Seizure and MRSA Pneumonia on the Ventilator in ICU

Families' FAQ: “How do we fight for our loved one?” | Quick tip for families in intensive care

A niece's aunt had a seizure almost three weeks ago and was put on a ventilator to control it. She was awake, giving thumbs up and wanting to get out of bed, on 50% support at night, when she developed MRSA pneumonia and became more sedated. The family felt pressure to withdraw care, she is not DNR, and the team is now discussing a tracheostomy and PEG even though she has a damaged airway from a prior intubation five years ago. Here is what families in this situation need to know.

Q. Why does the cause of the seizure matter so much?

It determines the prognosis, treatment, likelihood of weaning and long-term outlook. Common causes leading to ICU and ventilation: **epilepsy** (known disorder that broke through), **stroke or brain haemorrhage**, **brain tumour**, **metabolic causes** (low sodium or blood sugar, organ failure), **autoimmune encephalitis** (such as anti-NMDA receptor encephalitis, frequently missed and frequently treatable) and **status epilepticus** (prolonged or repeated seizures needing sedation and ventilation). Some causes are fully reversible. Ask for the working diagnosis **in writing**.

Q. Does being awake and giving thumbs up before the MRSA infection matter?

Very much. It shows neurological recovery was happening, which is critically important information. This was a conscious, communicating patient, not one who was brain dead or vegetative, so don't let anyone gloss over it. Any conversation about withdrawing care before the infection is fully treated and a genuine weaning attempt has been made is **premature**.

Q. What is MRSA pneumonia on a ventilator, and why does it affect weaning?

MRSA is a bacterial infection resistant to many common antibiotics. On a ventilator it is called **ventilator-associated pneumonia (VAP)**: serious, but **treatable**. The antibiotic of choice is IV vancomycin, and about 10 days is a standard VAP course. You can't safely reduce ventilator support while active pneumonia is in the lungs: the lungs need support, the infection needs to clear, then weaning can resume. The team should have explained this instead of moving to talk of withdrawing care.

Q. What should happen once the vancomycin course ends?

Repeat chest imaging and check cultures to confirm the infection is clearing, then restart a **structured weaning protocol**: daily spontaneous breathing trials, reduced sedation, optimised nutrition, physiotherapy and, if not yet involved, a respiratory physician. Ask: **What is the specific weaning plan, and what is the timeline for assessing progress?**

Q. Why is a tracheostomy complicated for her?

A tracheostomy is usually discussed after 10 to 14 days on a ventilator with difficult weaning. It's more comfortable, needs less sedation and allows gradual weaning. But her “mushy deformed trach” after intubation five years ago likely means tracheal stenosis or tracheomalacia (scarring or damage to the trachea). A **specialist airway assessment** is non-negotiable before any tracheostomy: bronchoscopy and review by an ENT or thoracic surgeon experienced in airway reconstruction. Ask for the results in writing. A **PEG** (feeding tube into the stomach) is standard for long-term ventilation and doesn't by itself indicate a poor prognosis.

Q. What about seizure management, nutrition and rehabilitation?

Ask neurology: are anticonvulsants optimised, and has the cause been treated? Subclinical seizures can happen even when she looks calm and can impair consciousness and weaning, so an **EEG** may be warranted. Weeks of sedation cause major muscle loss, including the respiratory muscles she needs, so optimal nutrition (tube feeding now, PEG later) and early physiotherapy are essential.

Q. What if we feel pressure to “pull the plug”?

Doctors and nurses are human: their judgements can be influenced by resource constraints, patient age, complexity and sometimes bias. That doesn't make them bad people, but you have the right, and the responsibility, to ask hard questions. If she is not DNR, ask for a **formal, documented goals-of-care conversation**: the realistic treatment pathway, the milestones and the decision points, in writing and in the records.

Q. Which medical records should we get?

All of them, requested in writing now, before a crisis decision is forced on you: nursing and medical notes, investigation results (bloods, CT, MRI, cultures), medication chart, ventilator settings and goals-of-care documentation. They let you verify the MRSA treatment course and cultures, confirm the seizure diagnosis, review weaning attempts and responses, check the airway was formally assessed and see any withdrawal-of-care discussions you weren't part of. In most countries you have a legal right to them.

Q. What if she can't be weaned: must she stay in ICU?

No. **Intensive Care at Home**, Australia's only third-party accredited specialist home intensive care nursing service (150+ Critical Care Registered Nurses, all states and territories, NDIS, TAC and WorkSafe registered), supports long-term invasive ventilation via tracheostomy, BiPAP/CPAP, tracheostomy care, suction and cough assist, PEG feeding and palliative care at home. It also helps families in the USA, UK and Canada.

Q. What should we do next?

1. Get all the medical records. **2.** Demand a formal goals-of-care meeting with documented outcomes. **3.** Ask what the weaning plan is now that vancomycin is complete. **4.** Ask about the airway assessment given the prior tracheal damage. **5.** Ask neurology for the underlying seizure diagnosis and whether it is optimally managed. **6.** Get independent support.

Need independent expert advocacy? Intensive Care Hotline can help.
Patrik Hutzel brings 25 years of critical care nursing experience. We review records, ask the clinical questions families don't know to ask, and advocate alongside you, ideally with the ICU team present. Book a **free 15-minute phone consultation**.
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General information for families, not a substitute for advice from your loved one's treating medical team.