Published By:

INDIAN SOCIETY OF CRITICAL CARE MEDICINE
For Free Circulation Amongst Medical Professionals
Unit 13 & 14, First Floor, Hind Service Industries Premises Co-operative Society, Near Chaitya Bhoomi, Off Veer Savarkar Marg, Dadar, Mumbai – 400028
Tel. 022-24444737 • Telefax 022-24460348 • email: isccm1@gmail.com

We request our esteemed readers to send their valued feedback, suggestions & views at newsletter@isccm.org
Editorial...

Dear All

It’s an honour & privilege to be elected as the President of a vibrant, young & dynamic society, where majority of members are millennials.

Critical care has taken a deep root & its growth as a (sub) specialty has been due to pioneering work done by our predecessors in ISCCM, who were not only visionary but were able to lay its path & trajectory.

Growth of clinical medicine including its subspecialties have further added impetus to need & growth of critical care medicine.

It’s a (sub) specialty having multidisciplinary dimensions with interdisciplinary approach. Following its exponential growth, time has now come to look into not only orphan diseases like snake envenomation, poisonings, resurgence of old & new infections & trauma primarily affecting the common people but to develop innovative ways to manage them in cost effective manners. Besides there is a huge unmet need of medical, nursing & paramedical professionals for looking after the critical care units.

This is going to be both challenge as well as an opportunity. My endeavor will be to make a road map & set the agenda for development, growth & quality of training in critical care across the spectrum with help & advice of members & executive. We therefore have reconstituted the editorial board of critical care communications with aim to have change with involvement of intensivists across spectrum & regions, while maintaining continuity.

I again take this opportunity to thank every single member of the society for reposing faith.

warm regards & best wishes

Dr. Dhruva Chaudhry
MD (Medicine), DNB (Medicine) D. M. (Pulmonary & Chest Medicine) FICP, FICCM
President Elect ISCCM, Editor in Chief, Critical Care Communications
Address: 4/7 J. Medical Enclave, PGIMS, Rohtak – 124001, Haryana
Tel: +91
Mobile: +91 9416051616
Email: dhruvachaudhry@yahoo.co.in
Hello everyone! I’m Dr Subhal Dixit your society Indian Society of Critical Care Medicine President for the year 2019-2020. I consider it my privilege and honor to take charge today as the president of this prestigious society during the silver jubilee of ISCCM!

My journey in ISCCM began in September 1998 when I registered as the first candidate for critical care training in ISCCM under the guidance of Dr Shirish Prayag. It was a novel course - as there was no other formal course in critical care in India. After my years in this field today I’m happy and take pride to say this, in fact I am the first IDCCM candidate to become president of ISCCM!

ISCCM is growing with amazing speed with a solid foundation of medical study and training. The ISCCM tree has grown from 37 branches in 2009 to 82 branches in 2019. During my tenure I’ll will make all efforts to maintain the growth and scope of this society.

A society of the nature can grow only if it is based on academics, original research, books, guidelines,courses and by strengthening the bond with neighboring Asian association and the west!

It is a magical coincidence that this year’s annual conference is back in Mumbai exactly where its seed were sown in 1993.

The conference needs more solid constructive consolidations which I plan to work on and ensure to find new sparking dynamic faculties to be involved in it!

I’m happy and open to suggestions from you all and seek support from each member to make ISCCM as the most powerful critical care society!

Best wishes to you all!

Dr Subhal Dixit
MD, FCCM, IDCCM, FICCM, FICP
• Director ICU Sanjeevan & MJM Hosp
• President, ISCCM
• Chancellor, ICCCM
• Address: 1238/1 ApkaGhar, Apte road Pune 411004, Maharashtra, India
Tel: +91-20-25531539/25539538
Mobile: +91-9822050240
Email: president@isccm.org
General Secretary's Desk

Dear Respected ISCCM members,

I am thankful to all of you for bestowing upon me the golden opportunity to serve the society as The General Secretary. I have also been given a dream come true chance of organising Criticare 2020 Hyderabad as organising secretary. The honour and each moment, I am going to cherish for whole of my life.

Last year, we achieved a mammoth task of updating upto ninety percentage of members data. This was must for us to reach each and every member about society activity. While ISCCM guidelines, annual update book, monthly IJCCM journal, and bimonthly NEWS letter is in place for members, we as Intensivist confraternity would be actively investing in original ISCCM research.

The ISCCM, as a twenty six year old fraternity has grown leaps and bounds, so are our responsibilities. Our academic wing ICCM, has fulfilled a huge gap of trained and qualified intensivist for the country. A proud moment for the organisation for this achievement and thankful to the visionaries whose efforts has helped the states to get a pool of well trained and qualified Intensivist.

The ISCCM has taken a bold step to organise its annual conference by central committee. Criticare 2020 Hyderabad would be a big challenge for us as we would be stepping out of our comfort zone. We wish to set up a very high standard of organisation, academic feast, and extravaganza. This is only possible by your active participation.

As our theme is “precision in critical care medicine” so we would be planning each and every talk, workshops and stalls based on our essence.

We need your inputs what best can be done for Criticare 2020 Hyderabad.

Please send your suggestions for Criticare 2020, Hyderabad to: conference coordinator@isccm.org or generalsecretary@isccm.org.

Dr. Rajesh Chandra Mishra
General Secretary, ISCCM
generalsecretary@isccm.org
**Welcome Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Membership No</th>
<th>Category</th>
<th>Name</th>
<th>Membership No</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Ivesh Singh, Meerut</td>
<td>18/S-1693</td>
<td>Life Members</td>
<td>Dr. Ashish Arora, New Delhi</td>
<td>18/A-638</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. MANGI SHAH, Ahmedabad</td>
<td>18/S-1700</td>
<td>Life Members</td>
<td>Dr. Nitin Khansda, Nagpur</td>
<td>18/I-1076</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Raveendr Reddy, Bangalore</td>
<td>18/R-618</td>
<td>Life Members</td>
<td>Dr. Rampasad Gont, Durgapur</td>
<td>18/G-790</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Mohammed Hani, Noida</td>
<td>18/K-1078</td>
<td>Life Members</td>
<td>Dr. MohdIINMAD BADRUDDIN, Allahabad</td>
<td>18/D-615</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. HITESHKUMAR HUDA, RISHABH</td>
<td>18/R-610</td>
<td>Life Members</td>
<td>Dr. SUDHIRKUMAR KANAVALLI, Bangalore</td>
<td>18/I-1075</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. RAJAIK RSHAW, Erude</td>
<td>18/I-1080</td>
<td>Life Members</td>
<td>Dr. NIRANJAN SINGH, Varanasi</td>
<td>18/I-1697</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Neeraj Jari, Hyderabad</td>
<td>18/D-24</td>
<td>Advocate Life Member</td>
<td>Dr. Manoj Chopade, Nagpur</td>
<td>18/C-500</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. MAHENDRA PRASAD D R, Mysores</td>
<td>18/P-1002</td>
<td>Life Members</td>
<td>Dr. Rama V, Hyderabad</td>
<td>18/V-362</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. RAJEEV KHAN, Gujrat</td>
<td>18/I-1074</td>
<td>Advocate Life Member</td>
<td>Dr. Arun Goyal, Meerut</td>
<td>18/G-787</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. DHRAL YUKHA, Bhamnagar</td>
<td>18/V-364</td>
<td>Life Members</td>
<td>Dr. Aman Sharma, Panachhua</td>
<td>18/I-1694</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. DHRAM SATHE, Pune</td>
<td>18/S-1691</td>
<td>Life Members</td>
<td>Dr. Rupali Pathak, Berhampur</td>
<td>18/I-1001</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. SURAJ KUMAR ALAMU</td>
<td>18/5-1698</td>
<td>Advocate Life Member</td>
<td>Dr. Asity Bhat, Mumbai</td>
<td>18/R-762</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Samarth Shrivastava, New Delhi</td>
<td>18/S-1705</td>
<td>Advocate Life Member</td>
<td>Dr. Praveen Kumar G, Gurgaon</td>
<td>18/G-791</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Sanjay Singh, Varanasi</td>
<td>18/S-1699</td>
<td>Life Members</td>
<td>Dr. VIVEK SHARMA, Una</td>
<td>18/I-1696</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Asot Huvar, Mumbai</td>
<td>18/K-1073</td>
<td>Advocate Life Member</td>
<td>Dr. MOHAN VIJAYRATU, Bangalore</td>
<td>18/V-363</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. JAYA KHAJWA, Anand</td>
<td>18/I-1077</td>
<td>Life Members</td>
<td>Dr. MADHAVI REDDY, Hyderabad</td>
<td>18/R-620</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Shiva S, Jaipur</td>
<td>18/S-1704</td>
<td>Life Members</td>
<td>Dr. MD JIRAL, Gurgaon</td>
<td>18/I-1694</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Shreem Chery Barna, Chennai</td>
<td>18/I-763</td>
<td>Life Members</td>
<td>Dr. SRINIVASANTHA KUMAR, Delhi</td>
<td>18/I-167</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Mukta Mansaa, Hyderabad</td>
<td>18/I-928</td>
<td>Life Members</td>
<td>Dr. Harsh Mody, Kolkata</td>
<td>18/M-925</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Bhawna S, Bangalore</td>
<td>18/S-1703</td>
<td>Life Members</td>
<td>Dr. Anushka Chiraon, Pondicherry</td>
<td>18/C-503</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Aneesh Narayan, Chennai</td>
<td>18/I-315</td>
<td>Life Members</td>
<td>Dr. Shikha Deshpande, Bhopal</td>
<td>18/D-616</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Niyat Gadi, Trimmeri</td>
<td>18/G-793</td>
<td>Life Members</td>
<td>Dr. DHRISHTHIKUMAR BHANU, :Bangalore</td>
<td>18/I-167</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. PRABSER JAN, Mumbai</td>
<td>18/I-507</td>
<td>Life Members</td>
<td>Dr. Nandini Prabha, Varanasi</td>
<td>18/I-167</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Arun Gangadhar, New Delhi</td>
<td>18/G-786</td>
<td>Life Members</td>
<td>Dr. HARVEET KAUR, Lucknow</td>
<td>18/I-1082</td>
<td>Advocate Life Member</td>
</tr>
<tr>
<td>Dr. Dhruv Maini, Tiruchirapalli</td>
<td>18/M-928</td>
<td>Life Members</td>
<td>Dr. Arvind Mahapatra, Kolkata</td>
<td>18/I-1074</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Pranav Soni, Hyderabad</td>
<td>18/S-1703</td>
<td>Life Members</td>
<td>Dr. Singh Devendra, Punjab</td>
<td>18/I-1001</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Hridaya Sandal, Nellore</td>
<td>18/S-1691</td>
<td>Life Members</td>
<td>Dr. Praveen Chowdary, Raipur</td>
<td>18/C-502</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. MADHU DEVI, KURNOOL</td>
<td>18/S-1695</td>
<td>Life Members</td>
<td>Dr. Virendra Kumar, Kochi</td>
<td>18/I-1079</td>
<td>Advocate Life Member</td>
</tr>
<tr>
<td>Dr. Aniruddha Saha, Kolkata</td>
<td>18/S-1692</td>
<td>Life Members</td>
<td>Dr. Prasad Prasad, Kolkata</td>
<td>18/I-1005</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. VATSAL SINGH, Chandigarh</td>
<td>18/I-1710</td>
<td>Life Members</td>
<td>Dr. Saurabh Kumar, Lucknow</td>
<td>18/I-1083</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. THAKUR TARUNIR, Varanasi</td>
<td>18/C-409</td>
<td>Life Members</td>
<td>Dr. HARI SHARMA, Jaipur</td>
<td>18/I-1670</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Nilesh Gahlot, Mumbai</td>
<td>18/S-782</td>
<td>Life Members</td>
<td>Dr. Monika S, New Delhi</td>
<td>18/I-1670</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. ARINDAM MUKHERJEE, Kolkata</td>
<td>18/M-927</td>
<td>Life Members</td>
<td>Dr. ASIT KUSU, Raipur</td>
<td>18/I-1005</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Amritpal Kaur, Delhi</td>
<td>18/S-1692</td>
<td>Life Members</td>
<td>Dr. Pratik Sodhi, Ludhiana</td>
<td>18/I-1077</td>
<td>Advocate Life Member</td>
</tr>
<tr>
<td>Dr. ABHISHEK SHARMA, Chandigarh</td>
<td>18/S-1710</td>
<td>Life Members</td>
<td>Dr. Mukesh Kumar, Jalandhar</td>
<td>18/I-1083</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. HARSH CHADHA, Gurgaon</td>
<td>18/I-365</td>
<td>Life Members</td>
<td>Dr. Jeekha Lakha, New Delhi</td>
<td>18/I-113</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Akshay ThakkarSakshi, , Noida</td>
<td>18/S-1705</td>
<td>Life Members</td>
<td>Dr. Rajeev Ranjan, New Delhi</td>
<td>18/R-623</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. Nitesh Goyal, Gurgaon</td>
<td>18/G-789</td>
<td>Life Members</td>
<td>Dr. KHV Prashant, Visakhapatnam</td>
<td>18/P-1004</td>
<td>Life Members</td>
</tr>
<tr>
<td>Dr. ONKAR JI, Noida</td>
<td>18/I-508</td>
<td>Life Members</td>
<td>Dr. Devraj Rajour, Lucknow</td>
<td>18/R-625</td>
<td>Life Members</td>
</tr>
</tbody>
</table>
7TH ACADEMIC MEET OF SOCIETY OF CRITICAL CARE MEDICINE JALGAON BRANCH

Date 26 th December 2018

1) Obstetric shock – by Dr. Leena Patil
Discussion on various modalities of treatment of treating obstetric shock with two case presentations

2) Ultrasound in icu –dr shailendra petkar …cardiac anesthesiologist and intensivist at fortis mauritious
Ultrasound in icu almost relapcing x ray … from head to bottom …. Lung ultrasound, FAST asessment in trauma,,, difficult airway assessment, cardiac ejection fraction aseessment, technique of putting central line usg guided, measuring icp by optic nerve diameter and TCD.

3) Plural effusion --- Dr kalpesh Gandhi
Dd of pleural effusion when to intervene and when not to intervene .

Meeting attened by 30 delegates including chairman and secretory of society ......
ACE and ISCCM, Jaipur

Present

Renal Replacement Therapy in ICU
A short course of the theory and application of RRT in Acute Care

17 February 2019 | 9AM to 1:30PM
Venue: Hotel Ramada, Jaipur

✓ Basics of RRT ✓ RRT in ICU ✓ Prescription writing and anticoagulation in CRRT
✓ CITRATE anticoagulation IN CRRT ✓ Acute PD in ICU

Dr. Panlaj Anand  Dr. Shabbar HK Joad  Dr. Jeetendra Goswami  Dr. Peeyush Mathur

For registration contact / whatsapp: 97845-99605

Limited Seats Available

Registration Charge: 1250/-
ENLS Workshop

conducted & certificated by
Neuro Critical Care Society, NCS (USA)
Trauma & update

Endorsed by Society of Neuro Critical Care (SNCC) India, ISCCM Chennai
& Supported by
Kauvery Hospital

Time: 8.00 AM to 04.00 PM
Date: 23rd & 24th February 2019
Venue: Rain Tree, St. Marys Road, Alwarpet

Course Fee:
- Consultant: Rs.4000/-
- Nurses: Rs.2000/-
- Trainee: Rs.3000/-

For registration call: Mrs. Hema - 044 43502252
Email: isccmchennai@gmail.com

Convenor
Dr. Susovan Mitra
JALANDHAR ISCCM MEETING HELD ON 30TH NOVEMBER 2018

Jalandhar ISCCM meeting held on 30th November 2018

Topic was Guidelines of Nutrition in ICU Speaker was Dr. N. K Vinod, (HOD Critical Care, Bangalore institute of Bangalore). It was well attended by 57 members.
Dear all,

Department of Critical Care Medicine, Mazumdar Shaw Medical Center, Narayana Health City, Bengaluru delighted to announce a “Evidence based CME on community acquired and tropical infections: An ICU perspective” on 3rd March 2019.

Note: All the delegates will get certificate with credit hours accredited by Karnataka Medical Council. To make the event more of interactive, registrations are restricted to 80 only on first come-first served basis.
<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>SPEAKER</th>
<th>CHAIRPERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 - 09:00 am</td>
<td>Registration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 09:00 - 09:30 am | Partially treated severe community acquired pneumonia: Interactive case based discussion | Dr. Harish M M  
Consultant Incharge, Critical Care Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru | Dr. Sanjay OP  
Consultant  
Critical Care Medicine  
Narayana Institute of Cardiac Sciences, Bengaluru |
| 09:30 - 09:55 am | Practical approach to community acquired meningitis                   | Dr. Gopal Krishna Dash  
Consultant  
Critical Care Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru | Dr. Arjun Alva  
Consultant  
Critical Care Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |
| 09:55 - 10:20 am | Community acquired urosepsis: Risk stratification and treatment       | Dr. George K Varghese  
Senior Consultant  
Internal Medicine & Infectious Disease  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |                                                                             |
| 10:20 - 10:45 am | Adjunctive therapies in community acquired pneumonia: what is the current evidence | Dr. Basha J Khan  
Senior Consultant  
Pulmonology  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |                                                                             |
| 10:45 - 11:00 am | Tea Break                                                             |                                                                        |                                                                             |
| 11:00 - 11:25 am | Community acquired infections in immunocompromised host               | Dr. Murali Mohan B V  
Senior Consultant  
Pulmonology, Internal Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru | Dr. Muralidhar Kanchi  
Academic Director  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |
| 11:25 - 11:50 am | Treating H1N1: What we know and what we don’t?                        | Dr. Natesh R Prabhu  
Assistant Professor  
Critical Care Medicine  
St. Johns Medical College, Bengaluru |                                                                             |
| 11:50 - 12:15 pm | Prognostication and Biomarkers in Community acquired infections        | Dr. Pradeep Rangappa  
Consultant  
Intensive Care  
Colombia Asia Referral Hospital  
Yeshwanthpur, Bengaluru | Dr. Hemanth HR  
Senior Consultant  
Critical Care Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |
| 12:15 - 12:40 pm | Leptospirosis and Scrub typhus What an intensivist should know?        | Dr. Bhuvana Krishna  
Professor and Head  
Critical Care Medicine  
St. Johns Medical College, Bengaluru |                                                                             |
| 12:40 - 01:05 pm | Tropical pyomyositis: Is it different than regular skin soft tissue infection? | Dr. Vimal Bhardwaj D  
Consultant  
Critical Care Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |                                                                             |
<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>SPEAKER</th>
<th>CHAIRPERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>01:05 - 01:50 pm</td>
<td>Lunch Break</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 01:50 - 02:15 pm | Empirical approach to tropical prodrome: Interactive case based discussion | Dr. Jose Chacko  
Senior Consultant  
Critical Care Medicine  
Narayana Multispeciality Hospital  
Whitefield, Bengaluru |  |
| 02:15 - 02:40 pm | ICU management of complicated malaria | Dr. Nithya C A  
Junior Consultant  
Critical Care Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru | Dr. Shiva Prasad  
Senior Consultant  
Critical Care Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |
| 02:40 - 03:05 pm | An unresolved community acquired pneumonia: How to tackle? | Dr. Ranganatha R  
Consultant  
Pulmonology  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |  |
| 03:05 - 03:30 pm | Syndromic approach to febrile encephalopathy | Dr. Sunil Karanth  
Senior Consultant  
Critical Care Medicine  
Manipal Hospitals, Bengaluru |  |
| 03:30 - 03:45 pm | Tea Break |  |  |
| 03:45 - 04:10 pm | Role of rapid diagnostics in community acquired infections: Hype or Hope? | Dr. Ajith Kumar A K  
HOD  
Intensive Care Services  
Manipal Hospitals, Bengaluru | Dr. Srinath Kumar T S  
Senior Consultant  
Emergency Medicine  
Mazumdar Shaw Medical Center  
Narayana Health City, Bengaluru |
| 04:10 - 04:35 pm | Managing complicated Dengue: ICU Perspective | Dr. Rathan Gupta  
Senior Consultant  
Critical Care Medicine  
Narayana Hrudayalaya-Bengaluru |  |
| 04:35 - 05:00 pm | Myocarditis in ICU: Diagnosis and management | Dr. Deepak Padmanabhan  
Consultant  
Electrophysiology  
Sri Jayadeva Institute of Cardiovascular Sciences, Bengaluru |  |
## TIME | TOPIC | SPEAKER
--- | --- | ---
05:00 - 05:30 pm | Doubt clearing session: Ask an expert? - steroids in CAP - NIV/HFNC in CAP - HCAP vs CAP - is it pneumonia or ARDS? - steroids in H1N1 - vaccination in H1N1 - steroids in Dengue thrombocytopenia - fluid choice in Dengue - platelet target in Dengue Many more…….. | Dr. Harish M M Consultant Incharge, Critical Care Medicine Mazumdar Shaw Medical Center Narayana Health City, Bengaluru Dr. Channamma Associate Consultant, Critical Care medicine Dr. Jinay Gala Consultant, Critical Care Medicine

---

**Registration Fees:** ₹. 1000 (Each Individual)

**PAYMENT INFORMATION:** NEFT or Cheque
Bank: ICICI Bank, MG Road Branch in favor of “Narayana Hrudayalaya Ltd”
A/c No: 000205025287, IFSC Code: ICIC0000002

**For Registration Contact:**
Dr. Harish M M - 9869250397 | Dr. Vimal Bharadwaj - 9686124830
Dr. Arjun Alva - 9108026001 | Dr. Nithya - 9075790057 | Mr. Amal Joseph - 8884007850

Address: Mazumdar Shaw Medical Center, NH Health City, 258/A, Bommasandra Industrial Area, Hosur Road, Anekal Taluk, Bengaluru
Dear all,

Department of Critical Care Medicine, Mazumdar Shaw Medical Center, Narayana Health City, Bengaluru delighted to announce a “Evidence based CME on community acquired and tropical infections: An ICU perspective” on 3rd March 2019.

Date: 3rd March 2019 | Time: 08:30 am to 5:30 pm
Venue: Harold Varmus Auditorium, 7th Floor, Mazumdar Shaw Medical Center, NH Health City, Bangalore

Note: All the delegates will get certificate with credit hours accredited by Karnataka Medical Council. To make the event more of interactive, registrations are restricted to 80 only on first come-first served basis.

Registration Fees: ₹. 1000 (Each Individual)
PAYMENT INFORMATION: NEFT or Cheque
Bank: ICICI Bank, MG Road Branch in favor of “Narayana Hrudayalaya Ltd”
A/c No: 000205025287, IFSC Code: ICIC0000002

For Registration Contact: Dr. Harish MM - 9869250397 | Dr. Vimal Bharadwaj - 9686124830
Dr. Arjun Alva - 9108026001 | Dr. Nithya - 9075790057 | Mr. Amal Joseph - 8884007850
<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>SPEAKER</th>
<th>CHAIRPERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 am - 09:00 am</td>
<td>Registration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:00 am - 09:30 am</td>
<td>Partially treated severe community acquired pneumonia: Interactive case based discussion</td>
<td>Dr. Harish M M MSMC</td>
<td>Dr. Sanjay OP NICS</td>
</tr>
<tr>
<td>09:30 am - 09:55 am</td>
<td>Practical approach to community acquired meningitis</td>
<td>Dr. Gopal Krishna Dash MSMC</td>
<td>Dr. Arjun Alva MSMC</td>
</tr>
<tr>
<td>09:55 am - 10:20 am</td>
<td>Community acquired urosepsis: Risk stratification and treatment</td>
<td>Dr. George K Varghese MSMC</td>
<td></td>
</tr>
<tr>
<td>10:20 am - 10:45 am</td>
<td>Adjunctive therapies in community acquired pneumonia: what is the current evidence</td>
<td>Dr. Basha J Khan MSMC</td>
<td></td>
</tr>
<tr>
<td>10:45 am - 11:00 am</td>
<td>Tea Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00 am - 11:25 am</td>
<td>Community acquired infections in immunocompromised host</td>
<td>Dr. Murali Mohan B V MSMC</td>
<td>Dr. Muralidhar Kanchi NH Health City</td>
</tr>
<tr>
<td>11:25 am - 11:50 am</td>
<td>Treating H1N1: What we know and what we don’t?</td>
<td>Dr. Natesh R Prabu St. Johns MC, Hospital</td>
<td>Dr. Hernanth HR MSMC</td>
</tr>
<tr>
<td>11:50 am - 12:15 pm</td>
<td>Prognostication and Biomarkers in Community acquired infections</td>
<td>Dr. Pradeep Rangappa Colombia Asia Hospital</td>
<td></td>
</tr>
<tr>
<td>12:15 pm - 12:40 pm</td>
<td>Leptospirosis and Scrub typhus – What an intensivist should know?</td>
<td>Dr. Bhuvana Krishna St. Johns MC, Hospital</td>
<td></td>
</tr>
<tr>
<td>12:40 pm - 01:05 pm</td>
<td>Tropical pyomyositis: Is it different than regular skin soft tissue infection?</td>
<td>Dr. Vimal Bhardwaj D MSMC</td>
<td></td>
</tr>
<tr>
<td>01:05 pm - 01:50 pm</td>
<td>Lunch Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01:50 pm - 02:15 pm</td>
<td>Empirical approach to tropical prodrome : Interactive case based discussion</td>
<td>Dr. Jose Chacko Narayana M H, Whitefield</td>
<td></td>
</tr>
<tr>
<td>02:15 pm - 02:40 pm</td>
<td>ICU management of complicated malaria</td>
<td>Dr. Nithya C A MSMC</td>
<td>Dr. Shiva Prasad NH Health City</td>
</tr>
<tr>
<td>02:40 pm - 03:05 pm</td>
<td>An unresolved community acquired pneumonia: How to tackle?</td>
<td>Dr. Ranganatha R MSMC</td>
<td></td>
</tr>
<tr>
<td>03:05 pm - 03:30 pm</td>
<td>Syndromic approach to febrile encephalopathy</td>
<td>Dr. Sunil Karanth Manipal Hospital, BLR</td>
<td></td>
</tr>
<tr>
<td>03:30 pm - 03:45 pm</td>
<td>Tea Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03:45 pm - 04:10 pm</td>
<td>Role of rapid diagnostics in community acquired infections: Hype or Hope?</td>
<td>Dr. Ajith Kumar A K Manipal Hospital, BLR</td>
<td></td>
</tr>
<tr>
<td>04:10 pm - 04:35 pm</td>
<td>Managing complicated Dengue : ICU Perspective</td>
<td>Dr. Rathan Gupta NH Health City</td>
<td></td>
</tr>
<tr>
<td>04:35 pm - 05:00 pm</td>
<td>Myocarditis in ICU : Diagnosis and management</td>
<td>Dr. Deepak Padmanabhan Jayadeva Hospital</td>
<td></td>
</tr>
<tr>
<td>05:00 pm - 05:30 pm</td>
<td>Doubt clearing session: Ask an expert? -steroids in CAP -NIV/HFNC in CAP -HCAP vs CAP -is it pneumonia or ARDS? -steroids in H1N1 -vaccination in H1N1 -steroids in Dengue thrombocytopenia -fluid choice in Dengue -platelet target in Dengue Many more……...</td>
<td>Dr. Harish MM Dr. Channamma Dr. Jinay Gala</td>
<td></td>
</tr>
</tbody>
</table>
The Dept. of Anesthesiology & Critical Care Medicine, Sri Sathya Sai Institute of Higher Medical Sciences, Whitefield, Bengaluru India, has organized 4th INDO-US CRITICAL CARE MEDICINE UPDATE in association with Indian Society of Critical Care Medicine, Bengaluru Chapter & USA faculty, on 5th & 6th January 2019. Total registrations were 114. Faculty is from both USA and India.

Academics: a. didactic lectures are as follows:

**NEURO CRITICAL CARE**
1. Plenary lecture on Respiratory complications of neurological disease, Dr. Marie R. Baldisseri, Professor of Critical Care, University of Pittsburgh, Pennsylvania, USA.
2. Severe Traumatic Brain Injury with raised ICP Dr. Jose Chacko, Director, ICU, NH, Whitefield, Bangalore.
3. Neurosurgical options for medical problems Dr. Shankar Gopinath, Assoc Professor, Chief of Neuro Surgery, Ben Taub Hospital, BCM, and Texas.

**PULMONARY CRITICAL CARE**
1. Pulmonary Hypertension in ICU,Dr. Namita Sood , Professor, University of Texas, Houston, USA.
2. Being observant in the ICU,Dr. Kalpalatha Guntupalli,Professor, Pulmonology & Critical Care, BCM, Texas, USA.
3. Adult ECMO: Indications & Controversies, Dr Ajith Kumar A.K, Sr.ICU Consultant & HOD, Manipal Hospitals, Bengaluru.

**CARDIAC CRITICAL CARE**
1. Echocardiography in the management of ICU Patients, Dr. Shamim Badruddin Mawji, Asst. Professor Cardiology, University of Texas.
2. Endovascular aortic repair – An update Dr. Srikanth Damaraju, Asst. Professor Cardiology, University of Texas.
3. Management of Acute Heart Failure and Shock, Dr. Srinivas Murali Professor of Medicine, Chairman, Dept of Cardiovascular Medicine, Lewis Katz School of Medicine at Temple University Drexel University College of Medicine Pittsburgh, PA.

**SEPSIS**
1. Pathophysiology of Sepsis Dr. T.R Chandrasekhar, BMC, Bengaluru.
2. Sepsis Diagnosis and Empiric Antibiotic Management Dr. Ramya Gopinath, Consultant, Infectious Diseases, Maryland, USA.
3. Prevention of AKI in critically ill Dr. Sai Kaumudi Saridey, Assistant Professor, Nephrology, BCM, Houston, TX.
4. Sepsis Bundles Dr. Kolli S. Chalam, HOD, Anesthesiology & CCM, SSSIHMS, WFD.
5. Functional hemodynamic monitoring in Sepsis, Dr. Manjunath T, Consultant intensivist, Manipal Hospitals, Whitefield, Bengaluru.

**GENERAL CRITICAL CARE**
2. Liver Transplant complications and ICU care, Dr. Vrushali Choudhary, consultant, Anesthesiology & CCM, SSSIHMS, WFD.

**Workshops** held were two, namely Mechanical ventilation attended by 45 delegates and Fundamentals of Critical Care Obstetrics attended by 35 delegates. FCCS (OBG) Course was led by Dr. Marie Rosanne Baldisseri, MD, MPH, Professor, Department of Critical Care Medicine University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

**Critical Care Nursing CME** : As part of 4th Indo US Critical Care Medicine Update, Critical Care Nursing CME was conducted in Sushruta hall, Saturday 5th Jan 2019: Time. 8.30 AM – 3.00PM. 75 nurses attended.

**Topics and faculty are as follows:**
1. Inotropes, Fluid resuscitation Dr. Namita Sood, Professor, Pul/CC, university of Texas, Houston.
2. AM Partnership for Performance Improvement, Dr. Kalpalatha Guntupalli, Pul/CC, Professor, Baylor College of Medicine, Houston, Texas.
3. Reducing CAUTIs and surgical site infections, Dr Ramya Gopinath, Consultant, Infectious Diseases Maryland.

4. Common problems and solutions in Neuro ICU, Dr. Shankar Gopinath, Associate Professor, Chief of Neuro Surgery, Ben Taub Hospital, Houston, Texas.

5. The deteriorating patient: Recognition and management, Dr. Mayur Narayan, Attending Trauma Surgeon, Weill Cornell Medical Center, New York.

6. Arrhythmia problems in critical care units, Dr. Shamim Badruddin Mawji, Asst. Professor Cardiology, University of Texas.

7. Troubleshooting during hemodialysis, Dr. Sai Kaumudi Saridey, Assistant Professor, Nephrology, Houston, Texas.

8. How to handle when Life threatening labs are reported, Dr. Sridevi Devaraj PhD DABCC, Professor, Baylor College of Medicine, Houston, Texas.

9. Evidence based practice in wound care, Mr. Suresh Srinivas Balasubramnian RN, Texas.
Glimpses of academic meet of ISCCM Meerut Branch on Friday 18th Jan 2019, D. A. K. Sethi HOD anaesthesiology and critical care, GTB hospital, New Delhi, delivered his talk on “Interpretation of Blood Gases-Made Easy.” Session was chaired by Brig. Dr. V. P. Singh (HOD Anaesthesiology, Subharati Medical college, meerut), and Dr. Pradeep Jain (senior consultant physician, meerut). It was a good academic meet with wonderful interaction between speaker, chairperson and audians. There was maximum gathering on that day, the number reached to 103 delegates to participate in the meet. I thanks to all the participants and executives of ISCCM Meerut branch for making it a grand success once again.

Thanks and Regards

Dr. Amit Agarwal Secretary ISCCM
Meerut Branch
### New Branch Committee Member List

**GURUGRAM**

<table>
<thead>
<tr>
<th>Chairman</th>
<th>Secretary</th>
<th>Treasurer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Sadeep Dewan</td>
<td>Dr. Jeelendra Sharma</td>
<td>Dr. Shrikanth Srinivasan</td>
</tr>
</tbody>
</table>

**E C Members**

Dr. Tapesh Bansal | Dr. Ashish Kumar | Dr. Mohit Kumar | Dr. Mukesh Kumar Gupta | Dr. Tarun Jhamb | Dr. Sweta Patel |

### Executive Committee Member List

**FARIDABAD**

<table>
<thead>
<tr>
<th>Chairman</th>
<th>Secretary</th>
<th>Treasurer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Sandip Bhattacharya</td>
<td>Dr. Supradip Ghosh</td>
<td>Dr. Vijay Kumar Aggarwal</td>
</tr>
</tbody>
</table>

**E C Members**

Dr. Amandeep Singh | Dr. Abhishek Bansal | Dr. Ripenmeet Salhotra | Dr. Aayush Chawla | Dr. Ashok Kumar Sharma | Dr. Piyush Giridhar |

### New Branch Committee Member List

**CUTTACK**

<table>
<thead>
<tr>
<th>Chairman</th>
<th>Secretary</th>
<th>Treasurer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof. Prasanna K. Mishra</td>
<td>Prof. Rekha Das</td>
<td>Dr. Tadit Mohanty</td>
</tr>
</tbody>
</table>

**E C Members**

Prof. Jyoti Patnaik | Dr. Manas Nayak | Dr. Sampat Nayak | Dr. Manoranjan Dash |
Dr. Swagata Tripathy

Enteral versus intravenous approach for the sedation of critically ill patients: a randomized and controlled trial.


Introduction

The hypothesis of the present study is that enteral (EN) sedative drugs protocol could avoid over sedation and maintain a light and effective sedation, compared to IV continuous infusion of sedatives. Side effects and costs may also be less.

Methodology

In this randomized, controlled, multicentric, single-blind trial study in 12 Italian ICUs, adult patients expected to be ventilated for > 72 hours with SAPS score > 32 (in first 24 hour) were randomised into 2 sedation protocols after adequate analgesia. In the control group patients received IV propofol or midazolam throughout, whereas in the experimental group, after the first 48 hours’ where IV drugs were allowed, melatonin, hydroxyzine, and possibly lorazepam were administered enterally. Physicians were invited to state the target sedation level for each work shift, aiming as soon as possible for a conscious, calm, patient. IV boluses of fentanyl or morphine and/or IV sedatives were not considered violations in the EN arm when used for painful. The main outcome was percentage of work shifts with the patient having an observed Richmond Agitation-Sedation Scale (RASS) = target RASS ±1. Secondary outcomes were feasibility, delirium-free and coma-free days, costs of drugs, length of ICU and hospital stay, and ICU, hospital, and one-year mortality.

Results

348 patients enrolled, with > 10% loss to follow up at 1 year follow up. Primary outcome: enteral 89.8% (74.1–100), intravenous 94.4% (78–100), p = 0.20 was not different. Enteral-treated patients had more protocol violations: n = 81 (46.6%) vs 7 (4.2%), p < 0.01; more self-extubations: n = 14 (8.1%) vs 4 (2.4%), p = 0.03; a lighter sedative target (RASS = 0): 93% (71–100) vs 83% (61–100), p < 0.01; and lower total drug costs: 2.39 (0.75–9.78) vs 4.15 (1.20–20.19) /day with mechanical ventilation (p = 0.01).

Main Limitations and strength

An unexpected difference in RASS targets was a significant limitation of this study (target RASS = 0 in 93.3% of the EN vs 82.9% of the IV group) and might have favoured the IV sedation protocol. Half the patients in the EN group had protocol violations, meaning the groups were not adequately separated. Also, authors are themselves concerned about the cultural changes that might be needed to accept a broad based enteral sedation protocol.

Multicentric. Authors claim that lack of homogeneity among participant centres could render the results generalizable. The protocol followed is for maintaining an alert patient, which is a desirable one.

Conclusions

Enteral sedation may be cheaper and permit a lighter sedation target, but it is not superior to iv sedation for reaching RASS target. Trial registration: ClinicalTrials.gov, NCT01360346.

Food for thought - external validation

- How clinically significant is a cost difference of 1.5 euros /day? - (theyhaven’tuseddexmedetomidine)
- Are the higher rates of self extubation (although no increased patient harm and similar rates of reintubation) acceptable?
- Will the drugs used for enteral sedation be freely available to us?
- Authors call for a cultural change – perhaps the biggest Achilles heel in its external validity!

Dr. Swagata Tripathy

Pantoprazole in Patients at Risk for Gastrointestinal Bleeding in the ICU.


BACKGROUND

The risks and benefits of the routine use of pantoprazole in the ICU are not well known.

METHODS

In an European multicentric (5 centres in Europe and UK) blinded RCT, all patients admitted to the ICU acutely (unplanned admission) with a risk of GI bleeding, were randomised to receive 40 mg intravenous Pantoprazole or placebo daily. Primary outcome was death at 90 days after inclusion into study. Patients were quite sick, in general, with median SOFA scores of 9: shock, antiocoagulant use, renal-replacement therapy, mechanical ventilation, liver disease, or coagulopathy were among the risk factors present.

RESULTS

Out of 3300 patients enrolled, about 1650 in each group, 99.5% had data available on the primary outcome. 31.3% in pantoprazole group and 30.4% in placebo group had died at 90 days, the difference being non-significant. During the ICU stay, at least one clinically important event (a composite of clinically important gastrointestinal bleeding, pneumonia, Clostridium difficile infection, or myocardial ischemia) had occurred in 21.9% of patients assigned to pantoprazole and 22.6% of those assigned to placebo (relative risk, 0.96; 95% CI, 0.83 to 1.11). In the pantoprazole group, 2.5% of patients had clinically important gastrointestinal bleeding, as compared with 4.2% in the placebo group. The number of patients with infections or serious adverse reactions (GI bleeding, C. difficile infection, or myocardial ischemia) and the percentage of days alive without life support within 90 days were similar in the two groups.

CONCLUSIONS

Among adult patients in the ICU who were at risk for gastrointestinal bleeding, mortality at 90 days and the number of clinically important events were similar.

SYNOPSIS

- Although there was no statistical difference for some secondary
adverse events as the study was not powered to measure them, the absolute numbers necessitate deeper thought.

- 47 more placebo group needed RBC transfusion. (NNT 35)
- 10 more patients in placebo group were transfused ≥2 units of packed red cells. (NNT 164)
- 13 more patients in placebo group required new or increased vasopressors (NNT 126)
- 12 more placebo patients required endoscopy and two more each required surgery (5 vs. 3) or embolization (4 vs. 2).

So what do we conclude? Definitely not that Pantoprazole doesn’t help. But if such a large study in patients with such high-risk groups shows only limited benefits over placebo, then one has to question their benefits over H2 Receptor blockers or when administered to patients in ICU who are less ill or have lesser risk factors.

**Kundan Mittal, Utkarsh Sharma, H K Aggarwal, Vivek Gupta, Ranvir Tyagi**

**Non-invasive approach for de novo acute hypoxemic respiratory failure: non-invasive ventilation, high-flow nasal cannula, both or none?**


**Purpose of review**

To summarize the recent evidence regarding the use of non-invasive strategies for de novo acute hypoxemic respiratory failure (AHRF).

**Recent findings**

New guidelines for the use of non-invasive ventilation (NIV) in acute respiratory failure have been published. In parallel, high-flow nasal cannula (HFNC) is an emerging non-invasive strategy for AHRF patients. Although some have cautioned against the use of NIV in AHRF, new encouraging data about the use of a helmet interface for NIV in acute respiratory distress syndrome may overcome the limitations of facemask NIV.

**Summary**

In the last two decades, the use of NIV and HFNC in patients with AHRF has considerably expanded, changing the paradigm of management of AHRF. Choice of each technique should be based according to centre experience and patient tolerability. However, when using non-invasive strategies for AHRF, it is crucial to predefine specific criteria for intubation and monitor patients closely for early detection of clinical deterioration to avoid delayed intubation.

**Reviewer’s Comments**

There are many ways to improve oxygenation and ventilation in a patient with acute respiratory failure. Invasive ventilation has its own limitations beside many advantages. Use of non-invasive ventilation and HFNC are currently debated in ARF. Both techniques, HFNC and NIV may be used in patients with ARFH. In fact, they have similar intubation rates (48 and 46%, respectively) even in severely hypoxemic patients. Facemask NIV may provide higher levels of PEEP but can be associated with excessive leak and mask intolerance. In contrast, HFNC may be a safe and well tolerated option for early hypoxemic ARF even in patients with PaO2/FIO2 less than 300 and bilateral infiltrates. Personalized bedside titration of HFNC settings might improve tolerance and physiologic benefits. A feasible approach may include starting with the highest flowrate tolerated (up to 60 l/min) at a lower temperature with a FIO2 at 1 followed by titration to SpO2 target of 88–92%. Given that the majority of the HFNC benefits are flow-dependent, it seems reasonable not to decrease the flow until the FIO2 is less than 0.5. Current ERS/ATS clinical guidelines for NIV do not offer any recommendation about the use of NIV for de novo ARF. In a study by Frat JP et al. (2015) it was found that HFNC was better tolerated than NIV. Giulia Spoletini and Nicholas S. Hii (2016) reported that in recent studies supported the idea that HFNC can be safely used in place of NIV in patients with hypoxemic respiratory failure, though not yet convinced that it was superior to NIV in all AHRF settings, other than with regard to comfort. In another systematic review published in Respiratory Medicine 2016 also concluded that HFNC may be superior to conventional oxygen therapy in AHRF patients in terms of oxygenation, patient comfort, and work of breathing. It may be reasonable to consider HFNC as an intermediate level of oxygen therapy between conventional oxygen therapy and NIV. Thus, lot of evidence is gathering regarding use of HFNC in ARF in adults. However potential benefit and harm of delayed invasive mechanical ventilation must be weighed. Further research is needed.

**Kundan Mittal, Manish Munjal, Ranvir Tyagi, Rajesh Mishra, H K Aggarwal, Savarna Aggarwal**

**Physiotherapy and Weaning From Prolonged Mechanical Ventilation**

Annia F Schreiber, Piero Ceriana, Nicolino Ambrosino, Alberto Malovini, and Stefano Nava. Respir Care. 2019 Jan;64(1):17-25

**BACKGROUND**

Patients undergoing prolonged mechanical ventilation represent up to 15% of all patients requiring weaning from mechanical ventilation. Although recent guidelines have recommended including physiotherapy early during mechanical ventilation to speed the process of weaning, only indirect evidence supporting the use of physiotherapy is available for patients receiving prolonged mechanical ventilation. The aim of our study was to evaluate the effects of a physiotherapy program in subjects requiring prolonged mechanical ventilation and the correlates of successful weaning.

**METHODS**

A retrospective analysis was performed on 1,313 consecutive patients admitted to a weaning unit over a 15-y period to be liberated from prolonged mechanical ventilation. Subjects underwent a program of intensive physiotherapy organized in 4 incremental steps (1–4) and were analysed according to the steps achieved (>2 steps or <2 steps). The rate of successful weaning was recorded, and possible predictors were considered. The 15-y period of observation was divided into 3 consecutive 5-y intervals.
RESULTS
Out of 560 subjects undergoing final analysis, 349 (62.3%) were successfully weaned. The weaning success rate was significantly greater in subjects attaining ≥ 2 steps than in subjects who attained < 2 steps (72.1% vs 55.9%, respectively, odds ratio = 2.04, 95% CI = 1.42–2.96, P < .001). Stepwise logistic regression analysis showed that achievement of ≥ 2 physiotherapy steps was the main predictor of successful weaning (odds ratio = 2.17, 95% CI = 1.48–3.23, P < .001). Underlying disease was also a predictor of successful weaning. The overall rate of successful weaning decreased, and the median duration of weaning increased, during the period of observation.

CONCLUSIONS
Our data support the inclusion of physiotherapy in the management of patients requiring prolonged mechanical ventilation.

Reviewer’s Comments
The process of liberation from mechanical ventilation is started as soon as the disease process starts recovering and 50% of time is spent on weaning of total duration of mechanical ventilation. Some patients require prolonged mechanical ventilation for various reasons. In these patient’s muscle weakness, malnutrition, anxiety, depression, chronic cardiac and respiratory diseases were important factor responsible for difficulty in weaning and extubation. Various studies have supported early mobilization and physiotherapy help in weaning from prolonged mechanical ventilation. For the purpose of the study, successful weaning was defined as a 7-d ventilator-free period after a successful SBT. Weaning outcome was also influenced by age and disease status. Various techniques of physiotherapy have been used with variable results. Early intervention helps in preventing complications, reducing patient hospital stay and improve function and quality of life. In this 15-y analysis of subjects undergoing PMV, an intensive physiotherapy program was useful in the management of these subjects. Subjects who achieved more physiotherapy steps showed higher weaning success. Attaining ≥ 2 physiotherapy steps was the main predictor of successful weaning. However, confounding factors such as age and underlying disease also influence weaning, thus making it impossible to draw conclusions regarding the effect of physiotherapy on weaning. N. Ambrosino et al. in their study published in Pulmonology Journal in 2011 also concluded similar results. Hence early physiotherapy helps in multiple ways during mechanical ventilation.

Kundan Mittal, H K Aggarwal, Manish Munjal, Ranvir Tyagi

Medical Ethics in Clinical Practice
Author: Matjaz Zwitter; Publisher: Springer Switzerland; Year of Publication: 2019; Pages: 216

Ethics and laws are essential components of physician life. They encounter lots of situations where ethical issues are critical. This book contains twenty-two chapters written for medical graduates covering various issues in day to day practice. This book covers even minute issue in each age group from treatment to death and research. Author has discussed various issues like ethics and laws, communication, malpractice, emergency medicine, genetics, transplantation, mentally ill, diagnosis, death, physician role beyond patient care and issues related to surrogate mother. Overall, this is a good book to read for physicians who are beginning their carrier.

Dr. Inderpaul Singh Sehgal

Effect of titrating PEEP with an esophageal guided strategy vs an empirical high PEEP-FIO2 strategy on death and days free from mechanical ventilation among patients with ARDS


Background
The efficacy of venovenous extracorporeal membrane oxygenation (ECMO) in patients with severe acute respiratory distress syndrome (ARDS) remains controversial.

Objective
To investigate if PEEP titration guided by esophageal pressure was more effective than empirical high PEEP strategy in subjects with moderate to severe ARDS.

Methods
Subjects with ARDS for 14 hospitals in North America were randomized 1:1 to set the PEEP either using the esophageal pressure guidance or the high PEEP. All subjects were ventilated using the low tidal volume strategy. The primary outcome was a ranked composite score comprising of deaths and days free from mechanical ventilator amongst the survivors through day 28. The secondary outcomes were 28-day mortality, ventilator free days and the need for rescue therapy.

Results
Two hundred subjects were included (n=102, esophageal pressure guided PEEP; n=98, high PEEP strategy). The mean (standard deviation [SD]) age of the study population (46% female sex) was 56 (16) years. There was no difference in the composite primary outcome between the two groups. The mortality in the esophageal pressure guided strategy (32.4%, 33/102) was not different from the high PEEP strategy (30.6%, 30/98). However, subjects in the esophageal pressure guided strategy required significantly fewer rescue therapy compared to the high-PEEP strategy group (24/102 [3.9%] vs. 12/98 [12.2%]). Barotrauma was seen in 6 subjects in the esophageal pressure guided strategy group and 5 subjects in the high PEEP strategy group.

Conclusion:
Setting of PEEP using esophageal pressure guidance did not reduce mortality or ventilator free days in subjects with moderate to severe ARDS. Positive end expiratory pressure (PEEP) is an important component in the management of acute respiratory distress syndrome (ARDS). PEEP improves hypoxemia by recruiting the
collapsed alveoli thereby reducing intrapulmonary shunting. Thus it is prudent to set proper PEEP as inappropriately high levels of PEEP may cause over-distension of the alveoli thus causing baro- and volu-trauma, whereas an inadequate PEEP can result in atelectrauma. In a previous study, the use of esophageal pressure guidance resulted in better oxygenation and lung compliance. However, it was a small study and did not demonstrate any survival benefit using the esophageal pressure guided ventilation.\[^1\] So a multicentric study with an aim to include 200 subjects with moderate to severe ARDS was planned to study the impact of esophageal pressure guided ventilation.\[^2\] The authors hypothesized that the use of esophageal pressure guided strategy would be superior to the high PEEP strategy.\[^3\] The key differences in the two trials are highlighted in table 1. There were a few differences with the previous trial.\[^1\]

Table 1. Comparison of baseline characteristics and outcomes of subjects in trials using esophageal guided peep strategy at baseline.

<table>
<thead>
<tr>
<th>Parameters</th>
<th>EPVent[^1]</th>
<th>EPVent[^2]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PES</td>
<td>Control</td>
</tr>
<tr>
<td>Number of subjects</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>Mean PaO2/FiO2, ratio</td>
<td>147±56</td>
<td>145±57</td>
</tr>
<tr>
<td>Respiratory compliance, in mL/cm H2O</td>
<td>36±12</td>
<td>36±10</td>
</tr>
<tr>
<td>Predicted Body weight, kg</td>
<td>67±8.9</td>
<td>63.2±11.1</td>
</tr>
<tr>
<td>APACHE II score</td>
<td>26.3±6.4</td>
<td>26.8±6.5</td>
</tr>
<tr>
<td>Applied PEEP, cm H2O</td>
<td>18±5</td>
<td>12±5</td>
</tr>
<tr>
<td>Upper limit of plateau pressure, cm H2O</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>PThres, cm H2O</td>
<td>&lt;25</td>
<td>&lt;20</td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>17%</td>
<td>39%</td>
</tr>
<tr>
<td>Ventilation free days at day 28, in days</td>
<td>11.5</td>
<td>7</td>
</tr>
</tbody>
</table>

APACHE: acute physiology and chronic health evaluation; ARDS: acute respiratory distress syndrome; PaO2/ FiO2 ratio: partial pressure of oxygen/ fraction of inspired oxygen ratio; PEEP: positive end expiratory pressure; PES:esophageal pressure guided strategy; PTPexp: transpulmonary pressure at end expiration; PTPinsp: transpulmonary pressure at end inspiration.

The difference between the two studies could be attributed to the difference in baseline characteristics and intervention. EPvent1 study was a single centre study and had a higher proportion of subjects with extrapulmonary ARDS compared to the EPvent 2 study in which the proportion of subjects with pneumonia was higher. There was also a difference in the level of applied PEEP in the control arms of the two studies. The authors did not find any difference in the composite primary outcome whether esophageal pressure guided strategy or an empiric high PEEP was used.\[^3\] However, fewer rescue therapies were required in the esophageal pressure guided strategy. Importantly, the subjects did not undergo prone position ventilation and thus this remains unknown if esophageal pressure monitoring would be beneficial during prone position ventilation. Also, the study was underpowered to demonstrate mortality benefit using either strategy. To study a fall in mortality from 30% in the control arm to 20% in the intervention arm a sample size of 294 subjects were required in each arm to provide the study a power of 80%.

So, what are the clinical implications of this study?

The results of this study suggest that at centers where the facility of esophageal pressure monitoring is not available a high PEEP strategy could be used for ventilating subjects with moderate-severe ARDS. More studies however are needed to demonstrate a survival benefit using esophageal pressure guided ventilation strategy. Future trials should also investigate the role of esophageal pressure monitoring during prone position ventilation in subjects with ARDS.

REFERENCES
Q1 Who am I?
Identify the personality?
What is he famously known as?
Q2 When was the first issue of IJCCM released?
Q3 What does ‘PRN’ in a medication chart stand for?
Q4 Explain ‘Daughter from California’ Syndrome?
Q5 Identify the two devices seen in the x-ray

Q6 Which famous trial is this?

If the vessel tone has collapsed…
And use of catecholamines is overtaxed…
Correction of BP and SOFA score is faster…
Angiotensin II is the master!
Q7 Full form of INDICAPS
Q8 Which is the category 6 patient in a triage in ER?
Q9 What device was inspired from the use of a toilet plunger on a patient by his wife?
Q10 A 62 year old female, presents with severe bout of coughing, after choking over an amla.
She has severe pain in chest and is coughing out blood. She is tachycardic and tachympnoic, on presentation.
Below is the CT image. Diagnosis?

ANSWER IN NEXT ISSUE
THEME
PRECISION IN INTENSIVE CARE

Workshop: 26th - 27th February 2020
Conference: 28th February - 1st March 2020
Venue: Hyderabad International Convention Centre (HICC)