Non-invasive high-frequency oscillatory ventilation in neonates: review of physiology, biology and clinical data

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ABSTRACT

Non-invasive high-frequency oscillatory ventilation (NHFOV) consists of the application of a bias flow generating a continuous distending positive pressure with superimposed oscillations, which have constant frequency and active expiratory phase. NHFOV matches together the advantages of high-frequency ventilation (no need for synchronisation, high efficacy in removing CO₂ and nasal continuous positive airway pressure (CPAP) (non-invasive interface, increase in functional residual capacity allowing oxygenation to improve). There is enough clinical expertise demonstrating that NHFOV may be tried in some selected cases, in whom CPAP or conventional non-invasive ventilation have failed. Nonetheless, there are no clear data about its clinical usefulness and there is a need for randomised controlled studies. Our purpose is to review the physiology and biological effects of NHFOV, to present the current clinical evidence on its use, to provide some guiding principles to clinicians and suggest directions for further research.

INTRODUCTION

High-frequency oscillatory ventilation in intubated neonates (HFOV) is frequently used in neonatal and paediatric critical care.¹ ² Nonetheless, the clinical management for neonatal respiratory distress syndrome (RDS) has evolved towards a non-invasive approach using continuous positive airway pressure (CPAP) or various types of non-invasive ventilation (NIV): thus, an early application of nasal CPAP is nowadays recommended both in Europe³ and in the USA.⁴ The experience in the use of invasive HFOV and the recommended non-invasive approach has somehow pushed clinicians to combine both concepts. Theoretically, non-invasive HFOV (NHFOV) should provide the advantages of HFOV (no need for synchronisation, high CO₂ removal, less volume/barotrauma) and nasal CPAP (non-invasive interface, increase in functional residual capacity allowing oxygenation to improve). Thus, NHFOV could be useful to avoid invasive ventilation and its complications.

PHYSIOLOGY OF NHFOV

In intubated patients ventilated with HFOV, oscillations deliver a small volume, which is the main advantage of this technique compared with CPAP or NIV. However, NHFOV has some peculiarities that should be known to the clinician. The NHFOV waveforms are characterised by a superimposed oscillation on a basic pattern. The basic pattern is a square wave, which is simpler than the waveform of HFOV. The oscillation is superimposed on the square wave and is composed of multiple frequencies, which are usually lower than 7 Hz. The oscillation is generated by a bias flow, which is a continuous positive pressure that is applied to the patient’s airway. The bias flow is delivered through a non-invasive interface, which is usually a nasal mask or a face mask.

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determinant of CO₂ removal. During NHFOV, spontaneous breathing is maintained and oscillations are superimposed on the airway pressure changes due to tidal breathing. We studied the interaction between spontaneous breathing and oscillations modifying a bench model designed for adult ventilation studies; we used a neonatal or paediatric mannequin and an adequate lung simulator. An example of pressure and volume tracing obtained in the neonatal bench model of NHFOV is given in figure 1. When simulating infants beyond neonatal age under full-face-mask-delivered NHFOV, both tidal and oscillatory volumes contribute to gas exchange and there is a correlation between them; moreover, oscillation transmission is the variable more significantly influencing ventilation. Gas exchange during HFOV is not completely understood and includes several phenomena. However, bench data recently confirmed that NHFOV is able to wash out CO₂ from the upper airways’ dead-space. Thus, NHFOV and tidal breathing may impact on CO₂ removal at different levels and this may create a synergistic effect.

Oscillation transmission is measured using oscillatory pressure ratio (OPR), which is the ratio between the ΔP set at the ventilator and the oscillation amplitude actually measured at a given level (eg, at the interface or the pharynx). Oscillations are better transmitted through stiff structures, they may be significantly dampened by the interfaces, as these latter of soft materials increase patient’s comfort. The use of external interfaces (nasal or face masks) could also lead to some additional oscillation damping by the tissues, while use of nasal prongs could theoretically reduce this effect. In fact, infants beyond neonatal age ventilated through face-mask-delivered NHFOV only have an OPR of 0.17 in the mouth. In summary, the actual transmission of oscillations to the alveoli is likely to be minimal due to unavoidable leaks and the above-described reasons; nevertheless, visible chest oscillations are probably unnecessary to achieve adequate ventilation in most cases, since NHFOV eliminates CO₂ mainly from upper airways’ dead-space.

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The choice of the interface should balance two goals: achieving a satisfactory comfort and reducing dampening and pressure loss. Clinical studies published so far mostly used single, long, high resistive nasopharyngeal tubes. However, bench studies demonstrated that the use of binasal short prongs is technically feasible and can provide efficacious ventilation. Most importantly, such prongs are the most common interface since they are recommended over single nasopharyngeal tubes to deliver CPAP. In fact, they reduce leaks from the counter-lateral nostril and provide lower resistance, although nasopharyngeal tubes may have wall compliance lower than nasal prongs. However, even among short binasal prongs there may be different mechanical properties. All these factors might influence the efficiency of NHFOV and further studies will be needed to clarify these issues. There are no bench mechanical studies about nasal-mask-delivered NHFOV. Masks are likely to dampen oscillation transmission as it happens for infants beyond neonatal age; however, nasal masks are at least as efficacious as binasal prongs in delivering CPAP. Nasal-mask-delivered NHFOV has been used in clinical practice and seems suitable also for NHFOV (see online supplementary video file). In summary, interfaces have different mechanical properties, so different interfaces may be needed in different moments and for different patients; changing the interfaces serially might also be useful to reduce the risk of skin injury in case of long-lasting application.

The presence of high-frequency oscillations eliminates the need to synchronise mechanical ventilation. This is an advantage given the difficulties in achieving good synchronisation during neonatal NIV and because a poor patient-ventilator interaction may significantly decrease ventilation efficiency. Interestingly, an animal study showed that, in contrast to non-invasive pressure support ventilation, NHFOV did not induce phasic inspiratory glottal constriction and conversely did not decrease inspiratory glottal dilatation. Thus, patient-ventilator interaction could be better during NHFOV than with conventional NIV. However, the same study showed suppression of central respiratory drive when nasal-mask-delivered NHFOV was applied at 4 Hz. This effect was not mediated by hypocarbia and could be linked to several phenomena, such as an increase in vagal pulmonary stretch receptor activity or thoracic wall afferent activity. Inflammation, pain or discomfort could have impacted as well. Conversely, other authors showed that nasal-mask delivered high-frequency oscillations stimulate respiratory effort in adult patients with central sleep apnoea. Therefore, the effects of NHFOV on spontaneous breathing pattern may be complex and would need further physiological studies.

**BIOLOGICAL EFFECTS OF NHFOV**

Like any other respiratory support technique, NHFOV can have some biological effects. They can be related to the oscillations or to the use of a non-invasive interface. Regarding the first type of effect, Reddy et al showed that superimposing oscillations over the tidal volume excursions in a surfactant bubble lowers surface tension significantly more than using tidal volume excision alone. Surface tension decreased with increasing frequencies and reached a minimum value of about 7 dyne/cm (7 mN/m) at extremely supraphysiologic frequencies (70–80 Hz). According to this study, surface tension of 1.5–30 dyne/cm (15–30 mN/m) is reached with frequencies usually applied when using HFOV in...
neonates and infants. Consistent values have been found testing surfactant from bronchoalveolar lavage recovered from infants with severe acute RDS under invasive HFOV. Thus, it seems that the application of an oscillatory pressure might improve surfactant function, but it is difficult to imagine a clinical role for this effect, since such extreme frequencies are not achievable with available oscillators and because a good surfactant activity should achieve an alveolar surface tension ≤3–10 mN/m.

Two animal studies recently showed increased surfactant protein-B production and better alveolarisation in preterm lambs treated for 3 weeks with NHFPV. These studies might ideally represent a neonate developing bronchopulmonary dysplasia (BPD), but NHFPV is a different type of high-frequency ventilation, thus these data should be cautiously interpreted with regard to NHFOV. Another study showed that surfactant-untreated rats ventilated with invasive HFOV for 2 hours had larger surfactant aggregates, better oxygenation and greater lung compliance compared with surfactant-untreated animals under conventional ventilation. This study could reproduce the early phase of neonatal RDS before surfactant administration. Despite the limitations of these models, these data allow to speculate that, if high-frequency oscillations are applied before surfactant replacement (eg, using NHFOV in non-intubated babies during the early phase of RDS), surfactant function could be improved, although this remains hypothetical.

Regarding the effects linked to a non-invasive interface, it is conceivable that having an oscillating interface on the skin could produce some local reactions or skin injuries, but this has never been studied, and a European survey has not described any local reactions or skin injuries among the side effects of NHFOV. Early HFOV has been claimed to be less pro-inflammatory than conventional ventilation and one could imagine the same effect for NHFOV as compared with conventional NIV. However, there are no data available on this issue, which remains difficult to be investigated.

### CLINICAL STUDIES OF NHFOV

No randomised clinical trial about NHFOV has yet been conducted. The first application of NHFOV dates back to 1998 by van der Hoeven et al. They reported a case series of 21 neonates with various respiratory conditions switched from CPAP to NHFOV and described a significant improvement in PaCO₂ with slightly improved pH. Paw was also significantly increased switching from CPAP to NHFOV, although no data were provided about oxygenation. These authors did not actually apply NHFOV, as a flow-interruption device provided oscillations instead of an actively oscillating piston; the same applies for some other preliminary investigations and details of studies are provided in Table 1. The first extremely preterm neonate successfully ventilated with NHFOV was reported in 2000, and another three extremely preterm neonates were recently ventilated with NHFOV through binaural prongs with satisfactory results. Colázey et al published a non-randomised longitudinal, before-and-after, study enrolling 14 preterm infants in the recovery phase of RDS. These authors were able to confirm the reduction in PaCO₂ and consequent pH improvement after 2 hours of NHFOV. Similar effects were described in a small randomised crossover trial enrolling adults, with acute hypercapnic respiratory failure treated with face-mask-delivered NHFOV, although this was only published in abstract form.

Another German case series suggested the possible usefulness of NHFOV for extremely preterm babies at high risk of extubation failure. Finally, in 2014, a Canadian network of four neonatal units published the largest series of NHFOV-treated neonates so far. This uncontrolled study involved 52 neonates for a total of 79 instances of NHFOV. These patients were given NHFOV predominantly because of hypoxemic spells and/or gas exchange derangement. The authors suggested that the number of spells decreased within the first 6 hours of NHFOV and that 58% of patients were successfully transitioned to conventional NIV after a period of NHFOV. Need for oxygen and PaCO₂ also improved.

Unfortunately, these studies are either uncontrolled or variably biased (mixed or small population, unclear criteria to start or evaluate NHFOV, retrospective design, variable criteria to manage NHFOV parameters). Thus, it is not possible to draw conclusions about the clinical efficacy of NHFOV regarding its effect on CO₂ elimination, although this latter is otherwise well

### Table 1 Published clinical studies about NHFOV in neonates

| Author/year | Sample size | Type of study | Patients’ condition | Type of patients | Interface | Generating system | Main results |
|-------------|-------------|---------------|---------------------|------------------|-----------|-------------------|--------------|
| van der Hoeven/1998 | 21 | Case series | RDS, TTN, AOP, air leaks | Term and preterm | Nasopharyngeal tube | Flow-interruption | ↓PaCO₂ |
| Hoehn/2000 | 1 | Case report | RDS | Extremely preterm | Nasopharyngeal tube | Flow-interruption | ↓PaCO₂, avoid one reintubation |
| Colázey/2008 | 14 | Non-randomised crossover trial | RDS in recovery phase | Term and preterm | Nasopharyngeal tube | Flow-interruption | NHFOV is safe ↓PaCO₂ |
| Czemik/2012 | 20 | Case series | Difficult extubation after various types of respiratory failure | Term and preterm | Nasopharyngeal tube | Piston/membrane | Suggested usefulness for high-risk extubation |
| Aktas/2014 | 3 | Case series | RDS or developing BPD | Extremely preterm | Nasal prongs | Flow-interruption | NHFOV is safe and feasible |
| Munker/2014 | 52 | Case series | BPD spells, postextubation, others unspecified | Term and preterm | Nasal prongs/mask | Piston/membrane or flow-interruption | Less spells ↓PaCO₂ ↓FiO₂ |

| Neonates (total) | 111 |

[Search in PubMed with NHFOV [All Fields] or non [All Fields] AND invasive [All Fields] AND HFOV [All Fields]. The search was also conducted in Pediatric Academic Societies abstracts archive (2002–2014) and authors’ personal archives (as per 7 February 2016). Studies are listed in order of publication. AOP, apnoea of the prematurity; BPD, bronchopulmonary dysplasia; NHFOV, non-invasive high-frequency oscillatory ventilation; RDS, respiratory distress syndrome; TTN, transient tachypnoea of the neonate.]

De Luca D, Dell’Orto V. Arch Dis Child Fetal Neonatal Ed 2016;101:F565–F570. doi:10.1136/archdischild-2016-310664 F567
established.18 35 36 38 39 Until now, 111 babies have been described in clinical studies (table 1), although many more are likely to receive this type of respiratory support during daily care.5 6

Regarding NHFOV safety, the available data seem more consistent. The European survey described thick secretions, agitation and leaks/malfunctioning as main NHFOV side effects.3 However, these were only surveyed as physicians’ opinions, but none of these problems was formally reported in any of the NHFOV studies. One could also hypothesise the occurrence of abdominal distension during NHFOV, but this was not reported in the above-described studies. Moreover, it is likely to be only a mild problem, as it happens for other forms of non-invasive respiratory support.41 Moreover NHFOV, unlike conventional NIV, does not cause laryngeal closure and this should at least partially prevent any abdominal distension.13

Dumas De La Roque et al62 conducted a randomised study about NHFPV for transient tachypnoea of the neonate. This is the only randomised study in this area and NHFPV turned out to be superior to CPAP in terms of duration of tachypnoea and respiratory support. However, as stated above, NHFPV is a completely different mode of respiratory support and these results cannot be directly applied to HFOV or to neonates with RDS or BPD.

PRINCIPLES FOR THE CLINICAL USE OF NHFOV

A European survey described a huge span in terms of Paw, ΔP and frequency.7 Available studies reported the use of NHFOV in postextubation phase with a Paw of 8 and ΔP ≤25 cmH2O40 or in stable neonates with Paw at the same level of CPAP that babies were previously receiving and ΔP titrated to obtain visible chest oscillations.38 Since CO2 elimination under NHFOV is also provided in the upper airway dead-space,16 it is probably unnecessary to increase ΔP to achieve a visible chest oscillation. Neonates developing BPD might also benefit from NHFOV. In fact, they may have a mixed, restrictive/obstructive pattern causing hypercarbia/hypoxia.43 Thus, these babies need high Paw, which is rarely achievable with conventional NIV and a risk of gas trapping exists: this might be greatly reduced by NHFOV-induced upper airway washout. To illustrate the practical setting, an online supplementary video file shows a neonate of 25 weeks gestation under nasal-mask-delivered NHFOV with satisfactory comfort and clinical stability. Figure 2 illustrates clinical data for this patient.

Nasal prong diameter is the main determinant for ventilation during NHFOV: the largest diameter possible should be preferred18 or ΔP should be increased to augment ventilation.19 Nonetheless, this might require high ΔP values, the impact of which on patient’s comfort remains to be examined. Another possible strategy is to increase inspiratory time (IT) to 50%. Bench data showed that when IT is 50%, a ΔP of 50 cmH2O will be able to deliver a volume of about 2 mL.19 If we consider an ideal volume of about 1–2 mL/kg, increasing ΔP and IT should be able to deliver this volume to a patient of 1500–2000 g,15 although this remains speculative. Moreover, performances might vary using different prongs: higher-pressure loss and reduced CO2 clearance have been demonstrated with some recently marketed prongs.14 45

To summarise, according to the clinical experience accumulated so far, we believe that Paw could be set at values higher than those usually provided with conventional NIV (table 2). More extreme values are not advised either because of unavoidable leaks or because effects on patient’s comfort and respiratory pattern are still unclear.

RECOMMENDATIONS FOR RESEARCH

NHFOV has been subjected only to bench and animal investigations, as well as small, uncontrolled clinical studies. Bench studies are still needed to clarify mechanical properties of nasal masks and different prongs. Conversely, further animal studies are probably unnecessary: in fact, NHFOV is likely to be safe and we now need to better clarify its clinical usefulness.

To achieve this goal a pilot study is recommended, focusing either on infants postextubation or those at risk of developing...
BPD. Then a large, multicentre, randomised, clinical trial should be conducted having as outcomes the duration of respiratory support, ventilator free days or similar end points. Harder outcomes, such as BPD, mortality and long-term respiratory function might also be considered as secondary end points.

Such a trial has not yet been conceived and might be problematic in terms of funding. In fact, a recent analysis shows that about 50% of the neonatal ventilation trials have been conducted without any funding,16 appropriate investments are warranted by research funding agencies and/or the industry. Table 3 shows all the currently ongoing trials on NHFOV; four trials are listed in ClinicalTriial.gov, while none appears in the International Standard Randomised Controlled Trial Number Registry or in the Australian-New Zealand Clinical Trials Registry. Unfortunately, none of these trials follows a multicentre design and their power is unknown. Another European multicentre trial, aiming to provide NHFOV as primary respiratory support starting at birth has not yet started (P. Rimensberger, personal communication 2015).

While waiting for adequate randomised controlled trials, given the possible usefulness of NHFOV from a physiopathological point of view and its relative easiness of use, one may consider its application on a case-by-case scenario after risk/benefit ratio evaluation.

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REFERENCES

1 Knebey MC, van Heerde M, Markhorst DG. Reflections on pediatric high-frequency oscillatory ventilation from a physiologic perspective. Respir Care 2012;57:1496–504.

2 van Kaam AH, Rimensberger PC, Borensztajn D, et al., Neovent Study Group. Ventilation practices in the neonatal intensive care unit: a cross-sectional study. J Pediatr 2010;157:767–71.e1–3.

3 Sweet DG, Carnielli V, Greisen G, et al., European Association of Perinatal Medicine. European consensus guidelines on the management of neonatal respiratory distress syndrome in preterm infants—2013 update. Neonatology 2013;103:393–402.

4 Committee on Fetus and Newborn; American Academy of Pediatrics. Respiratory support in preterm infants at birth. Pediatrics 2014;133:171–4.

5 Fisher HS, Bohlin K, Buhler C, et al. Nasal high-frequency oscillation ventilation in neonates: a survey in five European Countries. Eur J Pediatr 2015;174:465–71.

6 Mukerji A, Singh B, Helou SE, et al. Use of noninvasive high-frequency ventilation in the neonatal intensive care unit: a retrospective review. Arch J Pediatr 2015;30:171–6.

7 DiBlasi RM. Nasal continuous positive airway pressure (CPAP) for the respiratory care of the newborn infant. Respir Care 2009;54:1209–35.

8 Tingay DG, John J, Harcourt ER, et al. Are All Oscillators Created Equal? In vitro Performance Characteristics of Eight High-Frequency Oscillatory Ventilators. Neonatology 2015;108:220–8.

9 Grilli S, Karam O, Rimensberger PC. New generation neonatal high frequency ventilations: effect of oscillatory frequency and working on patients. Respir Care 2015;60:363–70.

10 Yuan Y, Sun J, Wang B, et al. A noninvasive high frequency oscillation ventilator: achieved by utilizing a blower and a valve. Rev Sci Instrum 2016;87:025113.

11 Seidek KA, Takeuchi M, Suchodolski K, et al. Determinants of tidal volume during high-frequency oscillation. Crit Care Med 2003;31:227–31.

12 Costa R, Navalesi P, Spinazzola G, et al. Influence of ventilator settings on patient-ventilator synchrony during pressure support ventilation with different interfaces. Intensive Care Med 2008;34:1102–8.

13 De Luca D, Costa R, Visconti F, et al. Oscillation transmission and volume delivery during face mask-delivered HFOV in infants: bench and in vivo study. Pediatr Pulmonol 2016;51:1705–12.

14 De Luca D, Costa R, Spinazzola G, et al. Oscillation transmission and ventilation during face mask-delivered high frequency oscillatory ventilation in infants: a bench study with active lung simulator [abstract]. Arch Dis Child 2012;97(Suppl 2):A117–18.

15 Boynton BR, Hammond MD, Fredberg JJ, et al. Gas exchange in healthy rabbits during high frequency oscillatory ventilation. J Appl Physiol 1989;66:1343–51.

16 Mukerji A, Finelli M, Belik J. Nasal high-frequency oscillation for lung carbon dioxide clearance in the newborn. Neonatology 2013;103:161–5.

17 van Genderingen HR, Versprille A, Leenhoven T, et al. Reduction of oscillatory pressure along the endotracheal tube is indicative for maximal respiratory compliance during high-frequency oscillatory ventilation: a mathematical model study. Pediatr Pulmonol 2001;31:458–63.

18 De Luca D, Carnielli VP, Conti G, et al. Noninvasive high frequency oscillatory ventilation through nasal prongs: bench evaluation of efficacy and mechanics. Intensive Care Med 2010;36:2094–100.

19 De Luca D, Piasta M, Piniotii D, et al. Effect of amplitude and inspiratory time in a bench model of non-invasive HFOV through nasal prongs. Pediatr Pulmonol 2012;47:1012–18.

20 De Paoli AG, Molley CJ, Davis PG, et al. In vitro comparison of nasal continuous positive airway pressure devices for neonates. Arch Dis Child Fetal Neonatal Ed 2011;96:F411–5.

21 Kieran EA, Twomey AR, Molloy EJ, et al. Randomized trial of prongs or mask for nasal continuous positive airway pressure in preterm infants. Pediatrics 2012;130:e1170–7.

22 Owen LS, Molley CJ, Dawson JA, et al. Effects of non-synchronised nasal intermittent positive pressure ventilation on spontaneous breathing in preterm infants. Arch Dis Child Fetal Neonatal Ed 2011;96:F422–8.

23 Hadji-Ahmed MA, Samson M, Nadeau C, et al. Laryngeal muscle activity during nasal high frequency oscillatory ventilation in nonseated newborn lambs. Neonatology 2015;107:199–205.

| Country | Status (cause) | Patients | Control arm | Primary outcome | Secondary outcomes | Identifier |
|---------|---------------|----------|-------------|-----------------|-------------------|------------|
| China   | Not recruiting | >28 weeks; postextubation | NIPPV | Intubation rate | Apnoea, air leaks, BPD, NEC incidence | NCT02543125 |
|         | Suspended (poor recruitment) | <28 weeks; postextubation | CPAP | Intubation rate | PaCO2, air leaks, IVH, feeding intolerance | NCT01852916 |
| Germany | Recruiting | <32 weeks; postextubation | CPAP | PaCO2 | Other gas exchange measures, intubation rate, IVH, BPD, NEC | NCT02340299 |
| Canada  | Recruiting | <1250 g; >72 hours of life; failing postextubation CPAP | BIPAP | Failure of NHFOV/BIPAP | Intubation rate, ventilation length, PaCO2, NICU stay, IVH, BPD, apnoeic spells, common adverse outcomes | NCT02051491 |
Review

24 Kohl J, Freund U, Koller EA. Reflex apnea induced by high-frequency oscillatory ventilation in rabbits. *Respir Physiol* 1991;84:209–22.

25 England SJ, Onayemi A, Bryan AC. Neuromuscular blockade enhances phrenic nerve activity during high-frequency ventilation. *J Appl Physiol* 1984;56:31–4.

26 Di Fiore JM, Martin RJ, Gauda EB. Apnea of prematurity–perfect storm. *Respir Physiol Neurobiol* 2013;189:213–22.

27 Henke KG, Sullivan CE. Effects of high-frequency pressure waves applied to upper airway on respiration in central apnea. *J Appl Physiol* 1992;73:1141–5.

28 Reddy PI, Al-Jumaily AM, Bold GT. Dynamic surface tension of natural surfactant extract under superimposed oscillations. *J Biomech* 2011;44:156–63.

29 De Luca D, Lopez-Rodriguez E, Minucci A, et al. Clinical and biological role of secretory phospholipase A2 in acute respiratory distress syndrome infants. *Crit Care* 2013;17:R163.

30 Hite RD, Seeds MC, Jacinto RB, et al. Lysophospholipid and fatty acid inhibition of pulmonary surfactant: nonenzymatic models of phospholipase A2 surfactant hydrolysis. *Biochim Biophys Acta* 2005;1720:1241–8.

31 Rehan VK, Fong J, Lee R, et al. Mechanism of reduced lung injury by high-frequency nasal ventilation in a preterm lamb model of neonatal chronic lung disease. *Pediatr Res* 2011;70:462–6.

32 Null DM, Alvord J, Leavitt W, et al. High-frequency nasal ventilation for 21 d maintains gas exchange with lower respiratory pressures and promotes alveolarization in preterm lambs. *Pediatr Res* 2014;75:507–16.

33 Aspros AJ, Coto CG, Lewis JF, et al. High-frequency oscillation and surfactant treatment in an acid aspiration model. *Camil J Physiol Pharmacol* 2010;88:14–20.

34 Dani C, Bertini G, Pezzati M, et al. Effects of pressure support ventilation plus volume guarantee vs. high-frequency oscillatory ventilation on lung inflammation in preterm infants. *Pediatr Pulmonol* 2006;41:242–9.

35 van der Hoeven M, Brouwer E, Blanco CE. Nasal high frequency ventilation in neonates with moderate respiratory insufficiency. *Arch Dis Child Fetal Neonatal Ed* 1998;79:F61–3.

36 Hoehn T, Krause MF. Effective elimination of carbon dioxide by nasopharyngeal high-frequency ventilation. *Respir Med* 2000;94:1132–4.

37 Aktas S, Unal S, Aksoy M, et al. Nasal HFOV with binasal cannula appears effective and feasible in ELBW newborns. *J Trop Pediatr* 2016;62:165–8.

38 Colaizy TT, Younis UMM, Bell EF, et al. Nasal high-frequency ventilation for premature infants. *Acta Paediatr* 2008;97:1518–22.

39 Esquinas AM, Santiago Martin FM. Effects of oscillatory devices during noninvasive mechanical ventilation in acute hypercapnic respiratory failure (AHFR). A clinical pilot study [abstract]. *Intensive Care Med* 2010;36(Suppl 2):S109.

40 Czemik C, Schmausch G, Bührer C, et al. Weaning of neonates from mechanical ventilation by use of nasopharyngeal high-frequency oscillatory ventilation: a preliminary study. *J Matern Fetal Neonatal Med* 2012;25:374–8.

41 Jais JC, Levin T, Wung JT, et al. Benign gaseous distension of the bowel in premature infants treated with nasal continuous airway pressure: a study of contributing factors. *AJR Am J Roentgenol* 1992;158:125–7.

42 Dumas De La Roque E, Bertrand C, Tandonnet O, et al. Nasal high frequency percussive ventilation versus nasal continuous positive airway pressure in transient tachypnea of the newborn: a pilot randomized controlled trial (NCT00556738). *Pediatr Pulmonol* 2011;46:218–23.

43 Hjalmarson O, Sandberg KL. Lung function at term reflects severity of bronchopulmonary dysplasia. *J Pediatr* 2005;146:86–90.

44 Mukerji A, Belik J. Neonatal nasal intermittent positive pressure ventilation efficacy and lung pressure transmission. *J Perinatol* 2015;35:716–19.

45 Gerdes JS, Sivieri EM, Abbasi S. Factors influencing delivered mean airway pressure during nasal CPAP with the RAM cannula. *Pediatr Pulmonol* 2016;51:60–9.

46 Shankar-Aguilera S, Taveira M, De Luca D. Neonatal ventilation trials need specific funding. *Lancet Respir Med* 2014;2:867–9.