



EDITORIAL

Sedation and COVID-19. Time to forget, time for a comeback

Sedación y COVID-19. Tiempo de olvidar, tiempo de retornar



Medicina Intensiva has recently published two studies focused on analgesia and sedation practices in the critically ill patient during the SARS-CoV-2 pandemic period. In the first study, Giménez-Esparza et al. analyzed the perceptions of analgesia, sedation, and delirium management before, during, and after the COVID-19 pandemic.¹ This analysis was based on over 1000 surveys collected from Intensive Care Units (ICUs) across the Iberian Peninsula and Latin America. The results indicated a marked shift towards deep sedation—predominantly using benzodiazepines—over light and dynamic sedation strategies in the post-pandemic period. The authors concluded that the pandemic had a detrimental impact on sedation, analgesia and delirium management practices, with deep sedation remaining prevalent even in the absence of clear clinical indications.

The second study, published in the former issue of this journal by Loudet et al., presents the outcomes of implementing a standardized protocol for analgesia, sedation, and neuromuscular blockade (NMB) in mechanically ventilated COVID-19 patients at a tertiary care hospital in Argentina.² This study included nearly 200 patients and found that most were managed with deep sedation [Richmond Agitation-Sedation Scale (RASS) $-4/-5$] and NMB, with fentanyl and midazolam being the most frequently employed agents. Importantly, the use of lighter sedation and non-benzodiazepine drugs were independently associated with lower mortality, reinforcing the critical importance of prioritizing light sedation strategies in the critically ill.

The findings from Spanish-speaking populations are consistent with those reported in English-speaking regions, where deep sedation practices also predominated during the pandemic.^{3,4} This shift in sedation strategy likely stemmed from multiple factors, including overwhelmed ICUs, high workloads that necessitated the recruitment of less-experienced staff, the high incidence of severe

acute respiratory distress syndrome (ARDS), widespread use of NMB, patient isolation protocols, and increased rates of delirium.⁵ These conditions created a “perfect storm” that made adherence to recommended sedation guidelines—which advocate for sequential and light sedation—extremely challenging.⁶

However, even as the acute phase of the pandemic has passed, sedation practices have not fully returned to pre-pandemic standards, as highlighted by Giménez-Esparza et al.¹ Moreover, some studies have shown that even non-COVID-19 patients requiring mechanical ventilation during the pandemic were managed with deeper sedation levels, a trend that persisted in the following year.⁴

Therefore, it is essential to alert ICU teams to the continued prevalence of these practices.

As Loudet et al. noted,² other studies have shown that deep sedation within the first 48 h after orotracheal intubation is associated with worse outcomes in critically ill patients, including prolonged mechanical ventilation, increased tracheostomy rates, higher mortality, greater incidence of delirium, and extended hospital stays.⁷ Additionally, continuing deep sedation after discontinuation of NMB in ARDS patients is linked to higher mortality.⁸

We now better understand how the pandemic altered our sedation practices. In a context that can only be described as apocalyptic, the widespread use of deep sedation may have been an unavoidable response. Nonetheless, the adverse effects of deep sedation are well-documented, and it is concerning that this approach remains dominant. It is our responsibility to return to evidence-based practices.

Current clinical guidelines recommend light sedation (RASS 0 to -2) using non-benzodiazepine sedatives.^{9,10} Yet light sedation should go beyond just drug choice. The ABCDEF bundle (Assess and manage pain, Both spontaneous awakening and breathing trials, Choice of analgesia

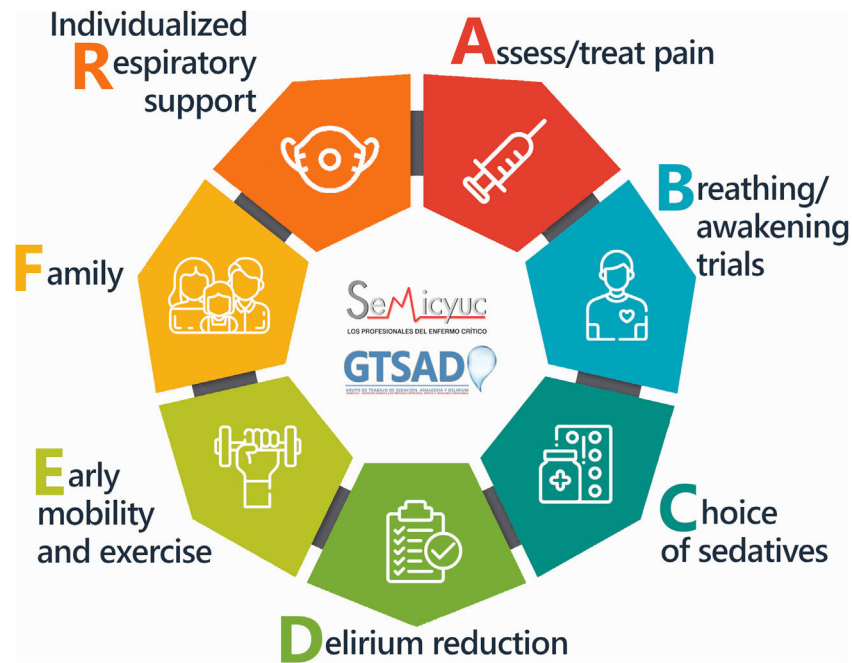


Figure 1 ABCDEF + R bundle.

and sedation, Delirium monitoring and management, Early mobility, and Family engagement) has been shown—nearly a decade ago—to significantly improve outcomes such as survival, duration of mechanical ventilation, incidence of delirium and coma, and the use of physical restraints.¹¹ During the pandemic, the addition of the “+R” component (A–F + R, Fig. 1) that refers to respiratory optimization before increasing sedation or initiating NMB, emphasized the importance of prioritizing ventilator management to improve patient outcomes.¹²

In the early 21st century, many ICUs across the country made enormous efforts to align with national and international guidelines on analgesia, sedation, and delirium. These efforts involved not only a cultural transformation but also the development of educational programs and the establishment of post-ICU follow-up clinics for the diagnosis and treatment of Post-Intensive Care Syndrome (PICS). The time and resources invested in these initiatives must not be wasted.

Intensivists must once again prioritize timely liberation from the ICU, employing strategies that ensure adequate analgesia and light sedation, proactively prevent and manage delirium, and keep patients awake, calm, and cooperative—steering away from oversedation. Only by doing so can we return to pre-COVID-19 standards and improve our patients’ long-term outcomes. This is not about learning something new—it is about returning to what we already knew.

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