from the reduction in exsufflation time, would compress gas in the ventilator circuit, which was not sensed by the algorithm which eventually failed to increase \( V_T \). With Flow-i\textsuperscript{TM}, \( V_T \) increased with pause, suggesting that the algorithm targets plateau Pao for set \( V_T \) 300 and 500 ml. In contrast, \( V_T \) did not change for set \( V_T \) 800 ml, suggesting that the algorithm targeted peak Pao. These findings were consistent over the FGF range.

**Accuracy of the anaesthesia ventilators on the bench**

When compared with the manufacturers' specifications (Table 1), we found that the Aisys\textsuperscript{TM} had the lowest accuracy when the volume error was >7% in almost all conditions (Table 2). Furthermore, the volume error >10% was obtained in almost 60% of all measurements for this ventilator (Table 3). For the Flow-i\textsuperscript{TM}, we found that the volume error consistently lower than the 15% provided by the manufacturer (Tables 1–3). The same applied for the Zeus\textsuperscript{TM} system (Tables 1–3). The Primus\textsuperscript{TM} had the highest accuracy as the volume error was consistently lower than the threshold provided by the manufacturer (Tables 1–3). There are some circumstances where there was little difference between the ventilators. These circumstances are set \( V_T \) 800 C60R20 and mostly pertain to the Primus\textsuperscript{TM} and Zeus\textsuperscript{TM} ventilators. Some practitioners may find any error <10% acceptable. From our Table 3, it can be seen that this was the case for all ventilators except for Aisys\textsuperscript{TM}.

**Clinical implications**

Artificial ventilators, when used in ICU patients with abnormal lungs, must continue to provide lung protective mechanical ventilation and low \( V_T \) and prevent ventilator-induced lung injury (VILI).\textsuperscript{14, 15} Furthermore, patients with normal lungs who have undergone general anaesthesia and mechanical ventilation are also at risk for VILI.\textsuperscript{16} Therefore, it is important to reduce \( V_T \) in these patients, as suggested by some investigations.\textsuperscript{17, 18} Michelet and colleagues\textsuperscript{17} prospectively compared two ventilatory strategies during general anaesthesia for elective oesophagectomy in patients with normal lungs: \( V_T \) 9 ml kg\textsuperscript{-1} with ZEEP and \( V_T \) 5 ml kg\textsuperscript{-1} with PEEP of 5 cm H\textsubscript{2}O. The respiratory rate was set at 12 bpm and FiO\textsubscript{2} 50% in both groups. These settings were applied during the single-lung ventilation part of surgery. The low \( V_T \) strategy resulted in a shorter duration of mechanical ventilation and lower plasma concentrations of inflammatory cytokines. Fernandez-Perez and colleagues\textsuperscript{18} found that large \( V_T \) (8.3 vs 6.7 ml ml kg\textsuperscript{-1}) was the single main risk factor for developing postoperative respiratory failure after pneumonectomy in 170 patients (odds ratio 1.56 per ml kg\textsuperscript{-1} increase). By using the extreme values of the volume error in the present experiment (−8% to +17.5%), we found that a target set \( V_T \) of 6 ml kg\textsuperscript{-1} resulted in an actual \( V_T \) between 5.5 and 7 ml kg\textsuperscript{-1}. Therefore, if the clinician prescribes \( V_T \) of 6 ml kg\textsuperscript{-1} having in mind lung protection, the lung can receive a different \( V_T \). It should be stressed that Primus\textsuperscript{TM} was the most accurate to deliver a set \( V_T \).
**Limitations and strengths**

Limitations of our study are that bench testing cannot mimic in vivo conditions, that we only used VCV, and we tested a single anaesthesia ventilator from each manufacturer. The same ICU ventilator delivered different VT over time in patients.19

However, experiments can be performed under carefully controlled conditions and with a wide range of combinations of settings in a bench-top study. The variability of VT measurements was very small in our study. We used a gas mixture of 40% oxygen to be as close as possible to clinical practice.

In summary, using the experimental conditions described, we found that VT delivery from new anaesthesia ventilators differed significantly between them and was influenced by FGF and end-inspiratory pause. These effects may not be clinically relevant.

**Supplementary material**

Supplementary material is available at British Journal of Anaesthesia online.

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**Declaration of interest**

None declared.

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