

A multidomain 0D model for continuous positive airway pressure ventilation circuit design: Validation and applications

Original

A multidomain 0D model for continuous positive airway pressure ventilation circuit design: Validation and applications / Formaggio, Andrea; Luca, Margherita De; Borrelli, Simone; Putame, Giovanni; Vita, Nello De; Minelli, Fabio; Corte, Francesco Della; Vaschetto, Rosanna; Audenino, Alberto L.; Olivieri, Carlo; Terzini, Mara. - In: BIOCYBERNETICS AND BIOMEDICAL ENGINEERING. - ISSN 0208-5216. - 45:2(2025), pp. 170-180. [10.1016/j.bbe.2025.02.004]

Availability:

This version is available at: 11583/2998196 since: 2025-03-10T09:38:10Z

Publisher:

Elsevier

Published

DOI:10.1016/j.bbe.2025.02.004

Terms of use:

This article is made available under terms and conditions as specified in the corresponding bibliographic description in the repository

Publisher copyright

Elsevier postprint/Author's Accepted Manuscript

© 2025. This manuscript version is made available under the CC-BY-NC-ND 4.0 license
<http://creativecommons.org/licenses/by-nc-nd/4.0/>. The final authenticated version is available online at:
<http://dx.doi.org/10.1016/j.bbe.2025.02.004>

(Article begins on next page)

A Multidomain OD Model for Continuous Positive Airway Pressure Ventilation Circuit Design: Validation and Applications

Andrea Formaggio^{a,b,*}, Margherita De Luca^{a,b}, Simone Borrelli^{a,b}, Giovanni Putame^{a,b}, Nello De Vita^{c,d}, Fabio Minelli^d, Francesco Della Corte^c, Rosanna Vaschetto^c, Alberto L. Audenino^{a,b}, Carlo Olivieri^e, Mara Terzini^{a,b}

^a Department of Mechanical and Aerospace Engineering, Politecnico di Torino, Turin, Italy

^b Polito^{BIO}Med Lab, Politecnico di Torino, Turin, Italy

^c Department of Translational Medicine, Università del Piemonte Orientale, Novara, Italy

^d Anesthesia and Intensive Care, Azienda Ospedaliero-Universitaria Maggiore Della Carità, Novara, Italy

^e Anesthesia and Intensive Care, Sant'Andrea Hospital, ASL VC, Vercelli, Italy

* Corresponding author at: Corso Duca degli Abruzzi, 24, 10129 Torino, Italy. E-mail address: andrea.formaggio@polito.it

Abstract

This study focuses on optimizing a non-invasive ventilation (NIV) circuit for the treatment of hypoxemic respiratory failure using continuous positive airway pressure (CPAP). A multidomain OD *in silico* approach was employed, creating a lumped circuit model of an innovative NIV-CPAP system in Mathworks® Simulink. The model relies on *in vitro* tests on commercial components characterizing pneumatic resistive behavior, and it exploits an extended resistance-inductance-capacitance model for the patient's respiratory system, recurring to sigmoidal pressure-volume behavior characteristic of pathological conditions. The NIV-CPAP system was assembled *in vitro* and connected to a lung simulator to validate the model under healthy and pathological conditions (acute respiratory distress syndrome and chronic obstructive pulmonary disease). The study explored the impact of key features on the ventilation circuit, such as interface leakage, air volume within the circuit, and resistance induced by circuit components.

Validation of the OD model through *in vitro* tests showed correlation coefficients between 0.9 and 1. Interface leakage caused reductions of up to 6% in delivered static pressure. Changes in air volume (mask or helmet interface, reservoirs adding) resulted in a maximum 8% decrease in pressure oscillations. Increased resistances from the starting ventilation circuit produced a tidal volume reduction of less than 1%. An optimized configuration that balanced resistances between limbs improved intrinsic positive end-expiratory pressure generation.

The proposed OD model proved to be effective in guiding the design of the innovative device, providing computational efficiency and flexibility; it demonstrated its reliability as a tool to support the optimization of non-invasive ventilation circuits.

Keywords: OD model, closed breathing circuit, continuous positive airway pressure, MATLAB/Simulink, non-invasive ventilation

Mechanical ventilation (MV), invasive mechanical ventilation (IMV), non-invasive ventilation (NIV), Continuous Positive Airway Pressure (CPAP), positive end-expiratory pressure (PEEP), intrinsic positive end-expiratory pressure (PEEPi), functional residual capacity (FRC), acute respiratory distress syndrome (ARDS), Chronic Obstructive Pulmonary Disease (COPD), resistance-inductance-capacitance (RIC), predicted body weight (PBW),

1 Introduction

37 Mechanical ventilation (MV) constitutes a therapeutic approach wherein a mechanical ventilator supports
38 patients with severe respiratory failure, allowing them to ventilate adequately and to maintain normal gas
39 exchange between the lungs and the environment [1]. MV does not cure lung tract diseases, but it allows
40 the body to recuperate from the syndrome responsible for respiratory failure by providing adequate
41 oxygenation and by removing carbon dioxide. Indications for establishing mechanical ventilation are
42 refractory hypoxemia, ventilatory failure, shock with metabolic acidosis, and airway failure due to altered
43 mental status or physical obstruction [2,3]. MV can be delivered in two distinct forms: invasive mechanical
44 ventilation (IMV) and non-invasive ventilation (NIV). In the case of IMV, an endotracheal tube, nasotracheal
45 tube, or tracheostomy cannula are used to carry out the ventilation. On the other hand, NIV employs
46 interfaces such as a facial mask, mouthpiece, or helmet, which do not require endotracheal tube
47 placement. The implementation of non-invasive oxygenation strategies helps preserve the natural airway
48 protection mechanisms, such as the ability to cough and clear secretions. Additionally, it avoids the
49 potential complications associated with endotracheal intubation, which encompass laryngeal and tracheal
50 trauma, as well as the issues related to IMV which include ventilator-induced lung injury, ventilator-
51 associated pneumonia, mucosal ulceration, respiratory muscle wasting, and swallowing dysfunction,
52 diaphragm dysfunction and atrophy [4–9]. Despite this, NIV is not free from drawbacks such as the
53 development of skin pressure sores, the risk of malnutrition especially in patients with the need for
54 prolonged NIV and the risk of self-inflicted lung injury in patients with excessive respiratory effort and work
55 of breathing [10].

56 MV can be delivered in two primary modes: controlled ventilation and assisted ventilation. In controlled
57 modes, the ventilator entirely takes over the role of the respiratory muscles, and the target variable
58 controlled by the ventilator can be either the volume or the pressure. In assisted modes, the ventilator
59 provides support to the patient's respiratory efforts. In spontaneously breathing patients it is possible to
60 apply a continuous positive pressure into the lungs delivering the so-called CPAP (Continuous Positive
61 Airway Pressure) therapy in NIV modality. CPAP does not provide inspiratory support but maintains positive
62 airway pressure at end-expiration [11]. The delivered positive pressure increases the patient's functional
63 residual capacity (FRC), opens under-ventilated alveoli, decreases atelectasis, and improves lung
64 compliance [12]. Due to these advantages, CPAP therapy is employed in the treatment of different kinds of
65 hypoxemic respiratory failure. This condition was notably prevalent during COVID-19 pandemic, where a
66 significant number of patients exhibited symptoms that gradually led to progressive hypoxemic respiratory
67 failure [13]. One such case was the occurrence of acute respiratory distress syndrome (ARDS), where the
68 inflammatory lung condition leads to leakage of fluid into the lung spaces resulting in hypoxemia. The
69 efficacy of non-invasive ventilation delivered through a continuous positive airway pressure (NIV-CPAP) as a
70 supportive treatment for ARDS varies based both on the severity of the pathology (most successful in
71 patients with mild ARDS [14], and mild-to-moderate ARDS secondary to SARS-CoV-2 [15]) and possibly on
72 the disease type ("L" and "H" phenotypes) [16].

73 At present, NIV-CPAP is commonly administered through an open-configuration ventilation circuit, typically
74 using masks or helmet interfaces, which show better patient tolerance in clinical practice compared to
75 masks [17]. In these systems, a voluntary leak is generated at the interface, which controls the constant
76 positive pressure and the washout flow of exhaled gases in two ways: (1) by generating the flow through
77 the device (e.g., Venturi flowmeter) and regulating pressure via a PEEP valve that adjusts the leak, and (2)
78 by controlling the pressure generated by the device (typically via a turbine) and managing the flow through
79 an exit port at the interface. These systems have several disadvantages: high oxygen consumption to
80 achieve therapeutic concentrations, dependence on the hospital's high-pressure gas lines, elevated noise
81 levels, aerosolization of pathogens, as could have happened during COVID-19, and the need for a
82 humidification system. To minimize these drawbacks, an innovative ventilation system that operates in a

83 closed-loop circuit, and inspired by anaesthesia systems, was previously proposed and preliminarily tested
84 on a healthy subject [18,19]. However, conducting experiments on mechanical ventilators is not only
85 expensive but also could be dangerous for the patients. In this context, multidomain OD *in silico* models can
86 provide significant contribution in evaluating innovative ventilation mode and support the development of
87 mechanical ventilation devices. These mathematical methods represent different physical domains (such as
88 mechanics, electricity, fluid dynamics, etc.) in a system, where each part is treated as if it were a point
89 without dimensions. Each pointwise element of the circuit is therefore described by spatially averaged
90 values (OD) and physical variables that change only over time. The advantage is thus to simulate the
91 interaction of the various parts of the system on a global level with very low computational cost.

92 This approach has been employed in several studies, in order to understand the interaction between
93 mechanical ventilators and human lungs [20–26]. Previous studies focused on IMV, while scant attention
94 was dedicated to NIV-CPAP mode. Since pathological patients undergoing CPAP therapy can manifest
95 varying deformations across different regions of the pressure-volume curve, showing a non-linear sigmoidal
96 behaviour, the present study introduces a novel non-linear patient model based on the extended linear
97 resistance-inductance-capacitance (RIC) model present in literature [27–30]. Additionally, this work
98 introduces, for the first time, an *in silico* investigation of spontaneous breathing in ventilation circuits using
99 a OD modelling approach.

100 The goal is to develop a validated multidomain OD *in silico* approach to optimize the non-invasive closed-
101 loop ventilation circuit proposed by Cavaglià et al. [18], by investigating the potential effects of the design
102 choices of the circuit on the administered treatment across a variety of patients.

103 2 Materials and Methods

104 The novel NIV-CPAP closed circuit proposed in [18] can be implemented using existing components from
105 the traditional NIV-CPAP open-loop configuration. Figure 1 illustrates the pneumatic scheme of the system.
106 Once the air passes through a filter (1) to eliminate impurities, it is pressurized by a blower (2). A second
107 inlet is designated for the oxygen supply, allowing for potential enrichment of the breathing air using an O₂
108 source (3), like a tank or an oxygen concentrator. The oxygen enters the circuit via the O₂ directional
109 proportional valve (4), which works as a metering valve by regulating the degree of its opening. The mixture
110 of air and oxygen is delivered to the patient through the inspiratory limb, which includes an antiviral filter
111 (5), a balloon as a reservoir (6) and a check valve (7) to ensure unidirectional flow. The gas is directed into
112 the interface (8), which administers CPAP therapy to the patient. The interface (8) inevitably introduces an
113 air leakage into the surrounding environment (9). Symmetrically, a check valve (10), a reservoir (12) and an
114 antiviral filter (13) are placed in the expiratory limb. In addition, the soda lime (11) is used as a CO₂
115 absorber to purify the exhalation avoiding CO₂-rebreathing. The gas analysis unit includes a set of sensors
116 that monitor various ventilation-related parameters. The rotational speed of the blower is regulated to
117 maintain the pressure at the desired therapeutic level, as measured by the pressure sensor (15). An O₂
118 sensor (16) monitors the oxygen concentration, which is used to control the opening degree of the inlet
119 metering valve. To ensure patient safety, a CO₂ sensor (17) monitors the carbon dioxide concentration.
120 Finally, a safety three-way valve (14) is actuated to open the circuit when the pressure sensor or the CO₂
121 sensor detects abnormal and potentially harmful levels for the patient. The ventilation system was
122 designed with disposable components (outside the “device” box) and components housed within the
123 ventilator casing (inside the “device” box). Specifically, antiviral filters are placed at the connections of the
124 device limbs to prevent contamination of the device itself.

125

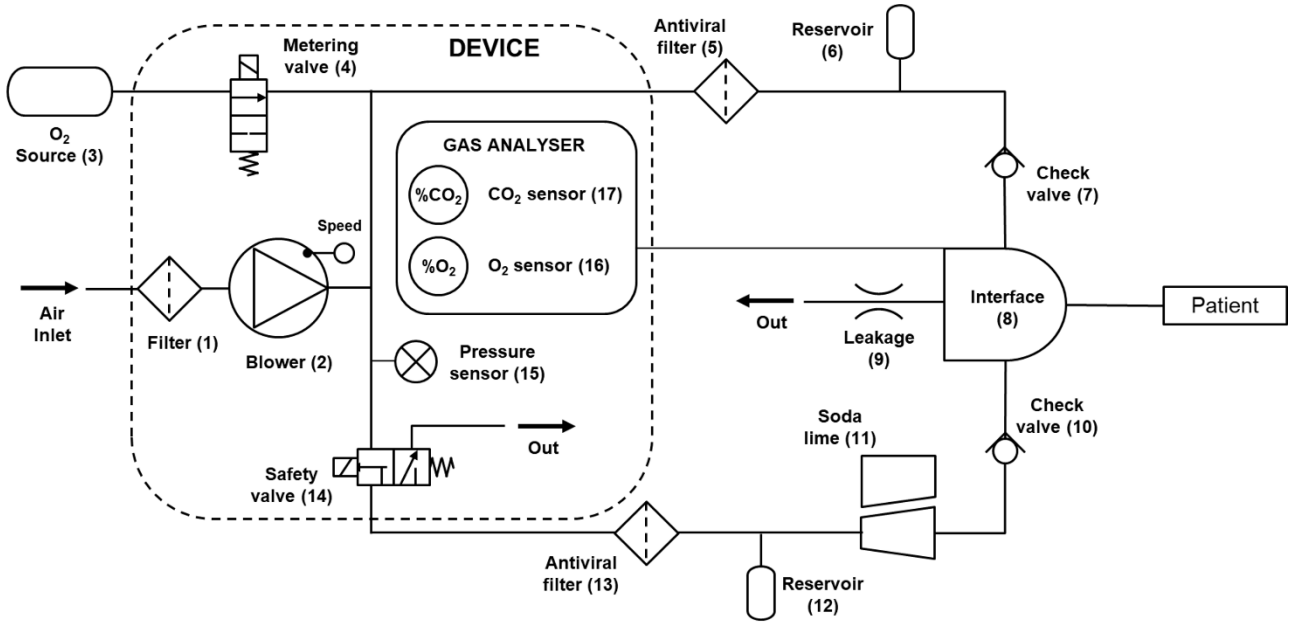


Figure 1. Pneumatic scheme of the ventilation circuit with ISO symbols.

2.1 Equation of motion of the respiratory system

In respiratory mechanics, at any time (t), the airways pressure P_{aw} is equal to the sum of three pressures according to Eq. (1): the alveolar pressure at the beginning of the inspiration (P_0) which can be the atmospheric pressure or a positive end-expiratory pressure (PEEP), the resistive pressure (P_{res}) and the elastic pressure (P_{el}).

$$P_{aw}(t) = P_0 + P_{res}(t) + P_{el}(t) \quad (1)$$

In particular, the resistive pressure represents the pressure difference required to generate a given gas flow rate within the airways, whereas the elastic pressure is the pressure needed to expand the lungs and chest wall. Indeed, we can describe the forces acting during ventilation by the simplified equation of motion of the respiratory system (Eq. 2):

$$P_{aw}(t) = P_0 + R \cdot \dot{V}(t) + \frac{V(t)}{C_{RS}} \quad (2)$$

Where R is the resistance of the airways (and the endotracheal tube in case of invasive ventilation), V is the lungs volume, \dot{V} is the airflow, C_{RS} is the compliance of the respiratory system.

During MV the airways pressure $P_{aw}(t)$, needed to provide a respiratory act, is given by the sum of the pressure developed by the respiratory muscles and the pressure developed by the ventilator:

$$P_{aw}(t) = P_{vent}(t) + P_{musc}(t) = P_0 + R \cdot \dot{V}(t) + \frac{V(t)}{C_{RS}} \quad (3)$$

Eq. (3) describes the synergistic impact of both the patient's muscular effort and the pressure delivered by the ventilator on the respiratory system. The type of MV is defined by the balance between these two pressures: controlled ventilation, assisted ventilation or non-assisted ventilation.

This study concentrated on non-assisted ventilation, specifically CPAP therapy, and involved solving the equation of motion for the respiratory system using a multidomain OD model. The time-varying curve of respiratory muscle activity ($P_{musc}(t)$) was incorporated as an input in the model to simulate the patient's spontaneous breathing. Meanwhile, the ventilator pressure ($P_{vent}(t)$) functioned to sustain a constant and positive airway pressure, compensating for the pressure fluctuations generated by the patient's breathing.

152 2.2 Multidomain 0D model

153 A lumped circuit model of the ventilation circuit (Figure 2) was developed in Mathworks® Simulink using
154 the SimScape library to replicate the pneumatic scheme shown in Figure 1. For the purposes of this study,
155 only the air properties (e.g., specific gas constant, dynamic viscosity, specific enthalpy) were considered
156 and defined in the model, as the discussion regarding oxygen supply falls outside the scope of this research.
157 The blower was simulated by inputting the performance curves provided in the datasheet of a selected
158 commercial blower. A pressure sensor was employed to monitor the pressure at point A (Figure 2) and to
159 adjust the blower rotational speed to maintain the pressure around the therapeutic value. This control was
160 obtained by implementing a proportional-integral-derivative controller ($P = 1.8$, $I = 0.7$, $D = 0$). Circuit
161 passive elements (i.e., filters, check valves, soda lime, safety valve, air leakage) were simulated using
162 localized load losses and their pneumatic resistive behavior was characterized through *in vitro* tests
163 performed on the corresponding commercial components. In detail, the pressure drop (measured with
164 AMS 6915, OEM) at the ends of each component was recorded for different imposed flows (measured with
165 FM3200, Sensirion); the resulting pressure-flow curves were interpolated using the descriptive curve of the
166 "Flow Resistance" block:

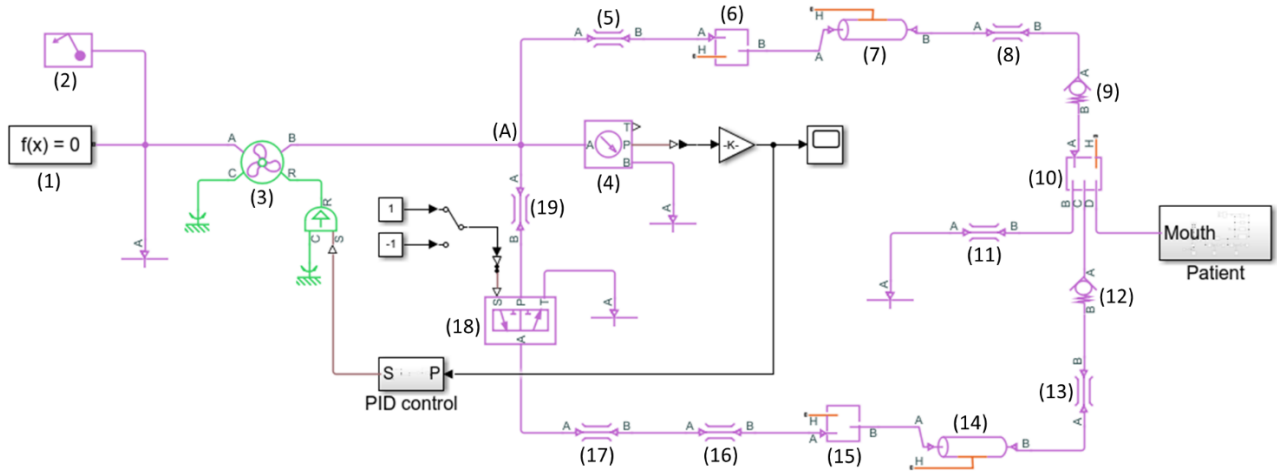
$$167 \quad \Delta p = \frac{\xi \dot{m}^2}{2\rho S}$$

168 where Δp is the pressure drop from port A to port B, ξ is the loss factor, \dot{m} is the imposed flow, ρ is the fluid
169 density, and S is the flow area. The pressure drops obtained for each component are reported in Table 1.

170 *Table 1. Pressure drops for a nominal flow rate of 20 L/min*

| | Δp (cmH ₂ O) |
|--------------------------|---------------------------------|
| Antiviral filter | 0.27 |
| Check valve | 0.39 |
| Soda lime | 0.30 |
| Safety valve | 0.09 |
| Interface leakage | 150 |

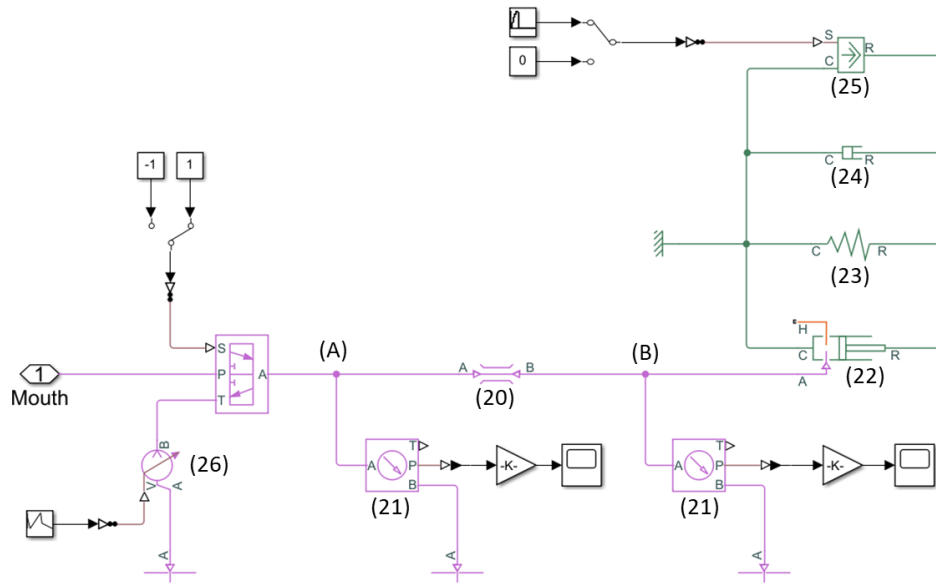
175 In order to replicate the inspiratory and expiratory pipes, a length of 2 meters, an internal diameter of
176 15mm, and a roughness of 0.01mm were considered, with consistency with commercially available
177 ventilation pipes. An aggregate equivalent length of 1 m was introduced to consider the pipe bending, in
178 accordance with the *in vitro* tests. The low deformability of the interface, typically associated with helmet
179 interfaces, was disregarded. In fact, once the helmet is fully expanded by positive pressure, any volume
180 changes are negligible, as air compressibility dominates over helmet deformability. The same reasoning
181 applies to balloons used as reservoirs. The check valves and the safety valve were represented as ideal in
182 the model, since their pneumatic resistance behavior was considered through the inclusion of a "Flow
183 Resistance" block for each valve.



184

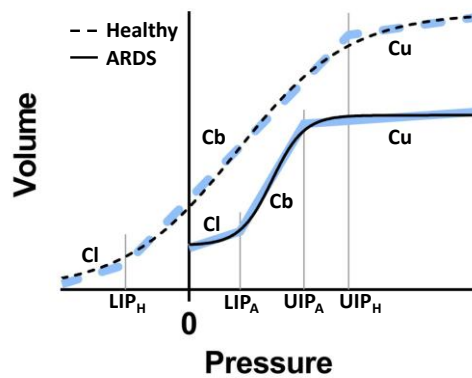
185 *Figure 2. Graphics of the ventilation circuit model (SimScape): 1) Solver configuration, 2) gas property, 3) blower, 4)*
 186 *pressure and temperature sensor, 5) antiviral filter (insp.), 6) reservoir (insp.), 7) inspiratory pipe, 8) check valve*
 187 *resistance (insp.), 9) check valve (insp.), 10) patient interface, 11) leakage resistance, 12) check valve (exp.), 13) check*
 188 *valve resistance (exp.), 14) expiratory pipe, 15) reservoir (exp.), 16) soda lime, 17) antiviral filter (exp.), 18) safety valve,*
 189 *19) safety valve resistance.*

190 The model of the patient is reported in Figure 3. The extended RIC model was selected among the electric
 191 circuit-based linear OD models of the respiratory system [27–30]. The airways were modelled as a localized
 192 load loss, and two sensors enabled the measurement of two key parameters: the pressure at the airway
 193 entrance (P_{aw}) and the alveolar pressure (P_{alv}), recorded at points A and B, respectively (Figure 3). The
 194 lungs were simulated as a plunger moving inside a cylinder. In parallel to this block, the model incorporates
 195 a spring, a damper and an actuator, to simulate the compliance of the lung-chest wall system, the damping
 196 of the lung tissue, and the effort exerted by the respiratory muscles, respectively. Whether in physiological
 197 resting conditions lung compliance can be adequately represented by a total respiratory compliance (C_{rs})
 198 exhibiting a linear behavior, in pathological conditions where CPAP therapy is administered a more complex
 199 non-linear description is required. Therefore, in this study the spring (block 23, Figure 3) has a non-linear
 200 mechanical behavior to replicate the characteristic sigmoid pressure-volume curve of the lung-chest wall
 201 system [31] (Figure 4). The curve was divided into three distinct segments, each approximated using a
 202 piecewise linear behavior. Three different compliances were assigned to these segments: a first compliance
 203 below the pressure at the lower inflection point (LIP) (C_l), a compliance between LIP and upper inflection
 204 points (UIP) (C_b), and a final compliance above UIP (C_u) [32]. This approach allowed for an accurate
 205 representation of the lung-chest wall system's behavior throughout the pressure-volume curve.



206

207 Figure 3. Graphics of the patient model (SimScape): 20) airways, 21) pressure and temperature sensor, 22) lungs, 23)
 208 lung compliance, 24) tissues damping, 25) respiratory muscles, 26) volume control insufflator.



209

210 Figure 4. Pressure-Volume curves of the respiratory system. Sigmoidal curves in black [31], model approximation curves
 211 in blue. The subscript 'H' indicates a parameter related to the healthy subject, while the subscript 'A' indicates a
 212 parameter related to the ARDS subject. Negative pressures are never reached during spontaneous breathing at rest but
 213 only during a forced expiration.

214 The developed patient model permits to simulate not only a healthy condition but also pathological ones;
 215 in particular, the ARDS is characterized by a decrease of lung compliance and of the FRC and an increase of
 216 breath frequency. In addition, to test the reliability of the model in reproducing subjects with altered
 217 airway resistance, Chronic Obstructive Pulmonary Disease (COPD) was also considered in this work,
 218 although this condition is typically treated with NIV-CPAP only in cases of acute exacerbation. COPD is
 219 characterized by an increased flow resistance within the airways, that hinders complete expiration before
 220 the subsequent inhalation, resulting in hyperinflation and increased work of breathing due to an intrinsic
 221 PEEP (PEEPi). NIV can provide external PEEP to counterbalance PEEPi in patients with COPD and to offset
 222 the effects of an acute exacerbation in acidotic patients [12,33].

223 To populate patient specific lung parameters within the patient model, relations summarized in Table 2
 224 were used, considering a predicted body weight (PBW) estimated according to the following simplified
 225 equations [34], where height is expressed in centimeters:

226

$$PBW \text{ in female (kg)} = (\text{height} - 100) \cdot 0.9 - 5 \quad (4)$$

227

$$PBW \text{ in male (kg)} = (\text{height} - 100) \cdot 0.9 \quad (5)$$

228

229

230

231

232

233

234

235

Specifically, the parameters refer to mild-to-moderate ARDS condition, which can be effectively treated with NIV-CPAP therapy in clinical practice [14–16]. Table 2 shows a 25% reduction in lung compliance in the ARDS patient compared to a healthy subject (C_I ARDS vs. C_b healthy) within the segment of the Pressure-Volume curves corresponding to positive pressures up to the patient's LIP (Figure 4), which includes the resting breathing condition. Beyond the LIP, the ARDS patient exhibits an approximately 35% increase in compliance relative to the healthy subject (C_b ARDS vs. C_b healthy), attributed to the progressive reopening of collapsed lung regions at positive pressures, primary goal of CPAP therapy.

Table 2. Lung parameters.

| | Healthy | COPD | ARDS |
|--|-------------------|-------------------|----------------|
| Compliance between the LIP and the UIP, C_b (ml/mbar) | 0.8·PBW [35,36] | 0.9·PBW [36] | 1.1·PBW [32] |
| Compliance below the LIP, C_I (ml/mbar) | * | * | 0.6·PBW [36] |
| Compliance above the UIP, C_u (ml/mbar) | 8 [37] | 8 [37] | 8 [37] |
| Lower Inflection Point, LIP (mbar) | * | * | 8 [38] |
| Upper Inflection Point, UIP (mbar) | 35 [37] | 35 [37] | 24 [37,38] |
| Tissues damping (mbar*s/L) | 2 [24] | 2 [24] | 2 [24] |
| Airways resistance (mbar*s/L) | 12 [35,36] | 20 [36] | 13 [36] |
| Functional Residual Capacity, FRC (ml) | 27·PBW [35,39,40] | 27·PBW [35,39,40] | 17·PBW [39,41] |

*The healthy and COPD subjects exhibit a LIP at negative pressures, so the parameters related to the LIP for these subjects was not considered in the model during spontaneous breathing at rest.

236

2.3 3-stages validation of the multidomain OD model

237

238

239

240

241

242

243

244

245

After designing the multidomain OD model, four distinct subjects were simulated: females with heights of 160cm and 170cm, males with heights of 175cm and 185cm. Each of these subjects, with their unique C_rs and FRC values attributed in line with their specific heights, were modelled in the healthy and pathological conditions (Table 3). The respiratory rate was set to 12 breath per minute for healthy and COPD patients and 28 breath per minute for ARDS patients. The twelve cases constituted a dataset covering a wide range of lung parameters to test the model performance. In particular, the subjects present an increasing challenge (referring to Table 3) from left to right (increasing lung compliance and tidal volume) and from top to bottom (increasing complexity of lung mechanical behavior and respiratory frequency) regarding the control of CPAP therapy delivery by the device.

246

247

Table 3. Healthy and pathological subjects implemented. The table is organized based on the four subjects and the three conditions that were considered during the study.

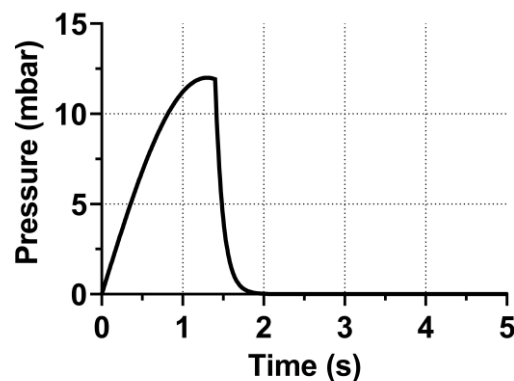
| | Female 160cm | Female 170cm | Male 175cm | Male 185cm |
|----------------|--------------|--------------|------------|------------|
| Healthy | C.1a | C.2a | C.3a | C.4a |
| COPD | C.1b | C.2b | C.3b | C.4b |
| ARDS | C.1c | C.2c | C.3c | C.4c |

248

249 The closed-loop ventilation circuit [18] was then assembled *in vitro* using commercially available
250 components and connected to a lung simulator able to replicate the twelve healthy and pathologic subjects
251 (TestChest® V3, Organix GmbH, CH). To ensure consistency and comparability, the same setup was
252 employed for both *in vitro* tests and *in silico* simulations. This approach guarantees a reliable comparison
253 between *in vitro* and *in silico* results across the twelve cases, enabling a 3-stages validation of the
254 multidomain OD.

255 The first stage focused on validating only the numerical passive behavior of the patient as if in a state of
256 apnea. Experimentally, the lung insufflation was obtained with a 500 ml syringe moved at a constant speed.
257 The measured inflow was given as input in the "Controlled Volumetric Flow Rate Source" block (block 26,
258 Figure 3) as an external lung ventilation in the patient subroutine whose respiratory muscles were properly
259 deactivated (block 25, Figure 3). Numerical and experimental data of both alveolar pressure and air volume
260 inside the lung were compared generating a chart with the experimental results serving as the independent
261 variable and the numerical results as the dependent variable; their similarity was assessed through a linear
262 regression, comparing the data to the 45-degree line, which represents a perfect overlap ($R^2 = 1$).

263 The second stage was dedicated to the validation of the active patient during spontaneous breathing,
264 which was generated by the activation of the respiratory muscles block. The effort of respiratory muscle
265 was defined by an activation curve (Figure 5) [29], inserted in both the actuator block and in the lung
266 simulator. The respiratory muscle pressure curve defines the phases of inspiration, expiration, and the
267 pause in the respiratory cycle based on the patient's breathing rate, generating a flow through the airways
268 with a more realistic non-sinusoidal profile. The flow passing through the patient's airway and the alveolar
269 pressure were recorded and compared.



270

271

Figure 5. Muscles activation curve.

272 The third stage addressed the validation of the ensembled model with the patients spontaneously
273 breathing in the ventilation circuit. Here, both the pressure sources were simultaneously activated (i.e., the
274 patient's respiratory muscles and the external blower). The CPAP therapy level was set to 6 cmH₂O. The
275 accuracy of the model in predicting the impact of ventilation on lungs was evaluated by comparing the
276 alveolar pressure and the flow through the patients' airway.

277 2.4 NIV-CPAP ventilation circuit design

278 The validated multidomain OD model was employed to guide the design of the ventilation circuit for the
279 correct delivery of CPAP therapy to the patient, which was evaluated according to three key requirements.
280 Specifically, the device: (1) must deliver the correct average positive pressure at the patient interface, (2)
281 must maintain constant positive pressure throughout the respiratory cycle, and (3) must not restrict the
282 patient's breathing. These three design requirements were investigated by exploring the impact of three

283 correlated features, respectively: (1) the leakage amount at the patient interface, (2) the air volume within
284 the circuit allowed by the interface dead volume and the presence of reservoirs, and (3) the amount of
285 resistance induced by the circuit components.

286 2.4.1 Interface leakage

287 Leaks refer to the unintended escape of air from the interface, causing airflow through the inspiratory limb.
288 This airflow leads to a pressure drop from the ventilator to the interface, which can reduce the static
289 pressure within the interface and consequently impact the delivery of the therapy to the patient. Interface
290 leakage was modelled by varying the patient interface resistance (block 11, Figure 2). The resulting
291 decrease of static pressures was quantified at three different therapeutic CPAP levels (5, 10 and 15 cmH₂O)
292 under three different interface leakage conditions: low leak (150 cmH₂O, as detailed in Table 1 for the
293 patient interface resistance, resulting to 5, 8 and 9 L/min of leak for 5, 10 and 15 cmH₂O of CPAP,
294 respectively), moderate leak (30 cmH₂O, resulting to 12, 17 and 21 L/min of leak), marked leak (15 cmH₂O,
295 resulting to 17, 23 and 29 L/min of leak). In this section, the respiratory muscles were deactivated (block
296 25, Figure 3) because assessing static pressure does not involve the patient's breathing.

297 2.4.2 Interface dead volume and reservoirs

298 Patient interfaces with a larger volume, such as the helmet interface, enable the attenuation of pressure
299 fluctuations caused by the patient's breathing. This, in turn, helps maintain a more constant positive
300 pressure in the airways throughout the entire breathing cycle. In this analysis, pressure oscillations were
301 investigated at 5, 10 and 15 cmH₂O of CPAP level, using a total face mask and a helmet interface. The
302 interface was modelled by varying the volume in the patient interface (block 10, Figure 2). Additionally, we
303 evaluated the effect of including a 6 L volume reservoir in both limbs of the ventilation circuit (blocks 6 and
304 15, Figure 2). The most critical patient (C.4c characterized by the highest respiratory rate and tidal volume)
305 was selected to conduct the analysis. Taking into account the patient's gradual adaptation to CPAP therapy
306 and the subsequent improvement of his pathological condition, the patient was also evaluated at a reduced
307 respiratory rate (20 breaths/min) (defined as C.4d). This case permitted to assess the effect of different
308 respiratory rates on oscillation attenuation.

309 2.4.3 Ventilation circuit resistance

310 During ventilation, the patient needs to overcome the additional resistances introduced by the ventilation
311 circuit to breathe effectively. When this doesn't occur, patients may be unable to complete the breathing
312 cycle, resulting in air retention in the lungs. This condition causes a reduction in tidal volume and the
313 generation of PEEPi and is more common in patients with a high respiratory rate [42]. These two
314 parameters were used to quantify the negative impact of the ventilation circuit on the patient's breathing.
315 Specifically, to explore tidal volume reduction, the turbine (block 3, Figure 2) was deactivated. This allowed
316 the evaluation of patient's lung volume without the beneficial effect of CPAP therapy, which helps
317 recruiting collapsed alveoli. Hence, different ventilation circuits were created to quantify the impact of their
318 configuration (in terms of number of components and their arrangements) on patients' tidal volume and
319 end-expiratory alveolar pressure during NIV-CPAP treatment. Table 4 summarizes the studied circuit
320 configurations.

321 *Table 4: Ventilation circuit configurations analyzed within the multidomain OD model.*

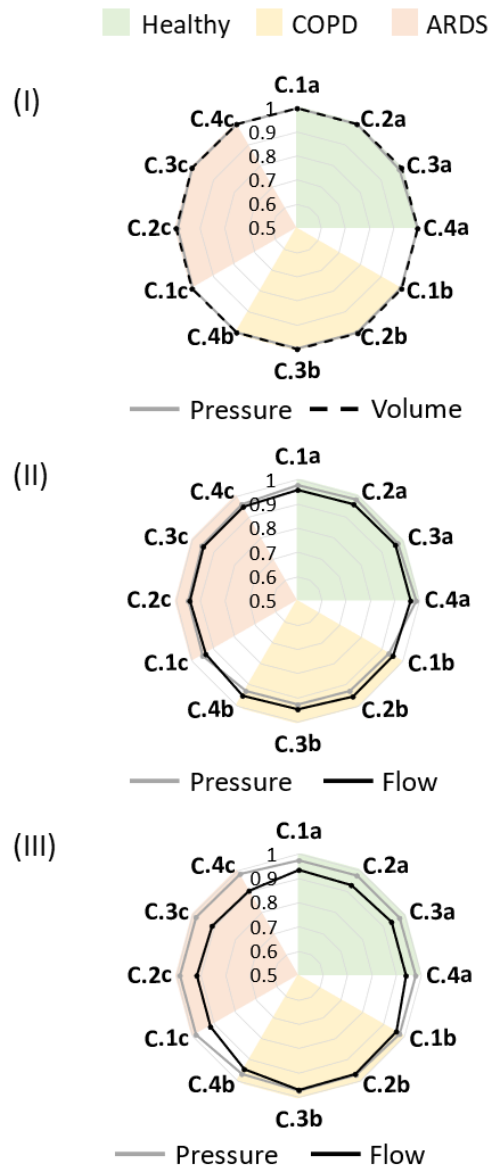
| ID* | Description |
|------|---|
| CC | Patient spontaneously breathing without the ventilation circuit (Control Case) |
| VC | The starting ventilation circuit, as described in section 2.2 |
| VCti | The length of the pipe in the inspiratory limb has been doubled to allow for device placement on one side of the patient. |

| | |
|----------|---|
| VCte | The length of the pipe in the expiratory limb has been doubled to allow for device placement on one side of the patient. |
| VCtei | The length of the pipe in both limbs has been doubled to allow for device placement on both sides of the patient. |
| VCfi | An additional antiviral filter has been inserted into the inspiratory limb to enhance viral isolation of the device. |
| VCfe | An additional antiviral filter has been inserted into the expiratory limb to enhance viral isolation of the device. |
| VCfei | Additional antiviral filters have been inserted in both limbs to enhance viral isolation of the device. |
| VCteifei | The length of the pipe in both limbs has been doubled to allow for device placement on both sides of the patient, and additional antiviral filters have been inserted in both limbs to enhance viral isolation of the device. |
| VCtife | The balanced ventilation circuit, characterized by a doubled length of the pipe in the inspiratory limb and an additional antiviral filter in the expiratory limb. |

322 * CC: Control Case; VC: Ventilation Circuit; t: doubled tubing length; f: doubled filters; i: inspiratory limb; e: expiratory limb

323 3 Results

324 The 3-stages validation of the multidomain OD model resulted in optimal consistency with *in vitro* tests.
325 Regarding the validation of the passive behavior of the patient (Figure 6a), the correlation coefficient R^2
326 values are nearly 1 for all the twelve cases, indicating a high degree of overlap between *in silico* and *in vitro*
327 results. The second stage addressed the model validation in spontaneous breathing, which suggests strong
328 reliability with R^2 coefficient values exceeding 0.93 for the alveolar pressures and 0.94 for the flows passing
329 through the patient's airway (Figure 6b). Connecting the spontaneously breathing patient to the ventilation
330 circuit (Figure 6c) remarkable good performances in computing flows ($R^2 = 0.90$), and pressure ($R^2 = 0.97$)
331 were obtained.



332

333 *Figure 6. R^2 results for the 3-stages validation of the multidomain OD model. (I) stage: Validation of the patients'*
 334 *passive behavior; (II) stage: Validation of the active patient during spontaneous breathing; (III) stage: Validation of*
 335 *the active patient breathing in the ventilation circuit. Detailed results are described in the Supplementary Materials.*

336 Table 5 lists the static pressures calculated at the interface varying the extent of leakage at the patient
 337 interface. It can be observed that a greater degree of leakage results in a more substantial reduction of the
 338 positive pressure at the interface: approximately 1%, 3%, and 6%, for low, moderate, and marked leak
 339 respectively. In terms of percentages, there is no apparent correlation between the pressure decrease and
 340 the set pressure value. However, in absolute terms, the most significant reduction, approximately 1 cmH₂O,
 341 occurs when the CPAP level is set at 15 cmH₂O and there is marked leak at the interface.

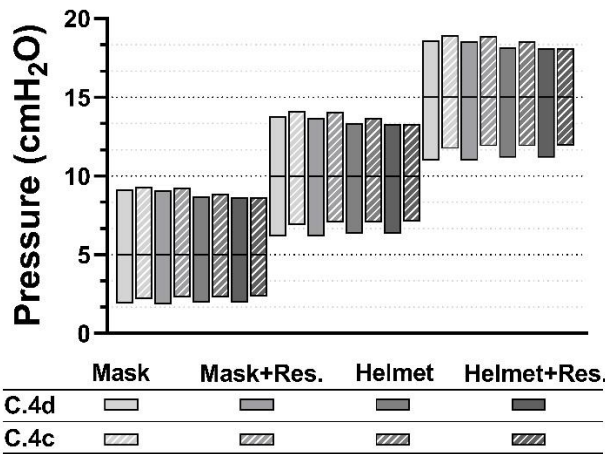
342

343 *Table 5. Static pressures calculated at the interface (cmH₂O) under varying interface leakage conditions.*

344

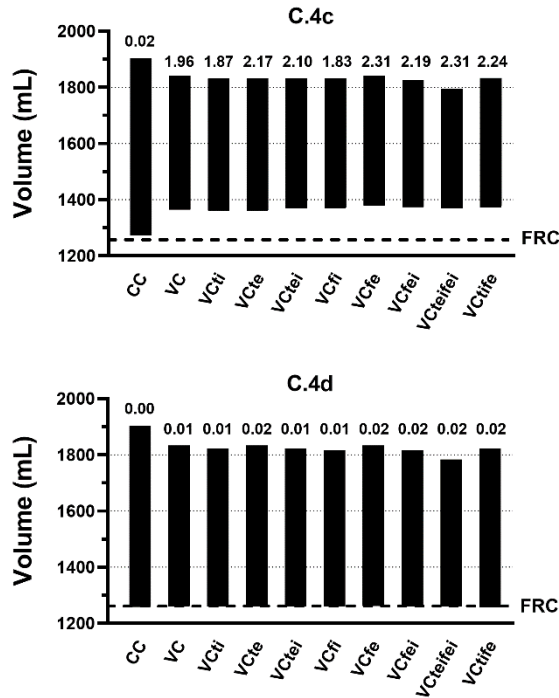
| | Low leak | Moderate leak | Marked leak |
|--------------------------------|----------|---------------|-------------|
| 345 5 cmH₂O | 4.96 | 4.83 | 4.68 |
| 10 cmH₂O | 9.92 | 9.67 | 9.38 |
| 346 15 cmH₂O | 14.89 | 14.52 | 14.07 |

347 Concerning the effect of the air volume accommodated within the circuit, Figure 7 shows that the use of
 348 the helmet interface reduces pressure oscillations by approximately 8% with respect to the total-face mask
 349 in both cases C.4c and C.4d. Furthermore, the addition of reservoirs to the limbs of the ventilation circuit
 350 allows a reduction of the oscillations by about 3% with the mask and approximately 6% with the helmet for
 351 C.4c, and about 1% with both interfaces for C.4d. Also, these outcomes don't exhibit a dependency on the
 352 set CPAP level. Moreover, Figure 7 confirms the influence of the breathing rate on pressure oscillations: the
 353 higher the patient's breathing rate, the more the oscillations are attenuated.



354
 355 *Figure 7. Pressure fluctuations in the presence of different interface volumes (i.e., mask or helmet) and with or without*
 356 *the addition of reservoirs. The results represent the range between the minimum and maximum pressures reached*
 357 *during patient breathing at both 28 breaths/min (C.4c, patterned filled bars) and at 20 breaths/min (C.4d, uniform*
 358 *filled bars).*

359



360

361 *Figure 8. Range between the minimum and maximum volume reached during patient breathing at both 28*
 362 *breaths/min (C.4c, top bar plot) and at 20 breaths/min (C.4d, bottom bar plot) and PEEPi (numeric values above bars,*
 363 *cmH₂O) for the nine ventilation circuit configurations analyzed within the multidomain OD model.*

364 Finally, Figure 8 illustrates the resistive effect of the circuit configurations on the patient's breathing. When
 365 connected to the therapy device, indeed, the respiratory muscles must overcome both airway and
 366 ventilation circuit resistances. In all the configurations proposed, a significant reduction in tidal volume (bar
 367 length) can be observed, averaging around 15% for case C.4c and around 28% for case C.4d. The decrease
 368 in tidal volume can be attributed to two aspects: the reduction of the lung volume at the end of the
 369 inspiratory phase (maximum bars value in figure) and the increase of the lung volume at the end of the
 370 expiratory phase (minimum bars value in figure). The first one can be primarily attributed to the delayed
 371 entry of air into the alveoli due to increased resistances met by the patient's inspiration. Consequently, the
 372 expiratory phase begins before the inspiratory phase has completed alveolar filling. The second one is
 373 related to a certain amount of air being trapped inside the lung at the end of the expiratory phase,
 374 maintaining positive alveolar pressure (PEEPi). In case C.4d, this second aspect is negligible, with associated
 375 PEEPi values ranging from 0.01 to 0.02 cmH₂O. Conversely, in case C.4c, the patient already exhibited a
 376 minimal PEEPi of 0.02 cmH₂O during spontaneous breathing, and the connection to the ventilation circuit
 377 produces a substantial PEEPi of approximately 2 cmH₂O, which varies based on the specific configuration
 378 under consideration. As a result of heightened resistance encountered during the patient's exhalation, the
 379 high respiratory rate of this patient triggers the initiation of the inspiratory phase before the expiratory
 380 phase is fully completed.

381 Additionally, comparing the circuit configurations, an increase in PEEPi can be observed in configurations
 382 with greater resistance in the expiratory limb (VCte, VCtei, VCfe, VCfei), while the circuit configuration has a
 383 minimal influence on the reduction of tidal volume, with a maximum variation of 23 ml. In particular, a
 384 lower PEEPi value is observed in configurations with higher resistance in both limbs (VCtei, VCfei) compared
 385 to configurations with higher resistance only in the expiratory limb (VCte, VCfe), despite having more
 386 overall resistances in the circuit. On the other hand, the VCtetfei configuration stands out as an exception,
 387 showing a more significant reduction in tidal volume, approximately 40 ml for both patients, and a PEEPi of
 388 2.31 cmH₂O for case C.4c, due to a more pronounced increase in resistances within the circuit. These

389 findings highlight the advantage of balancing the resistances between the limbs but increasing the
390 resistances in the circuit only where necessary.

391 4. Discussion

392 In the present study, a multidomain OD model capable of predicting the pneumatic behavior of a closed-
393 loop NIV-CPAP ventilation device was developed and validated through experimentally obtained data. In
394 order to validate the model, the simulation results, in terms of pressures, volumes, and flows, were
395 compared with in vitro tests conducted using a lung simulator, and optimal agreement was achieved
396 between the in silico prediction and simulator outputs, quantified through curve similarity (R^2).

397 A OD in silico model has been employed in numerous studies to investigate the impact of MV on simulated
398 patients [20–26]. In four publications [20–23] various ventilation modes were simulated and their control
399 algorithms were investigated; however, only the pressure exerted by the ventilator on the patient was
400 replicated. In other three publications [24–26], instead, the pneumatic circuit of the ventilator was also
401 considered, focusing on IMV provided in pressure-controlled continuous mandatory ventilation or volume-
402 controlled continuous mandatory ventilation modes. In this work, a ventilation system for NIV-CPAP
403 applied to spontaneously breathing patients was considered. In order to accurately simulate patients
404 treated in NIV-CPAP mode, a novel sigmoidal model of lung compliance and a non-sinusoidal respiratory
405 muscle pressure curve were employed. Results showed that this strategy permitted the successful
406 description of patients with different lung compliances and airway resistances spanning various respiratory
407 conditions that can be treated with CPAP therapy. To the best of the authors' knowledge, there are
408 currently no tools available in literature that facilitate the investigation and optimization of non-invasive
409 ventilation systems. Indeed, this study introduces the first mathematical model designed to simulate the
410 performance of a ventilation system with a spontaneously breathing patient.

411 Regarding the study of the identified design requirements of the device, the impact of interface leakage on
412 the delivered therapeutic static pressure resulted in acceptable reductions, even under conditions of
413 marked leak (approximately 6% reduction), with air leaks of almost 30 L/min [43]. Therefore, this result
414 supports the possibility of adopting interfaces that typically show significant leaks (e.g., oro-nasal or full-
415 face masks) with the device. Any potential increase in leakage effects observed in future clinical
416 experiments could possibly be mitigated by relocating the pressure sensor used in the turbine control
417 algorithm to the patient interface. This adjustment would allow the turbine to directly regulate the
418 pressure at the interface, effectively compensating for leakage effects. The increase in air volume within
419 the circuit, analyzed by changing the interface (replacing the mask with a helmet) and adding reservoirs to
420 the inspiratory and expiratory limbs, resulted in a higher reduction in pressure oscillations with the increase
421 of the patient breathing rate. This phenomenon can be explained by the capacitive behavior of the air that
422 accumulates within the interface and the reservoirs. Indeed, the air compressibility attenuates the pressure
423 oscillations, acting as a low-pass filter with respect to pressure. However, the reduction was evaluated as
424 negligible, and therefore it was decided to remove the reservoirs, which had the added benefit of reducing
425 the size of the ventilation circuit with positive implications for the patient's comfort and usability.

426 The investigation of the impact of circuit components resistance on the patient's spontaneous breathing
427 revealed that the mere introduction of a ventilation circuit induced the generation of PEEPi, which
428 increased with higher respiratory rate. It's crucial to highlight that the results and observations are
429 intricately tied to the respiratory muscle pressure curve (Figure 5), pointing out the importance of adopting
430 a more realistic non-sinusoidal profile. During NIV-CPAP therapy, inspiratory effort plays a crucial role in
431 investigating the risk of self-inflicted lung injury [44,45]. Specifically, in Menga et al. [44], pressure swings
432 were analyzed in fifteen hypoxemic patients treated with CPAP, yielding an average esophageal pressure
433 variation of 13 cmH₂O and a transpulmonary pressure variation of 12 cmH₂O. These results align with the

434 peak of the muscular effort curve reported in Figure 5 (12 mbar, approximately 12.24 cmH₂O). Increasing
435 resistances in the inspiratory and expiratory limbs resulted in minimal additional impairments in the
436 simulated patient's lung ventilation. However, the generation of a lower PEEPi was observed when
437 balancing the resistances between the limbs, leading to the selection of an optimized configuration (VCTife).
438 This configuration included doubling the length of the tubes in the inspiratory limb to allow for device
439 placement beside the patient and easy interface connection, as well as adding a second antiviral filter in the
440 expiratory limb to enhance viral isolation of the device from the patient's expired gases.

441 The use of a 0D model for the respiratory system, which lacks the description of the bronchial tree's
442 geometry, does not allow for the investigation of localized effects of ventilation in various lung segments. In
443 the literature, several 3D models are available that take into account lung geometry obtained from CT-scan
444 imaging [46–51]. However, the use of lumped elements ensures high computational-cost efficacy, with at
445 most 2 seconds per simulated second of breathing. As an additional limitation of the model, the
446 deformability of the reservoir walls was not simulated. Introducing reservoir compliance would complicate
447 the model and significantly increase computation times, negating the advantages of using the lumped
448 parameters described above. Furthermore, the model provides an analysis from a pneumatic perspective
449 and does not simulate metabolism or gas exchange in the alveoli, thus not accounting for the therapeutic
450 effect of oxygen supply. Future developments will focus on studying oxygen supply and blood oxygenation
451 through the creation of a cardiopulmonary model of the patient [52–56]. The study conducted in this work
452 presents some limitations. Firstly, it is confined to a limited number of patients and is restricted to an adult
453 population. The range of tidal volumes, compliance, inspiratory effort and pressure swings analyzed does
454 not encompass the full spectrum of clinical conditions typically encountered in intensive care units (e.g.,
455 neonatal application [57–60]). Secondly, the study focuses solely on evaluating the performance of the
456 ventilation circuit proposed in [18], without comparing it to other devices commonly used in clinical
457 practice for CPAP therapy delivery [61]. Despite these limitations, the use of lumped elements offers the
458 flexibility in easily modifying circuit components, making it possible to adapt the model to various non-
459 invasive ventilation systems and patient parameters. This adaptability broadens the model's applicability to
460 a wider range of patients. Consequently, the proposed multidomain 0D model demonstrates strong
461 reliability for future applications, providing valuable insights on the delivery of the ventilation therapy and
462 the impact of circuit components on device performance.

463 5. Conclusion

464 The multidomain 0D model developed in this study demonstrated its capability to accurately replicate
465 different patients during spontaneous breathing. In addition, this tool solved the equation of motion of the
466 respiratory system, analyzing the synergistic impact of both the patient's muscular effort and the positive
467 pressure delivered by a NIV system on the lung. This analysis allowed to investigate the impact of circuit
468 components arrangements on the efficacy of CPAP administration (i.e., interface leakage, air volume within
469 the circuit, components resistance) using a novel closed ventilation circuit. Moreover, the strong
470 agreement between the *in silico* and *in vitro* data, indicated the accuracy and reliability of adopting the
471 multidomain 0D modelling approach. In conclusion, this model demonstrated its effectiveness as a valuable
472 tool for guiding the design of an innovative device, and the optimization of non-invasive ventilation circuits,
473 with high computational efficiency, flexibility, and reliability.

474 Data availability

475 The majority of the data generated and analyzed during this study is included in the published article and
476 its supplementary file. Any additional data is available from the corresponding author upon reasonable
477 request.

478 Acknowledgements

479 This publication is part of the project NODES which has received funding from the MUR – M4C2 1.5 of PNRR
480 funded by the European Union - NextGenerationEU (Grant agreement no. ECS00000036). The author MDL
481 is supported under Ministerial Decree No. 1061/2021 within the framework of the FSE REACT-EU program -
482 PON Research and Innovation 2014-2020. The author GP is supported under Ministerial Decree No.
483 1062/2021 within the framework of the FSE REACT-EU program - PON Research and Innovation 2014-2020.
484 The author RV is (partially) supported by the Italian Ministry of University and Research (MUR) program
485 "Departments of Excellence 2023–2027", AGING Project – Department of Translational Medicine,
486 Università del Piemonte Orientale.

487 Declaration of interests

488 All Authors except CO and RV declare that they have no known competing financial interests or personal
489 relationships that could have appeared to influence the work reported in this paper. CO participated to the
490 development of an interface for NIV, and receives royalties from Intersurgical SpA for that invention. RV
491 received honorarium for lecture from Intersurgical (2021).

492 Author contributions

493 AF: Conceptualization, Methodology, Writing - Original Draft. MDL: Validation, Investigation. SB:
494 Visualization, Writing - Original Draft. GP: Conceptualization, Formal analysis. NDV: Investigation, Writing -
495 Review & Editing, FM: Investigation, Writing - Review & Editing, FDC: Resources, Writing - Review & Editing,
496 RV: Resources, Writing - Review & Editing. ALA: Project administration, Funding acquisition. CO:
497 Conceptualization, Writing - review & editing. MT: Supervision, Visualization, Writing - review & editing.

498 References

- 499 [1] T. Pham, L.J. Brochard, A.S. Slutsky, Mechanical Ventilation: State of the Art, *Mayo Clin. Proc.* 92
500 (2017) 1382–1400. <https://doi.org/10.1016/j.mayocp.2017.05.004>.
- 501 [2] T.C. Hardcastle, D.J.J. Muckart, R.V. Maier, Ventilation in Trauma Patients: The First 24 h is
502 Different!, *World J. Surg.* 41 (2017) 1153–1158. <https://doi.org/10.1007/s00268-016-3530-1>.
- 503 [3] K. Asehnoune, P. Rooze, C. Robba, M. Bouras, L. Mascia, R. Cinotti, P. Pelosi, A. Roquilly, Mechanical
504 ventilation in patients with acute brain injury: a systematic review with meta-analysis, *Crit. Care* 27 (2023)
505 221. <https://doi.org/10.1186/s13054-023-04509-3>.
- 506 [4] N. Farzan, S. Vahabi, S.S. Hashemi Madani, B. Farzan, Evaluating characteristics associated with the
507 mortality among invasive ventilation COVID-19 patients, *Ann. Med. Surg.* 69 (2021).
508 <https://doi.org/10.1016/j.amsu.2021.102832>.
- 509 [5] A. Zhou, Q. Song, Y. Peng, D. Deng, X. Liao, P. Huang, W. Liu, Z. Xiang, Q. Liu, M. Jiang, X. Huang, X.
510 Xiang, H. Peng, P. Chen, The Effect of Noninvasive Ventilation Support on COVID-19 Patients and Risk
511 Factors for Invasive Ventilation – A Retrospective and Multicenter Study, *Int. J. Gen. Med.* Volume 14
512 (2021) 6085–6092. <https://doi.org/10.2147/IJGM.S327429>.
- 513 [6] M.C. Chang, T.U. Kim, D. Park, National early warning score on admission as risk factor for invasive
514 mechanical ventilation in COVID-19 patients: A STROBE-compliant study, *Medicine (Baltimore)* 100 (2021)
515 e25917. <https://doi.org/10.1097/MD.00000000000025917>.

- 516 [7] M.C. Chang, Y.-K. Park, B.-O. Kim, D. Park, Risk factors for disease progression in COVID-19 patients,
517 *BMC Infect. Dis.* 20 (2020) 445. <https://doi.org/10.1186/s12879-020-05144-x>.
- 518 [8] J.A. Garcia-Gordillo, A. Camiro-Zúñiga, M. Aguilar-Soto, D. Cuenca, A. Cadena-Fernández, L.S.
519 Khouri, J.N. Rayek, M. Mercado, The ARMII Study Group, COVID-IRS: A novel predictive score for risk of
520 invasive mechanical ventilation in patients with COVID-19, *PLOS ONE* 16 (2021) e0248357.
521 <https://doi.org/10.1371/journal.pone.0248357>.
- 522 [9] A.G.B. Broadhurst, C. Botha, G. Calligaro, C. Lee, U. Lalla, C.F.N. Koegelenberg, P.D. Gopalan, I.A.
523 Joubert, G.A. Richards, B.W. Allwood, The optimal management of the patient with COVID-19 pneumonia:
524 HFNC, NIV/CPAP or mechanical ventilation?, *Afr. J. Thorac. Crit. Care Med.* (2022) 119–128.
525 <https://doi.org/10.7196/AJTCCM.2022.v28i3.241>.
- 526 [10] L. Brochard, A. Slutsky, A. Pesenti, Mechanical Ventilation to Minimize Progression of Lung Injury in
527 Acute Respiratory Failure, *Am. J. Respir. Crit. Care Med.* 195 (2017) 438–442.
528 <https://doi.org/10.1164/rccm.201605-1081cp>.
- 529 [11] International Consensus Conferences in Intensive Care Medicine: Noninvasive Positive Pressure
530 Ventilation in Acute Respiratory Failure, 163 (2001).
- 531 [12] P. Popowicz, K. Leonard, Noninvasive Ventilation and Oxygenation Strategies, *Surg. Clin. North Am.*
532 102 (2022) 149–157. <https://doi.org/10.1016/j.suc.2021.09.012>.
- 533 [13] Z. Wang, Y. Wang, Z. Yang, H. Wu, J. Liang, H. Liang, H. Lin, R. Chen, Y. Ou, F. Wang, Y. Wang, Y.
534 Wang, W. Luo, N. Li, Z. Li, J. Xie, M. Jiang, S. Li, The use of non-invasive ventilation in COVID-19: A
535 systematic review, *Int. J. Infect. Dis.* 106 (2021) 254–261. <https://doi.org/10.1016/j.ijid.2021.03.078>.
- 536 [14] D.L. Grieco, S.M. Maggiore, O. Roca, E. Spinelli, B.K. Patel, A.W. Thille, C.S.V. Barbas, M.G. De Acilu,
537 S.L. Cutuli, F. Bongiovanni, M. Amato, J.-P. Frat, T. Mauri, J.P. Kress, J. Mancebo, M. Antonelli, Non-invasive
538 ventilatory support and high-flow nasal oxygen as first-line treatment of acute hypoxemic respiratory
539 failure and ARDS, *Intensive Care Med.* 47 (2021) 851–866. <https://doi.org/10.1007/s00134-021-06459-2>.
- 540 [15] A. Pagano, G. Porta, G. Bosso, E. Allegorico, C. Serra, F. Dello Vicario, V. Minerva, T. Russo, C.
541 Altruda, P. Arbo, V. Mercurio, F.G. Numis, Non-invasive CPAP in mild and moderate ARDS secondary to
542 SARS-CoV-2, *Respir. Physiol. Neurobiol.* 280 (2020) 103489. <https://doi.org/10.1016/j.resp.2020.103489>.
- 543 [16] G.D. Perkins, C. Ji, B.A. Connolly, K. Couper, R. Lall, J.K. Baillie, J.M. Bradley, P. Dark, C. Dave, A. De
544 Soyza, A.V. Dennis, A. Devrell, S. Fairbairn, H. Ghani, E.A. Gorman, C.A. Green, N. Hart, S.W. Hee, Z. Kimbley,
545 S. Madathil, N. McGowan, B. Messer, J. Naisbitt, C. Norman, D. Parekh, E.M. Parkin, J. Patel, S.E. Regan, C.
546 Ross, A.J. Rostron, M. Saim, A.K. Simonds, E. Skilton, N. Stallard, M. Steiner, R. Vancheeswaran, J. Yeung,
547 D.F. McAuley, RECOVERY-RS Collaborators, N. Duffy, M. Kelly, D. Concannon, K. Ferguson, D. McClintock, R.
548 Jha, V. Krishnamurthy, S. O'Farrell, C. O'Kane, C. Ross, R.D. Turner, S. Miodragovic, P. Hawkins, J.
549 Welbourne, C. Wells, L. Lankester, S.D. Waddy, J. Lentaigne, J. Nesbitt, S. Clarke, C. Houghton, D. O'Riordan,
550 K. Shepherd, B. Turnpenny, R. Joseph, M. Steiner, C. Rossall, R. Munding, S. Boschi, H.J.C. McAuley, R.J.
551 Russell, S. Diver, O. Elneima, W. Ibrahim, A. Yousuf, S. Edwards, M. Saim, B. Hopkins, L. Kelly, D. Lenton, H.
552 Shackelford, L. Thrasyvoulou, H. Willis, S. Fairbairn, C. Green, M. Patel, L. Linhartova, E. Hayton, A. Chue, B.
553 Collins, M. Page, E. Birkhamshaw, M. Bellamy, H. Bancroft, E. Gallagher, P. Antoine-Pitterson, B. Jones, S.
554 Begum, S. Dhani, M. Crooks, K. Brindle, S. Faruqi, R. Flockton, E. Pinder, S. Thackray-Nocera, K. Dalemo, J.
555 Doidge, J. Edwards, J. Douse, S. Bell, B. Purewal, C. Chabo, C. Buckman, D. Beeby, G. Gray, R. Francis, V.
556 Rivers, M. Burton, N. Innes, S. Ghattas, R. Rabbani, V. Mahadevan, V. Mahadevan, A. Green, B. Burton, C.
557 Hacon, E. Wilhelmsen, P.R. Hughes, K. Lee, R. Lowsby, L. Baker, P. Board, V. Chauhan, S. Clarke, D. Fullerton,
558 C. Gabriel, T. Houston, D. Lees, R. Normanton, K. Pagett, S. Thornley, H. Wright, A. McMillan, M. Babores, X.
559 Lee, T. Nagarajan, M. Holland, T. Sanctuary, R. Innes, S. Fletcher, N. Sehgal, T. Duncan, J. Pooley, E. Watkins,

560 H. Moudgil, M. Carnahan, D. Donaldson, D. Rao, C.L. Tey, L. Linkson, T. Buttle, J. Vidler, N. Griffiths, A. Hicks,
561 H. Rupani, A. Alfridi, D. Barns, E. Cowan, M. David, A. Darbyshire, B. Giles, C. Roberts, C. Lameirinhas, D.
562 Neville, E. Hossain, F. Thompson, H. Edwards, J. Naftel, J. Winter, K. Burrows, L. Wiffen, L. Fox, L. Murray, L.
563 Hawes, M. Mamman, M. Moon, M. White, M. Rowley, N. Szarazova, S. Gosling, S. Cooper, S. Baryschpolec,
564 S. Arndtz, Y. H-Davies, Y.A. El Khaleq, Z. Garner, S. Vythilingam, Y. Yang, D. Parekh, S. Madathil, J. Patel, C.
565 Bergin, M. Bates, C. McGhee, D. Lynch, K. Bhandal, K. Tsakiridou, A. Bamford, L. Cooper, T. Whitehouse, T.
566 Veenith, E. Forster, S. Lane, N. Adams, S. MacDonald, S. Manan, S. Lugg, P.A. Shah, E. McKemey, L. Crowley,
567 G. Mussawar, A. Gogokhia, S. Gompertz, C. Snelson, T. Oelofse, J. Wilson, M. Bangash, S.S. Huq, F. Rauf, D.
568 Dosanjh, N. Salmon, J. Tengende, K.F. Senior, B. Cooper, B. Sutton, I. Woolhouse, A. Crawshaw, R.
569 Thompson, P. Glynn, J. Naylor, J. Alderman, M. Chotalia, M. Le Breuilly, N. Talbot, G. Packer, C. Carlin, D.
570 Harvey, A. Gray, M. Gautam, I. Welters, D.O. Hamilton, H. Burhan, K. Hunter, B. Johnston, M. Lopez, C.
571 Lowe, S. Mulla, J.F. Roman, D. Shaw, A. Waite, V. Waugh, K. Williams, A.K. Simonds, K.C. Tatham, E. Black, S.
572 Jhanji, G. Ng Man Kwong, B. Messer, A. De-Soyza, P. McAlinden, S.D. West, V. Anumakonda, P. Dark, L.
573 McMorrow, T. Marsden, N. Proudfoot, B. Charles, J. Pendlebury, B. Blackledge, A. Harvey, K. Knowles, R.
574 Doonan, S. Lee, J. Perez, M. Slaughter, M. Taylor, V. Thomas, E. Hardy, N. Bakerly, L. Catlow, N. Majeed, D.
575 Horner, L. Ali, D. Hutchinson, L. Fuller, J. Dodd, R. Bhatnagar, A. Clive, H. Adamali, A. Bibby, D. Higbee, H.
576 Welch, E. Gendall, L. Staddon, A. Morley, S. Clarke, K. Smith, E. Perry, N. Rippon, L. Jennings, L. Solomon, K.
577 Alloway, H. Lee, V. Sandrey, K. Bradburn, A. Milne, E. Goff, R. Williams, M. Ahmed, S. Bloch, A. Zaki, A. Roy,
578 A. Rostron, L. Woods, F. Wakinshaw, P. Bainbridge, P. Hersey, M. Carpenter, C. Leech, L. O'Connor, A.
579 Morrison, E. Rodgers, P. McAndrew, G. Lear, J. Coates, M. Richardson, D. Smith, W. Green, S. Murray, C.
580 Pennington, H. De Wong, D. Land, H. Wheeler, M. Harvey, M. Watson, M. Brown, B. Irving, J. Bigg, M.
581 Felongco, J. Mackenzie, D. Dhasmana, R. Thompson, P. Lui, F. Adam, F. Davey, J. Penman, A. McGregor, P.
582 Cochrane, K. Shalan, W. Bozic, J. Brown, J. Carey, C. Daffern, E. Dight, M. Gane, B. Ghuman, J. Grummett, J.
583 Guck, L. Hamilton, C. Hill, M. Hill, C. Muthiah, E. Padfield, J. Rai, K. Raynes, G. Scott, E. Stimpson, N.
584 Strickland, A. Willis, J. Wood, B. Attwood, I. Atwal, P. Parsons, R. Vancheeswaran, S. Konda, Y.M.M. Myint,
585 M. Mehta, A. Muhammad, A. Navarro, A. Rochester, S. Sundayi, M. Patel, A. Smith, C. Stewart, M. Tate, E.
586 McGarry, C. (Rebecca) Pearson, B. Walsh, L. Glass, K. Black, S. Clements, R. Boyle, C. MacDonald, L.
587 Hamilton, G. Moreland, R. Hamill, H. Reddy, S. Smuts, A. Bentley, Effect of Noninvasive Respiratory
588 Strategies on Intubation or Mortality Among Patients With Acute Hypoxemic Respiratory Failure and
589 COVID-19: The RECOVERY-RS Randomized Clinical Trial, *JAMA* 327 (2022) 546.
590 <https://doi.org/10.1001/jama.2022.0028>.

591 [17] G. Bellani, S. Isgro, R. Fumagalli, Helmet Continuous Positive Airway Pressure: Theory and
592 Technology, in: A.M. Esquinas (Ed.), *Noninvasive Mech. Vent.*, Springer Berlin Heidelberg, Berlin,
593 Heidelberg, 2010: pp. 7–12. https://doi.org/10.1007/978-3-642-11365-9_2.

594 [18] M. Cavaglia, C. Olivieri, U. Morbiducci, T. Raparelli, G. Jacazio, A. Ivanov, A. Chiesa, D. Savino, S.M.
595 Chiarenza, A. Romiti, A. Romiti, M. Ferrara, G. Musso, A. Audenino, Noninvasive mechanical ventilation in
596 the COVID-19 era: Proposal for a continuous positive airway pressure closed-loop circuit minimizing air
597 contamination, oxygen consumption, and noise, *Artif. Organs* 45 (2021) 754–761.
598 <https://doi.org/10.1111/aor.13888>.

599 [19] A. Audenino, T. Raparelli, U. Morbiducci, M. Cavaglia, A. Ivanov, A. Romiti, A. Romiti, M. Ferrara, A.
600 Chiesa, CPAP kit to support breathing, Patent cooperation treaty (2022), WO2022079642A1.

601 [20] N.Q. Al-Naggar, H.Y. Al-Hetari, F.M. Al-Akwaa, Simulation of Mathematical Model for Lung and
602 Mechanical Ventilation, *J. Sci. Technol.* 21 (2016) 1–9. <https://doi.org/10.20428/jst.v21i1.1017>.

603 [21] E. Dincel, Advanced mechanical ventilation modes: design and computer simulations, *Comput.*
604 *Methods Biomech. Biomed. Engin.* 24 (2021) 673–686. <https://doi.org/10.1080/10255842.2020.1845319>.

- 605 [22] L.Y. Serna, A.M. Hernandez, M.A. Mañanas, Computational tool for modeling and simulation of
606 mechanically ventilated patients, in: 2010 Annu. Int. Conf. IEEE Eng. Med. Biol., IEEE, Buenos Aires, 2010:
607 pp. 569–572. <https://doi.org/10.1109/IEMBS.2010.5626429>.
- 608 [23] A.S. Tran, H.Q. Thinh Ngo, V.K. Dong, A.H. Vo, Design, Control, Modeling, and Simulation of
609 Mechanical Ventilator for Respiratory Support, *Math. Probl. Eng.* 2021 (2021) 1–15.
610 <https://doi.org/10.1155/2021/2499804>.
- 611 [24] J. Giri, N. Kshirsagar, A. Wanjari, Design and simulation of AI-based low-cost mechanical ventilator:
612 An approach, *Mater. Today Proc.* 47 (2021) 5886–5891. <https://doi.org/10.1016/j.matpr.2021.04.369>.
- 613 [25] P. Tamburrano, P. De Palma, A.R. Plummer, E. Distaso, R. Amirante, Simulink Modelling For
614 Simulating Intensive Care Mechanical Ventilators, *E3S Web Conf.* 197 (2020) 07007.
615 <https://doi.org/10.1051/e3sconf/202019707007>.
- 616 [26] P. Tamburrano, F. Sciatti, E. Distaso, L. Di Lorenzo, R. Amirante, Validation of a Simulink Model for
617 Simulating the Two Typical Controlled Ventilation Modes of Intensive Care Units Mechanical Ventilators,
618 *Appl. Sci.* 12 (2022) 2057. <https://doi.org/10.3390/app12042057>.
- 619 [27] B. Diong, J. Grainger, M. Goldman, H. Nazeran, A comparison of linear respiratory system models
620 based on parameter estimates from PRN forced oscillation data, in: 2009 Annu. Int. Conf. IEEE Eng. Med.
621 Biol. Soc., IEEE, Minneapolis, MN, 2009: pp. 2879–2882. <https://doi.org/10.1109/IEMBS.2009.5333109>.
- 622 [28] T. Woo, B. Diong, L. Mansfield, M. Goldman, P. Nava, H. Nazeran, A Comparison of Various
623 Respiratory System Models Based on Parameter Estimates From Impulse Oscillometry Data, in: 26th Annu.
624 Int. Conf. IEEE Eng. Med. Biol. Soc., IEEE, San Francisco, CA, USA, 2004: pp. 3828–3831.
625 <https://doi.org/10.1109/IEMBS.2004.1404072>.
- 626 [29] S. Baswa, H. Nazeran, P. Nava, B. Diong, M. Goldman, Evaluation of Respiratory System Models
627 Based on Parameter Estimates from Impulse Oscillometry Data, in: 2005 IEEE Eng. Med. Biol. 27th Annu.
628 Conf., IEEE, Shanghai, China, 2005: pp. 2958–2961. <https://doi.org/10.1109/IEMBS.2005.1617094>.
- 629 [30] E. Saatci, E. Saatci, A. Akan, Analysis of linear lung models based on state-space models, *Comput.*
630 *Methods Programs Biomed.* 183 (2020) 105094. <https://doi.org/10.1016/j.cmpb.2019.105094>.
- 631 [31] S.M. Maggiore, J.-C. Richard, L. Brochard, What has been learnt from P/V curves in patients with
632 acute lung injury/acute respiratory distress syndrome, *Eur. Respir. J.* 22 (2003) 22s–26s.
633 <https://doi.org/10.1183/09031936.03.00004204>.
- 634 [32] J.G. Venegas, R.S. Harris, B.A. Simon, A comprehensive equation for the pulmonary pressure-
635 volume curve, *J. Appl. Physiol.* 84 (1998) 389–395. <https://doi.org/10.1152/jappl.1998.84.1.389>.
- 636 [33] J. Masip, A. Mas, Noninvasive ventilation in acute respiratory failure, *Int. J. Chron. Obstruct.*
637 *Pulmon. Dis.* (2014) 837. <https://doi.org/10.2147/COPD.S42664>.
- 638 [34] O. Linares-Perdomo, T.D. East, R. Brower, A.H. Morris, Standardizing Predicted Body Weight
639 Equations for Mechanical Ventilation Tidal Volume Settings, (n.d.).
- 640 [35] J.X. Brunner, G. Wolff, *Pulmonary Function Indices in Critical Care Patients*, Springer Berlin
641 Heidelberg, Berlin, Heidelberg, 1988. <https://doi.org/10.1007/978-3-642-73040-5>.
- 642 [36] J.-M. Arnal, A. Garnerio, M. Saoli, R.L. Chatburn, Parameters for Simulation of Adult Subjects During
643 Mechanical Ventilation, *Respir. Care* 63 (2018) 158–168. <https://doi.org/10.4187/respcare.05775>.
- 644 [37] R.S. Harris, Pressure-Volume Curves of the Respiratory System, *Respir. CARE* 50 (2005).

- 645 [38] G. Servillo, E. De Robertis, S. Maggiore, F. Lemaire, L. Brochard, R. Tufano, The upper inflection
646 point of the pressure-volume curve: Influence of methodology and of different modes of ventilation,
647 *Intensive Care Med.* 28 (2002) 842–849. <https://doi.org/10.1007/s00134-002-1293-7>.
- 648 [39] I.G. Bikker, J. Van Bommel, D. Miranda, J. Bakker, D. Gommers, End-expiratory lung volume during
649 mechanical ventilation: a comparison with reference values and the effect of positive end-expiratory
650 pressure in intensive care unit patients with different lung conditions, *Crit. Care* 12 (2008) R145.
651 <https://doi.org/10.1186/cc7125>.
- 652 [40] J. Ibañez, J.M. Raurich, Normal values of functional residual capacity in the sitting and supine
653 positions, *Intensive Care Med.* 8 (1982) 173–177. <https://doi.org/10.1007/BF01725734>.
- 654 [41] H. Aguirre-Bermeo, M. Turella, M. Bitondo, J. Grandjean, S. Italiano, O. Festa, I. Morán, J. Mancebo,
655 Lung volumes and lung volume recruitment in ARDS: a comparison between supine and prone position,
656 *Ann. Intensive Care* 8 (2018) 25. <https://doi.org/10.1186/s13613-018-0371-0>.
- 657 [42] G. Natalini, D. Tuzzo, A. Rosano, M. Testa, M. Grazioli, V. Pennestrì, G. Amodeo, P.F. Marsilia, A.
658 Tinnirello, F. Berruto, M. Fiorillo, M. Filippini, A. Peratoner, C. Minelli, A. Bernardini, Assessment of Factors
659 Related to Auto-PEEP, *Respir. Care* 61 (2016) 134–141. <https://doi.org/10.4187/respcare.04063>.
- 660 [43] S.B. Montesi, J.P. Bakker, M. Macdonald, L. Hueser, S. Pittman, D.P. White, A. Malhotra, Air Leak
661 during CPAP Titration as a Risk Factor for Central Apnea, *J. Clin. Sleep Med.* 09 (2013) 1187–1191.
662 <https://doi.org/10.5664/jcsm.3166>.
- 663 [44] L.S. Menga, L. Delle Cese, T. Rosà, M. Cesarano, R. Scarascia, T. Michi, D.G. Biasucci, E. Ruggiero,
664 A.M. Dell’Anna, S.L. Cutuli, E.S. Tanzarella, G. Pintaudi, G. De Pascale, C. Sandroni, S.M. Maggiore, D.L.
665 Grieco, M. Antonelli, Respective Effects of Helmet Pressure Support, Continuous Positive Airway Pressure,
666 and Nasal High-Flow in Hypoxemic Respiratory Failure: A Randomized Crossover Clinical Trial, *Am. J. Respir.*
667 *Crit. Care Med.* 207 (2023) 1310–1323. <https://doi.org/10.1164/rccm.202204-0629OC>.
- 668 [45] A. Mocellin, F. Guidotti, S. Rizzato, M. Tacconi, G. Bruzzi, J. Messina, D. Puggioni, A. Patsoura, R.
669 Fantini, L. Tabbì, I. Castaniere, A. Marchioni, E. Clini, R. Tonelli, Monitoring and modulation of respiratory
670 drive in patients with acute hypoxemic respiratory failure in spontaneous breathing, *Intern. Emerg. Med.* 19
671 (2024) 2105–2119. <https://doi.org/10.1007/s11739-024-03715-3>.
- 672 [46] G. Bellani, S. Isgrò, R. Fumagalli, Helmet Continuous Positive Airway Pressure: Theory and
673 Technology, in: A.M. Esquinas (Ed.), *Noninvasive Mech. Vent.*, Springer Berlin Heidelberg, Berlin,
674 Heidelberg, 2010: pp. 7–12. https://doi.org/10.1007/978-3-642-11365-9_2.
- 675 [47] C.J. Roth, T. Becher, I. Frerichs, N. Weiler, W.A. Wall, Coupling of EIT with computational lung
676 modeling for predicting patient-specific ventilatory responses, *J. Appl. Physiol.* 122 (2017) 855–867.
677 <https://doi.org/10.1152/jappphysiol.00236.2016>.
- 678 [48] S. Neelakantan, T. Mukherjee, K. Myers, R. Rizi, R. Avazmohammadi, Physics-informed motion
679 registration of lung parenchyma across static CT images, in: 2024 46th Annu. Int. Conf. IEEE Eng. Med. Biol.
680 Soc. EMBC, IEEE, Orlando, FL, USA, 2024: pp. 1–4. <https://doi.org/10.1109/EMBC53108.2024.10781530>.
- 681 [49] S. Neelakantan, T. Mukherjee, B.J. Smith, K. Myers, R.R. Rizi, R. Avazmohammadi, In-silico CT lung
682 phantom generated from finite-element mesh, in: M.E. Rettmann, J.H. Siewerdsen (Eds.), *Med. Imaging*
683 *2024 Image-Guid. Proced. Robot. Interv. Model.*, SPIE, San Diego, United States, 2024: p. 80.
684 <https://doi.org/10.1117/12.3006973>.

- 685 [50] S. Neelakantan, Y. Xin, D.P. Gaver, M. Cereda, R. Rizi, B.J. Smith, R. Avazmohammadi,
686 Computational lung modelling in respiratory medicine, *J. R. Soc. Interface* 19 (2022) 20220062.
687 <https://doi.org/10.1098/rsif.2022.0062>.
- 688 [51] C. M. Geitner, L. J. Köglmeier, I. Frerichs, P. Langguth, M. Lindner, D. Schädler, N. Weiler, T. Becher,
689 W. A. Wall, Pressure- and time-dependent alveolar recruitment derecruitment in a spatially resolved
690 patient-specific computational model for injured human lungs, *Numer Methods Biomed Eng* (2023).
- 691 [52] M. Cabeleira, D. Anand, S. Ray, C. Black, N. Ovenden, V. Diaz-Zuccarini, Comparing physiological
692 impacts of positive pressure ventilation versus self-breathing via a versatile cardiopulmonary model
693 incorporating a novel alveoli opening mechanism.
- 694 [53] L. D’Orsi, G. Pósfai, A. De Gaetano, A Model of the Maldistribution of Ventilation and Perfusion, in
695 the Lungs of Heart Failure Patients, *Acta Polytech. Hung.* 21 (2024) 147–158.
696 <https://doi.org/10.12700/APH.21.9.2024.9.10>.
- 697 [54] A. Deyranlou, A. Revell, A. Keshmiri, A Coupled Flow-Thermoregulation Lumped Model to
698 Investigate Cardiac Function, (2021). <https://doi.org/10.1101/2021.05.02.442367>.
- 699 [55] C. Ngo, S. Dahlmanns, T. Vollmer, B. Misgeld, S. Leonhardt, An object-oriented computational
700 model to study cardiopulmonary hemodynamic interactions in humans, *Comput. Methods Programs*
701 *Biomed.* 159 (2018) 167–183. <https://doi.org/10.1016/j.cmpb.2018.03.008>.
- 702 [56] A. Tonini, C. Vergara, F. Regazzoni, L. Dede’, R. Scrofani, C. Cogliati, A. Quarteroni, A mathematical
703 model to assess the effects of COVID-19 on the cardiocirculatory system, *Sci. Rep.* 14 (2024) 8304.
704 <https://doi.org/10.1038/s41598-024-58849-3>.
- 705 [57] H. Sterzik, M. Kumpf, C.F. Poets, B. Haase, Simulated model revealed significant continuous positive
706 airway pressure fluctuations with facemasks, *Acta Paediatr.* 113 (2024) 1531–1533.
707 <https://doi.org/10.1111/apa.17244>.
- 708 [58] V. Sartorius, B. Loi, L. Vivalda, G. Regiroli, S. De La Rubia-Ortega, L. Pezza, M. Midevaine, S. Shankar-
709 Aguilera, R. Ben-Ammar, D. De Luca, Effect of different CPAP levels on ultrasound-assessed lung aeration
710 and gas exchange in neonates, *Respir. Res.* 25 (2024) 375. <https://doi.org/10.1186/s12931-024-03010-x>.
- 711 [59] V. Gruber, M.B. Tracy, M.K. Hinder, S. Morakeas, M. Dronavalli, T. Drevhammar, What CPAP to use
712 in the delivery room? Bench comparison of two methods to provide continuous positive airways pressure in
713 neonates, *BMJ Paediatr. Open* 8 (2024) e002948. <https://doi.org/10.1136/bmjpo-2024-002948>.
- 714 [60] C.M. Ní Chathasaigh, E.A. Dunne, L.E. Geraghty, M.C. Murphy, E. O’Curraín, L.K. McCarthy, C.P.F.
715 O’Donnell, Selective or routine face mask application for breathing support of preterm infants at birth: a
716 randomised trial, *Resuscitation* (2024) 110467. <https://doi.org/10.1016/j.resuscitation.2024.110467>.
- 717 [61] J. Helms, P. Catoire, L. Abensur Vuillaume, H. Bannelier, D. Douillet, C. Dupuis, L. Federici, M.
718 Jezequel, M. Jozwiak, K. Kuteifan, G. Labro, G. Latournerie, F. Michelet, X. Monnet, R. Persichini, F. Polge, D.
719 Savary, A. Vromant, I. Adda, S. Hraiech, Oxygen therapy in acute hypoxemic respiratory failure: guidelines
720 from the SRLF-SFMU consensus conference, *Ann. Intensive Care* 14 (2024) 140.
721 <https://doi.org/10.1186/s13613-024-01367-2>.