Assessment of Extubation Readiness Using Spontaneous Breathing Trials in Extremely Preterm Neonates

Wissam Shalish, MD; Lara Kanbar, MSc; Lajos Kovacs, MD; Sanjay Chawla, MD; Martin Keszler, MD; Smita Rao; Samantha Latremouille, MSc; Doina Precup, PhD; Karen Brown, MD; Robert E. Kearney, PhD; Guilherme M. Sant’Anna, MD, PhD

**IMPORTANCE** Spontaneous breathing trials (SBTs) are used to determine extubation readiness in extremely preterm neonates (gestational age \(<\) 28 weeks), but these trials rely on empirical combinations of clinical events during endotracheal continuous positive airway pressure (ET-CPAP).

**OBJECTIVES** To describe clinical events during ET-CPAP and to assess accuracy of comprehensive clinical event combinations in predicting successful extubation compared with clinical judgment alone.

**DESIGN, SETTING, AND PARTICIPANTS** This multicenter diagnostic study used data from 259 neonates seen at 5 neonatal intensive care units from the prospective Automated Prediction of Extubation Readiness (APEX) study from September 1, 2013, through August 31, 2018. Neonates with birth weight less than 1250 g who required mechanical ventilation were eligible. Neonates deemed to be ready for extubation and who underwent ET-CPAP before extubation were included.

**INTERVENTIONS** In the APEX study, cardiorespiratory signals were recorded during 5-minute ET-CPAP, and signs of clinical instability were monitored.

**MAIN OUTCOMES AND MEASURES** Four clinical events were documented during ET-CPAP: apnea requiring stimulation, presence and cumulative durations of bradycardia and desaturation, and increased supplemental oxygen. Clinical event occurrence was assessed and compared between extubation pass and fail (defined as reintubation within 7 days). An automated algorithm was developed to generate SBT definitions using all clinical event combinations and to compute diagnostic accuracies of an SBT in predicting extubation success.

**RESULTS** Of 259 neonates (139 [54%] male) with a median gestational age of 26.1 weeks (interquartile range [IQR], 24.9-27.4 weeks) and median birth weight of 830 g (IQR, 690-1019 g), 147 (57%) had at least 1 clinical event during ET-CPAP. Apneas occurred in 10% (26 of 259) of neonates, bradycardias in 19% (48), desaturations in 53% (138), and increased oxygen needs in 41% (107). Neonates with successful extubation (71% [184 of 259]) had significantly fewer clinical events (51% [93 of 184] vs 72% [54 of 75], \(P = .002\)), shorter cumulative bradycardia duration (median, 0 seconds [IQR, 0 seconds] vs 0 seconds [IQR, 0-9 seconds], \(P < .001\)), shorter cumulative desaturation duration (median, 0 seconds [IQR, 0-9 seconds] vs 25 seconds [IQR, 0-90 seconds], \(P = .003\)), and less increase in oxygen (median, 0% [IQR, 0%-6%] vs 5% [0%-18%], \(P < .001\)) compared with neonates with failed extubation. In total, 41,602 SBT definitions were generated, demonstrating sensitivities of 51% to 100% (median, 96%) and specificities of 0% to 72% (median, 22%). Youden indices for all SBTs ranged from 0 to 0.32 (median, 0.17), suggesting low accuracy. The SBT with highest Youden index defined SBT pass as having no apnea (with desaturation requiring stimulation) or increase in oxygen requirements by 15% from baseline and predicted extubation success with a sensitivity of 93% and a specificity of 39%.

**CONCLUSIONS AND RELEVANCE** The findings suggest that extremely preterm neonates commonly show signs of clinical instability during ET-CPAP and that the accuracy of multiple clinical event combinations to define SBTs is low. Thus, SBTs may provide little added value in the assessment of extubation readiness.
Extremely preterm neonates (gestational age ≤28 weeks) commonly require mechanical ventilation after birth.\(^1\) Given the known harms associated with prolonged mechanical ventilation, clinicians strive to limit mechanical ventilation exposure by routinely assessing neonates’ readiness for extubation.\(^2\) Currently, the decision to extubate relies on clinical judgment through interpretation of ventilatory support, blood gas values, and overall clinical stability of the neonate.\(^3,4\) However, clinical judgment is subjective, leads to variable practices, and is often associated with inaccurate decisions.\(^5\) In fact, nearly one-third of neonates require reintubation within 7 days after the first extubation attempt.\(^5\)

In recent years, spontaneous breathing trials (SBTs) have increasingly been used to determine extubation readiness.\(^3,4\) The SBTs entail a 3- to 10-minute period of spontaneous breathing via endotracheal continuous positive airway pressure (ET-CPAP), during which pass or fail is determined from a combination of clinical events (apneas, bradycardias, and desaturations). To date, only 2 small studies\(^6,7\) investigated SBT accuracies in predicting successful extubation compared with clinical judgment alone; an SBT pass identified almost all successful extubations (excellent sensitivity) but misclassified one-third of failed extubations (low specificity).\(^6-8\) Of note, cutoffs to define SBT pass or fail were chosen empirically with no background knowledge about the range of clinical events that normally occur during the trial. Thus, the objectives of this study were to describe the occurrence of clinical events in extremely preterm neonates during ET-CPAP and to evaluate the accuracy of more-comprehensive pass or fail definitions in predicting extubation success compared with clinical judgment alone. We conjectured that such inclusive evaluation would identify an SBT definition with better overall accuracy.

### Methods

#### Study Design and Context

This diagnostic study used data from the Automated Prediction of Extubation Readiness (APEX) prospective multicenter study and was reported using the Standards for Reporting of Diagnostic Accuracy (STARD) reporting guideline. The APEX study aimed to develop an automated predictor of extubation readiness using machine learning tools that integrate clinical variables and quantitative measures of cardiorespiratory behavior in extremely preterm neonates deemed to be ready for extubation.\(^9\) Enrollment for APEX has been completed, but the development and validation of the predictor are ongoing. As part of APEX, neonates had cardiorespiratory signals acquired electronically during 5 minutes of ET-CPAP immediately preceding extubation. The rationale was to capture intrinsic respiratory behavior without interference from mechanical inflations. Extubation was not predicated on ET-CPAP findings, and no cutoffs for pass or fail were prespecified. However, bedside clinical events that occurred during ET-CPAP were prospectively documented, allowing for this analysis. The institutional review board at each participating institution provided approval for the original APEX study. As for the present study, institutional review board approval was waived because the analysis involved no additional data collection beyond that which was collected at APEX. Informed consent was written and only obtained for the original APEX study.

#### Test Methods

##### Reference Standard: Clinical Judgment

All neonates were extubated using the reference standard of clinical judgment (ie, once they were deemed to be ready for extubation by the treating team). At the time of extubation, data pertaining to postmenstrual age (presented in weeks and referring to the gestational age plus the time elapsed after birth [postnatal age]), postnatal age, weight, ventilator mode, mean airway pressure, fraction of inspired oxygen (FiO\(_2\)), and blood gas values (measured within 24 hours before extubation) were collected. Of note, SBTs were not a part of clinical practice at participating sites.

##### Index Test: ET-CPAP

All included neonates underwent 5-minute ET-CPAP before extubation. The ET-CPAP was equivalent to the positive end-expiratory pressure (PEEP) preset by the clinical team on conventional mechanical ventilation. No pressure support was provided, and the backup rate was turned off. During ET-CPAP, a research investigator (including W.S., M.K., S.R., S.L., and G.M.S.) and respiratory therapist monitored the neonates for apnea, bradycardia, or desaturation and intervened per clinical discretion. Interventions included increasing FiO\(_2\) from baseline, stimulation in case of apnea, and termination of ET-CPAP (ie, resumption of mechanical ventilation) if necessary. Concomitantly, the following data were collected: PEEP...
evel, baseline oxygen saturation, and FiO₂ just before start-
ing ET-CPAP; presence and cumulative durations of desatu-
rations (baseline oxygen saturation <85%) and bradycardias
(heart rate <100 bpm); need for additional oxygen from base-
line (and highest amount provided); and total ET-CPAP dura-
tion. After ET-CPAP was completed, the clinical team extu-
beated neonates to noninvasive respiratory support. Of note,
the study design did not include blinding the treating team
from the use of ET-CPAP. Consequently, the treating team
members were permitted to change their minds about ex-
tubation at any time, in which case neonates would be eligible
for the study again (ie, when deemed to be ready for the next
extubation by the clinical team). In those cases, only the final
ET-CPAP trial would be included for analysis.

**Statistical Analysis**
The first objective was to describe occurrences of 4 clinical
event categories during ET-CPAP: apneas requiring stimula-
tion, bradycardias, desaturations, and increase in oxygen
supplementation from baseline. To avoid any confounding,
neonates who transitioned to ET-CPAP with a baseline oxy-
gen saturation already below 85% were excluded. The num-
ber and proportion of neonates with apneas, bradycardias, de-
saturations, and increased oxygen needs were determined.
Also, medians and interquartile ranges (IQRs) were ascer-
tained for the cumulative durations of bradycardia or desat-
uration and the additional amount of oxygen needed.

The second objective was to evaluate the accuracy of dif-
ferent SBT definitions in predicting successful extubation com-
pared with clinical judgment alone. Extubation success was
defined as not needing reintubation within 7 days. First, clini-
cal events were compared between neonates who succeeded
or failed extubation using Wilcoxon rank sum test, χ² test, or
Fisher exact test as appropriate. For continuous variables, prob-
ability density functions were plotted to better visualize the
overlap between success and failure groups, and areas under
the receiver operating characteristic curve were computed.
Continuous variables were transformed into binary variables
using equally spaced cutoff points ranging from 0 to 100 sec-
onds for cumulative bradycardia or desaturation durations
and from 0% to 30% for supplemental oxygen needed. With use
of these variables, an automated algorithm was developed to
create multiple combinations of the 4 clinical events with both
AND/OR logical operators. Examples of generated SBT defini-
tions are shown in eTable 1 in the Supplement. Of note, neo-
nates with missing data for any clinical event were excluded.
Sensitivity, specificity, and positive and negative predictive
values of a passed SBT were computed for all derived SBTs along
with their respective 95% CIs. Sensitivity referred to the pro-
portion of neonates with successful extubation correctly iden-
tified by a passed SBT, whereas specificity referred to the pro-
portion of neonates with failed extubations correctly identified
by a failed SBT (definitions and interpretation of all diagnos-
tic terms are provided in the eMethods in the Supplement). The
diagnostic performance of each SBT was graphically dis-
played, and the accuracy of each SBT in predicting extuba-
tion success was estimated using the Youden index. The
latter is a measure of a test’s overall discriminative power
assuming equal weight between sensitivity and specificity and
ranges from zero (poor accuracy) to 1 (perfect accuracy). Fur-
thermore, the best SBT definition was identified for each of the
following diagnostic goals: (1) achievement of best overall ac-
curacy (ie, highest Youden index), (2) achievement of maxi-
mal ability to detect failures (ie, maximal specificity), and
(3) achievement of a minimal number of misclassified neo-
nates with extubation success (ie, maximal sensitivity).

A priori, we recognized that SBT accuracy might be influ-
enced by the pretest probability of extubation success in the
cohort and the observation window used to define extuba-
tion success. To test the former, the diagnostic performance
of SBTs was evaluated for neonates above and below the
median gestational age (a known marker of extubation
success).10,11 To test the latter, the diagnostic performance
of SBTs was computed for 4 additional definitions of extubation
success using observation windows of 24 hours, 48 hours,
72 hours, and 5 days after extubation.

Lastly, based on the sample size and prevalence of suc-
cessful extubation in the APEX cohort and assuming a 2-tailed
α = .05, the computed SBT sensitivities would be estimated
with approximately 5% precision and specificities would be es-
timated with approximately 10% precision.12 All analyses were
conducted using MATLAB R2018a (The MathWorks Inc).

**Results**
Of 605 eligible neonates, 278 underwent ET-CPAP after they
were deemed to be ready for extubation (Figure 1). There were
7 circumstances in which clinicians changed their minds about
extubation after ET-CPAP; 4 cases were subsequently ex-
cluded, and 3 were later restudied after the neonate was
deemed to be ready for extubation. Therefore, 274 neonates
were extubated after ET-CPAP. After all additional exclu-
sions, a total of 259 neonates (139 [54%] male) were included
in this study.

**Primary Objective**
Characteristics of patients at the time of extubation and during
ET-CPAP are presented in Table 1 and Figure 2. The median gesta-
tional age was 26.1 weeks (IQR, 24.9-27.4 weeks), median birth
weight was 830 g (IQR, 690-1019 g), and median postnatal age
was 8 days (IQR, 3-26 days) at extubation. Caffeine was admin-
istered in 253 of 259 neonates (98%). Continuous positive airway
pressure was the most common postextubation respiratory sup-
port (150 of 259 [58%]), followed by nasal intermittent positive
pressure ventilation (96 of 259 [37%]) and high-flow nasal can-
nula (13 of 259 [5%]). The ET-CPAP was performed using a me-
dian PEEP of 5 cm H₂O (IQR, 5-6 cm H₂O) and median interval
of 32 minutes (IQR, 21-59 minutes) before extubation. Assessors
decided to prematurely terminate ET-CPAP in 21 neonates based
on variable thresholds of clinical events (eTable 2 in the Supple-
ment). During ET-CPAP, apneas occurred in 10% (26 of 259), bra-
dycardias in 19% (48), desaturations in 53% (138), and increased
oxygen needs in 41% (107) of neonates. Cumulative durations of
bradycardias occurred from 2 to 114 seconds (median, 15 seconds),
and desaturations ranged from 2 to 240 seconds (median, 61 sec-

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on days, whereas the amount of additional oxygen provided ranged from 2% to 77% (median, 10%). Altogether, 147 neonates (57%) experienced at least 1 clinical event during ET-CPAP, with variable combinations. The combination of desaturation and increased oxygen needs was most common, occurring in 58 of 147 neonates (39%) with a clinical event.

Secondary Objective
A total of 184 neonates (71%) were successfully extubated. Extubation success was significantly associated with older gestational age, increased weight at birth, increased weight at extubation, and less respiratory support (reduced mean airway pressure and FiO₂) at extubation compared with extubation failure (Table 1). During ET-CPAP, neonates with successful extubation were significantly less likely to have early ET-CPAP termination (3% [6 of 184] vs 20% [15 of 75], P < .001), had fewer clinical events (51% [93 of 184] vs 72% [54 of 75], P = .002), had shorter cumulative durations of bradycardia (median, 0 seconds [IQR, 0 seconds] vs 0 seconds [IQR, 0-9 seconds], P < .001) or desaturations (median, 0 seconds [IQR, 0-59 seconds] vs 25 seconds [IQR, 0-90 seconds], P = .003), and received smaller amounts of oxygen (median, 0% [IQR, 0%-6%] vs 5% [0%-18%], P < .001) compared with neonates with failed extubation (Table 2). When evaluated separately, the absence of each categorical clinical event predicted successful extubation as follows: absence of apnea (sensitivity, 96%; specificity, 24%), absence of bradycardia (sensitivity, 87%; specificity, 32%), absence of desaturations (sensitivity, 53%; specificity, 69%), and absence of increased oxygen needs (sensitivity, 64%; specificity, 53%). Moreover, the diagnostic performance of each continuous clinical event was characterized by low areas under the receiver operating characteristic curve (cumulative bradycardia duration [0.60], cumulative desaturation duration [0.61], and amount of additional oxygen provided [0.63]) and a high degree of overlap between the probability density functions (eFigure 1 in the Supplement).

After excluding 7 neonates with missing data, the automated algorithm was applied to the remaining 252 neonates to create all combinations of the 4 clinical events, thus generating a total of 41,602 SBT definitions. The SBTs had sensitivities ranging from 51% to 100% (median, 96%), specificities from 0% to 72% (median, 22%), positive predictive values from 71% to 82% (median, 75%), and negative predictive values from 33% to 100% (median, 67%) (Figure 3). Youden indices ranged from 0 to 0.32 (median, 0.17), suggesting an overall low accuracy. The best SBT definitions to achieve the highest Youden index, maximal specificity, and maximal sensitivity are provided in eTable 3 of the Supplement. The combination of clinical events with highest Youden index defined a passed SBT as having no apnea (with desaturation requiring stimulation) or increase in oxygen requirements by 15% from baseline. After applying this definition to the cohort, 171 of 184 neonates (93%) with successful extubation would have passed SBT (sensitivity, 93%) and 29 of 75 neonates (39%) with failed extubation would have failed SBT (specificity, 39%). As such, 13 neonates (7%) with successful extubation would have failed the SBT (and would have received mechanical ventilation for longer than necessary), whereas 46 neonates (61%) with failed extubation would have still passed the SBT. The best SBT that achieved maximal specificity resulted in the detection of 72% of failed extubations, while misclassifying 46% of successful extubations. Finally, the best SBT that achieved maximal sensitivity (100%) correctly identified 14 of 75 failed extubations (19%) without misclassifying any successful extubation as a failure.

Analyses of Variability in Diagnostic Accuracy
The SBT accuracies were further evaluated for neonates above the median gestational age (pretest probability of 84% for successful extubation) and below the median gestational age
and using different observation windows to define extubation success (eFigures 2 and 3 in the Supplement). Both analyses yielded poor SBT accuracies, as reflected by the low Youden indices (none of which exceeding 0.36).

Discussion

In this diagnostic study of data from a large prospective cohort of extremely preterm neonates, we found that 57% of neonates exhibited at least 1 clinical event while undergoing 5-minute ET-CPAP immediately before extubation. Evaluation of multiple clinical event combinations to define passed or failed SBT revealed that none could distinguish between extubation success and failure with sufficient accuracy to justify their routine use. Together, these results provide additional information on the safety and value of SBTs as currently performed.

Assessment of extubation readiness during a period of spontaneous breathing during ET-CPAP has been done for several years. In the 1980s, some preterm neonates were extubated after passing a 6-hour to 24-hour ET-CPAP trial using PEEP levels of 2 to 3 cm H₂O.¹³⁻¹⁵ This practice was abandoned once evidence showed increased risks of apnea, respiratory acidosis, and extubation failure likely because of low levels of support provided for long periods.¹⁶ Years later, SBTs using shorter time frames (3-5 minutes) and higher PEEP...
levels (5-6 cm H2O) were attempted to lessen the risks of lung derecruitment and respiratory fatigue. In 2 small studies,6,7 the diagnostic accuracy of SBTs was evaluated among neonates deemed to be ready for extubation using empirical and/or combinations of clinical events to define SBT pass or fail. Both studies showed excellent SBT sensitivities (97% and 92%) but only modest specificities (73% and 50%) at predicting extubation success. Of interest, the only study to our knowledge to prospectively audit the consequences of incorporating routine SBTs into clinical practice showed that SBT-driven extubation weaning protocols.3,4 would have been automatically administered to neonates who failed extubation had an unforeseen ET-CPAP recording, they would have been automatically classified by any SBT definition. The addition of a 5-minute SBT to clinical judgment appears to be unwarranted because it exposes neonates to clinical instability without improving the ability to identify extubation failures.

Before initiating this analysis, we recognized that the observation window used to define extubation success might influence the diagnostic performance of the SBT. We chose an observation window of 7 days based on the rationale that it would capture most reintubations associated with respiratory factors.5 However, it was conceivable that SBTs would be better suited for detecting reintubations occurring within shorter time frames after extubation. Similarly, we recognized that the pretest probability of extubation success in the cohort might be significantly associated with alterations in the test’s sensitivity and specificity, as previously described.20,21 For those reasons, we explored whether neonates with higher or lower probabilities of successful extubation (based on their gestational age) or those reintubated within shorter time frames after extubation would benefit differently from an SBT. However, no improvements in SBT accuracies could be uncovered.

There are several possible explanations why SBTs evaluated in our study did not accurately capture neonates’ likelihood of successful extubation. First, confounding factors such as preterm gestational age, respiratory status, and clinical instability influenced the results. Second, the SBTs were performed by different neonatologists, each with varying levels of experience and expertise. Third, the SBTs were not standardized across the study period, introducing variability in test administration and interpretation. Finally, the small sample size may have limited the study’s ability to detect a true difference in diagnostic accuracy.

In conclusion, SBTs are a useful adjunct to clinical judgment in assessing extubation readiness in extremely preterm neonates. However, further research is needed to determine the optimal SBT definition and the best approach to incorporating SBTs into clinical practice. Future studies should aim to improve test reproducibility and standardize test administration to ensure consistent results. Additionally, larger, multicenter studies with standardized test protocols are necessary to validate the findings from this study and establish guidelines for the use of SBTs in the clinical setting.

Table 2. Clinical Events During ET-CPAP and Respective Diagnostic Accuracies at Predicting Successful Extubation

<table>
<thead>
<tr>
<th>Clinical Event</th>
<th>Extubation Success (n = 184)</th>
<th>Extubation Failure (n = 75)</th>
<th>Rate (95% CI), %</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Predictive Value</th>
<th>Negative Predictive Value</th>
<th>Area Under ROC Curve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apnea needing stimulation, No. (%)</td>
<td>8 (4)</td>
<td>18 (24)</td>
<td>96 (93-99)</td>
<td>24 (14-34)</td>
<td>76 (70-81)</td>
<td>69 (51-87)</td>
<td>NA</td>
<td>0.68</td>
</tr>
<tr>
<td>Bradycardia, No. (%)</td>
<td>24 (13)</td>
<td>24 (32)</td>
<td>87 (82-92)</td>
<td>32 (21-43)</td>
<td>76 (70-82)</td>
<td>50 (36-64)</td>
<td>NA</td>
<td>0.66</td>
</tr>
<tr>
<td>Desaturation (oxygen saturation &lt;85%), No. (%)</td>
<td>86 (47)</td>
<td>52 (69)</td>
<td>53 (46-60)</td>
<td>69 (59-80)</td>
<td>81 (74-88)</td>
<td>38 (30-46)</td>
<td>NA</td>
<td>0.67</td>
</tr>
<tr>
<td>Increase in oxygen requirement from baseline, No. (%)</td>
<td>67 (36)</td>
<td>40 (53)</td>
<td>64 (57-71)</td>
<td>53 (42-65)</td>
<td>78 (70-84)</td>
<td>37 (28-47)</td>
<td>NA</td>
<td>0.66</td>
</tr>
<tr>
<td>Early ET-CPAP termination, No. (%)</td>
<td>6 (3)</td>
<td>15 (20)</td>
<td>97 (94-99)</td>
<td>20 (11-29)</td>
<td>75 (69-80)</td>
<td>71 (52-91)</td>
<td>NA</td>
<td>0.69</td>
</tr>
<tr>
<td>Any clinical event, No. (%)</td>
<td>93 (51)</td>
<td>54 (72)</td>
<td>49 (42-57)</td>
<td>72 (62-82)</td>
<td>81 (74-88)</td>
<td>37 (29-45)</td>
<td>NA</td>
<td>0.68</td>
</tr>
<tr>
<td>All 4 clinical events, No. (%)</td>
<td>4 (2)</td>
<td>15 (20)</td>
<td>98 (96-100)</td>
<td>20 (11-29)</td>
<td>75 (70-80)</td>
<td>79 (61-97)</td>
<td>NA</td>
<td>0.69</td>
</tr>
<tr>
<td>Desaturation, median (IQR), s</td>
<td>0 (0-59)</td>
<td>25 (0-90)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>Bradycardia, median (IQR), s</td>
<td>0 (0-0)</td>
<td>0 (0-9)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>Supplemental oxygen, median (IQR), %</td>
<td>0 (0-6)</td>
<td>5 (0-18)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>0.63</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: ET-CPAP, endotracheal continuous positive airway pressure; IQR, interquartile range; NA, not applicable; ROC, receiver operating characteristic.

a All comparisons were statistically significant, with P ≤ .01.

b Diagnostic accuracy of the absence of each clinical event during ET-CPAP in predicting extubation success.
as endotracheal tube size, length, and partial obstruction (owing to respiratory secretions or biofilm formation) may have influenced clinical event occurrences during ET-CPAP. Second, the 5-minute trial duration may have been too short to accurately assess the neonates’ ability to sustain spontaneous breathing without significant apneas, especially considering that apneas are the most commonly reported cause of reintubation in this population. Third, it is unclear from the available literature whether a PEEP of 5 to 6 cm H2O during ET-CPAP would accurately match the patient’s physiologic conditions after extubation while receiving noninvasive respiratory support. The decrease in mean airway pressure and increased resistance associated with ET-CPAP may have further contributed to clinical instability.

Limitations
An integral part of the study was that clinical events were captured continuously and subjectively through direct observation of the patient and bedside monitor. Although the pragmatic nature of the assessment may be considered a limitation, it likely reflected the way that SBTs are actually evaluated in clinical practice, thereby adding external validity to the study. Nonetheless, more precise information on the timing, number, duration, and depth of each event and more direct associations between individual events may have provided further understanding of the neonates’ clinical behavior during ET-CPAP.

The study has some other limitations. The ET-CPAP, performed only after neonates were deemed to be ready for extubation, introduced test-referral bias, meaning that inevitably more stable patients (likely to be successfully extubated) were preselected for the diagnostic test. This phenomenon has been well described to overestimate sensitivity, underestimate specificity, and compromise test generalizability. Furthermore, because of lack of blinding of the ET-CPAP recording, extubation was postponed for 7 neonates who would have otherwise been extubated per clinical judgment. Whereas these neonates only represented 3% of the cohort, their inclusion may have marginally improved the specificity of the evaluated SBTs. Also, a considerable number of eligible neonates were not approached or missed. Our results may not be generalizable to neonates weighing more than 1250 g who received mechanical ventilation or extubations beyond the first elective attempt.

Conclusions
In this study, extremely preterm neonates commonly showed signs of clinical instability during a 5-minute ET-CPAP trial. Although neonates with extubation failure had significantly more clinical events compared with those with extubation success, the accuracy of more than 41,000 evaluated SBT pass or fail definitions remained low. As such, SBTs as currently performed may provide little to no added value in the assessment of extubation readiness (especially in the identification of extubation failures) compared with clinical judgment alone. Future studies appear to be needed to evaluate the role of SBT duration and the provided PEEP levels necessary in improving the accuracy of the test. Furthermore, ongoing analysis of the APEX study aims to evaluate the value of more complex and automated analyses of cardiorespiratory behavior during mechanical ventilation and ET-CPAP in better predicting extubation success.

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Author Affiliations: Division of Neonatology, Department of Pediatrics, Montreal Children’s Hospital, McGill University Health Center, Montreal, Quebec, Canada (Shalish, Kanbar, Kovacs, Sant’Anna); Division of Biomedical Engineering, McGill University, Montreal, Quebec, Canada (Kanbar, Kearney); Department of Neonatology, Jewish General Hospital, Montreal, Quebec, Canada (Kovacs); Division of Neonatal–Perinatal Medicine, Hutzel Women’s Hospital, Wayne State University, Detroit, Michigan (Chawla); Division of Neonatology, Women and Infants Hospital of Rhode Island, Brown University, Providence (Keszler); Department of Computer Science, McGill University, Montreal, Quebec, Canada (Precup); Department of Anesthesia, Montreal Children’s Hospital, McGill University Health Center, Montreal, Quebec, Canada (Brown).

Author Contributions: Drs Shalish and Sant’Anna had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Shalish, Kanbar, Kovacs, Chawla, Precup, Kearney, Sant’Anna.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Shalish, Kovacs, Rao, Sant’Anna.

Critical review of the manuscript for important intellectual content: Shalish, Kanbar, Kovacs, Chawla, Keszler, Latremouille, Precup, Brown, Kearney, Sant’Anna.

Statistical analysis: Shalish, Precup, Kearney.

Obtained funding: Precup, Kearney, Sant’Anna.

Administrative, technical, or material support: Shalish, Chawla, Rao, Sant’Anna.

Supervision: Keszler, Precup, Kearney, Sant’Anna.

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