## ISCCM NEWS HEADLINES

- Criticare 2017 an academic extravaganza
- Multiple regional conferences across the country
- First thematic conference on critical care and infections in liver disease
- ISCCM Examinations - Prometric
- Journal Scan
- 'Battle of the Brains' - Quiz

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**Block Your Dates**

**CRITICARE 2018**

7-11 March, 2018 • Varanasi

**EDITORIAL OFFICE**

Dr. Yatin Mehta  
272 Espace, Nirvana Country, Gurgaon 122001  
Mobile : +91 9971698149 • emails : presidentelect@isccm.org

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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
Dear Friends,

It is a pleasure to take over the editorship of the Critical Care communications which has been doing so well under Dr. Kapil Zirpe. It is a difficult act to follow and to maintain the high standards, I have selected a highly academic and motivated team from different parts of the country; some old, some new, bringing in a mixture of experience with enthusiasm and fresh ideas.

In addition to the standard features like information about various branch activities and messages from the President (Dr. Kapil Zirpe), Secretary (Dr. Subhal Dixit) and myself. We are introducing a few new features like ‘Image section’ and ‘Guidelines section’ for the post graduates so that within my tenure we should be able to cover at least the important (from the examination point of view) guidelines in Critical Care.

In the end my team and I, would like to congratulate Dr. Mohan Mathew and his team at Cochin for organising such a wonderful annual conference of ISCCM whose few memorable photographs are there in this issue.

Happy Reading!

Dr. Yatin Mehta
Editor in Chief,
The Critical Care Communications
President-Elect, ISCCM

www.isccm.org
Dear Friends,

I am deeply honoured to serve as President of our society. As I accept this opportunity I draw inspiration, strength and drive from my predecessors to deliver our commitment to take ISCCM to greater heights.

As we look back and reflect the last 23 years of ISCCM, I can see satisfaction, pride and a desire to do better with your blessings and support. We all know how rapidly Critical Care medicine has evolved in the last two decades and each and every one of us are proud to take due credit.

Embarking on this new journey I would like to express my deep gratitude for those who have guided us and those will continue to lead us into a brighter more glorious future tomorrow.

My first task in this office will be to simplify and address all challenges in easier implementation of critical standards for all stakeholders. In an era of digital and evidence based integrated care we shall embrace new technology, digitilization and make our clinical outcomes more robust. I dream of taking Critical Care to the most remote and deserving village of India.

I would look ahead to personally listen, speak, discuss, deliberate on all aspects of evolving our young blooming branch. I believe communication is the glue that will help us to strengthen this endeavour and stay connected.

We must pioneer new approaches to learning & teaching. The College Board will actively collaborate to promote education and research. Younger minds and creativity along with innovation in critical care medicine will be encouraged to actively indulge in pursuing higher goals by enhancing research fellowships, travel grants and international fellows exchange programs.

I will strive tirelessly to ensure no politics or individual agendas find a place, between our society & its goals. I invite your comments, suggestions, constructive criticism and feedback on a personal as well as society platform for any changes and improvements that are beneficial to our common goal.

Nurses Training Program -
ISCCM Jodhpur

A Nurses Training Program on Oral Care and VAP prevention was conducted by ISCCM Jodhpur City Branch in co-ordination with Department of Anaesthesiology & Critical Care, AIIMS Jodhpur on 10th February 2017. Total sixty-nine (69) ICU staff nurse participated from all over Jodhpur and discussion on following topics was done:

1. Oral Care for Mechanically Ventilated Patients: Dr.Nikhil Kothari, AIIMS Jodhpur.
2. Suction Protocols in an Intubated Patient: Dr.Shilpa Goyal, AIIMS Jodhpur.
3. Ventilator Associated Pneumonia (VAP) Definition & Prevention: Dr. Sadik Mohammed, AIIMS Jodhpur.

The lectures were followed by hands-on workstations, in which practical tips and guidelines regarding Oral Care, Endotracheal suctioning and on protocols for VAP prevention were discussed.
Dear all

Thanks for bestowing your faith in me and giving me my second term as general secretary with additional charge of secretary examination.

Over the last few years ISCCM has grown with a rapid pace in all aspects including membership, educational activities across the length and breadth of India and at an international level with mutual agreements with SCCM, ESICM.

ISCCM ensures to keep up with its educational programs throughout the year via meetings and webinars in order to reach and spread knowledge to one and all.

The college is very active in all aspects and has introduced the new online exam pattern which has been implemented from this year.

I am happy to inform that more and more hospitals and teachers are been inducted and approved for the training of young doctors in critical care.

ISCCM is also reaching out to all its members and students across various branches via the ISCCM app and student and branch management system which has been introduced from this year.

I request all my friends of ISCCM to feel free to get in touch with me anytime to plan and discuss any issues and also encourage their friends to become our members.

I assure you all that with the help of all my colleagues in the Executive committee under the dynamic leadership of Dr Kapil Zirpe we shall take ISCCM to greater heights.

Best wishes

ISCCM Examination – Prometric

ISCCM is proud to announce the introduction of its first online exam for IDCCM /POST MBBS courses. The first examination was conducted on 12th March 2017. This is the brain child of Dr Deepak Govil who has put in many hours of hard work. This has helped raise the bar for exit examinations even higher.

Prometric is the world’s leading provider of technology-enabled testing solutions. As a pioneer in computer-based testing, Prometric offer a history in testing that dates back 68 years as a pioneering enterprise in educational research and assessment. Together, Prometric and its parent company ETS® represent the “Gold Standard” against which other providers of test development and delivery services seek to operate.

Prometric is a trusted test development and delivery provider to more than 350 organizations worldwide. Exam sponsors trust Prometric to meet their certification and employment objectives by providing reliable, targeted, and innovative services that achieve their desired results and geographic reach. Prometric is an experienced leader in the field of healthcare catering to more than 60 clients ranging from allied health to medical specialties. Some of the key healthcare clients includes: National Board of Examinations (NBE), National Board of Medical Examiners (NBME), Association of American Medical Colleges (AAMC), Saudi Council of Health Specialties (SCHS), Medical Council of Canada (MCC), American Board of Pediatrics (ABP), American Board of Orthopedic Surgery and Irish Medical Council amongst others.

Beginning 2017, Prometric partnered with Indian Society of Critical Care Medicine (ISCCM) to deliver two of their prestigious exams namely Indian Diploma in Critical Care Medicine (IDCCM) and Post MBBS Certificate Course (CTCCM) in their own test centres at 8 locations across India. The first computerized administration of IDCCM was held on 12 March 2017. All exams were delivered in state of the art testing facilities providing best-in-class testing experience to candidates. Security and quality is of paramount importance to Prometric that aims to provide a professional testing experience to meritorious and honest test takers. For ISCCM, all candidates had to undergo enhanced security check along with image capture. All exams were proctored and were conducted under DVR surveillance. Candidate’s identification and admit cards were thoroughly checked and verified before they were seated in the lab for testing.
Guidelines for the Early Management of Patients with Acute Ischemic Stroke

GUIDELINES FOR THE EARLY MANAGEMENT OF PATIENTS WITH ACUTE ISCHEMIC STROKE

1. The use of a stroke rating scale, preferably the NIHSS, is recommended (I B).
2. Only the assessment of blood glucose must precede the initiation of intravenous rtPA (I B).
3. Either NECT or MRI is recommended before intravenous rtPA administration to exclude ICH (I A).
   • A sign of cerebral ischemia within the first few hours after symptom onset on NECT is loss of gray-white differentiation.
   • Blending of the densities of the cortex and underlying white matter in the insula (insular ribbon sign).
   • Increased densities within the occluded artery (MCA sign).
   • Clot within a branch of the MCA (MCA dot sign).
   • Diffusion-weighted imaging (DWI) has emerged as the most sensitive and specific imaging technique for acute infarct, far better than NECT or any other MRI sequence.
   • The artery susceptibility sign is the magnetic resonance (MR) correlate of the hyperdense MCA seen on NECT.
4. Intravenous fibrinolytic therapy is recommended in the setting of early ischemic changes (I A).
5. Noninvasive imaging of the cervical vessels should be performed routinely as part of the evaluation of patients with suspected TIA (I A).
6. Frank hypodensity on NECT may increase the risk of hemorrhage with fibrinolysis and should be considered in treatment decisions (III A).
7. Patients with elevated blood pressure and are otherwise eligible for treatment with intravenous rtPA should have their blood pressure lowered to systolic blood pressure <185 mm Hg and diastolic blood pressure <110 mm Hg (I B) before fibrinolytic therapy is initiated.
   • Higher blood pressures during the initial 24 hours were associated with greater risk of sICH in a linear fashion.
   • Intravenous Labetolol or Nicardipine can be used to decrease BP.
8. Airway support and ventilatory assistance are recommended for the treatment of patients with acute stroke who have decreased consciousness (I C).
   • Common causes of hypoxia include partial airway obstruction, hypoventilation, aspiration, atelectasis, and pneumonia.
   • Central periodic breathing (Cheyne-Stokes respirations) is a frequent complication of stroke and is associated with decreases in oxygen saturation.
9. Supplemental oxygen should be provided to maintain oxygen saturation >94% (I C).
   • Recent AHA guidelines for emergency cardiovascular care for stroke and resuscitated cardiac arrest patients recommend administration of oxygen to hypoxic patients to maintain oxygen saturation >94%.
10. Sources of hyperthermia (temperature >38°C) should be identified and treated (I C).
   • In acute ischemic stroke, hyperthermia is associated with poor neurological outcome, secondary to increased metabolic demands, enhanced release of neurotransmitters, and increased free radical production.
   • Hyperthermia may be secondary to a cause of stroke, such as infective endocarditis, or may represent a complication, such as pneumonia, urinary tract infection (UTI), or sepsis.
11. Hypovolemia should be corrected with intravenous normal saline (I C).
   • Hypovolemia may predispose to hypoperfusion and exacerbate the ischemic brain injury, cause renal impairment, and potentiate thrombosis.
   • Isotonic solutions such as 0.9% saline are more evenly distributed into the extracellular spaces (interstitial and intravascular) and may be better for patients with acute ischemic stroke.
12. Intravenous rtPA (0.9 mg/kg, maximum dose 90 mg) is recommended for selected patients who may be treated within 3 hours of onset of ischemic stroke (I A).
   • The US FDA approved the use of intravenous rtPA on the basis of the results of the 2-part NINDS rtPA Stroke Trial where there was an increase in the odds of a favorable outcome.
   • Spontaneous ICH remains the main risk.
13. The door-to-needle time (time of bolus administration) should be within 60 minutes from hospital arrival (I A).
   • The contraindications for intravenous fibrinolytic therapy are:
     ➢ Significant head trauma or prior stroke in previous 3 months.
     ➢ Symptoms suggest subarachnoid hemorrhage.
     ➢ Arterial puncture at noncompressible site in previous 7 days.
     ➢ History of previous intracranial hemorrhage.
     ➢ Intracranial neoplasm, arteriovenous malformation, or aneurysm.
     ➢ Recent intracranial or intraspinal surgery.
     ➢ Elevated blood pressure (systolic >185 mm Hg or diastolic >110 mm Hg).
     ➢ Active internal bleeding.
     ➢ Acute bleeding diathesis, including but not limited to.
     ➢ Platelet count <100 000/mm³.
     ➢ Heparin received within 48 hours, resulting in abnormally elevated aPTT greater than the upper limit of normal.
     ➢ Current use of anticoagulant with INR >1.7 or PT >15 seconds.
14. Intravenous rtPA (0.9 mg/kg, maximum dose 90 mg) is recommended for administration to eligible patients who can be treated in the time period of 3 to 4.5 hours after stroke onset (I B)
- As per ECASS III trial, the additional exclusion criteria were people >80 years old, those with a baseline NIHSS score >25, those taking oral anticoagulants (even if their INR was <1.7), and those who had the combination of a previous stroke and diabetes mellitus.

15. Intra-arterial fibrinolysis is beneficial for treatment of carefully selected patients with major ischemic strokes of <6 hours’ duration caused by occlusions of the MCA who are not otherwise candidates for intravenous rtPA (I B)
- Intra-arterial fibrinolysis is more efficacious for recanalization of proximal arterial occlusions.
- Severe neurological deficits (NIHSS score ≥10) that suggest a proximal arterial occlusion, radiographic evidence of occlusion of a major intracranial vessel and recent history of a major surgery which poses the risk for systemic bleeding with intravenous rtPA are considered potential indications for the use of intra-arterial therapy.

16. When mechanical thrombectomy is pursued, stent retrievers such as Merci (I A) and Trevo are generally preferred to coil retrievers such as Merci (I A).

17. The Merci, Penumbra System, Solitaire FR, and Trevo thrombectomy devices can be useful in achieving recanalization alone or in combination with pharmacological fibrinolysis in carefully selected patients (I IA)
- The Merci Retriever uses a memory-shaped nitinol wire with helical loops of decreasing diameter at its distal end to engage the clot. It is advanced through the microcatheter in its compressed form distal to the occlusion. Subsequent withdrawal of the microcatheter deploys the device in its preimposed helical shape.
- Urgent angioplasty with adjunctive stent deployment is being used to restore antegrade flow, with or without fibrinolysis or clot extraction.

18. At present, the usefulness of argatroban or other thrombin inhibitors for treatment of patients with acute ischemic stroke is not well established (IIb B), only to be used in clinical trials.

19. Urgent anticoagulation, with the goal of preventing early recurrent stroke, halting neurological worsening, or improving outcomes after acute ischemic stroke, is not recommended for treatment of patients with acute ischemic stroke (III A).

20. Initiation of anticoagulant therapy within 24 hours of treatment with intravenous rtPA is not recommended (III B).

21. Oral administration of aspirin (initial dose is 325 mg) within 24 to 48 hours after stroke onset is recommended (I A).

22. The usefulness of clopidogrel for the treatment of acute ischemic stroke is not well established (IIb C).

23. Aspirin and other antiplatelet agents that inhibit glycoprotein IIb/IIIa receptor are not recommended as a substitute for other acute interventions for treatment of stroke (III B).

24. The administration of high-dose albumin, use of devices to augment cerebral blood flow and the usefulness of drug-induced hypertension in patients with acute ischemic stroke is not well established (IIb B).

25. Hemodilution by volume expansion and use of vasodilatory drugs like pentoxifylline are not recommended (III A).

26. Patients already taking statins at the time of onset of ischemic stroke, continuation of statin therapy during the acute period is reasonable (IIa B).

27. The utility of induced hypothermia, transcranial near-infrared laser therapy is not well established for the treatment of acute ischemic stroke (IIb B).

28. The use of comprehensive specialized stroke care (stroke units) that incorporates rehabilitation is recommended (I A).

29. Patients with suspected pneumonia or UTIs should be treated with appropriate antibiotics. Subcutaneous administration of anticoagulants is recommended for treatment of immobilized patients to prevent DVT (I A).
ISCCM Academic Activity
CME Conducted 2017 - Visakhapatnam Branch

JAN-2017 23rd January, 2017  Ethical and Legal issues in End of Life care in ICU  Dr. Subhash Kumar Todi – Kolkata

FEB-2017 28th February, 2017  ICU Updates - 2017  Dr. Atchyuth, Dr. Kavitha & Dr. Hari Prasad - Vizag

ACE
(Academy for Critical Care Education)

IN ASSOCIATION WITH

ISCCM, Jaipur
(Indian Society of Critical Care Medicine)

PRESENT

Jaipur Haemodynamic Monitoring Workshop 2017

27th May, 2017 Saturday & 28th May, 2017 Sunday
Glimpse of CRITICARE 2017 Kochi
The 5th Annual Critical Care Refresher Course held on 15th to 18th February 2017 under the aegis of Delhi NCR chapter of ISCCM was conducted by the Gastro and Liver Transplant Critical Care Team of Medanta The Medicity. The course was conducted over a period of four days and covered various aspects of the subject in more than 70 lectures designed specifically for the exam going students. The Course Director, Dr Sachin Gupta, along with Dr. Mozammil Shafi, Course Co-ordinator ensured the course was made student friendly. Dr. Yatin Mehta, Chairman of Critical Care Institute at Medanta The Medicity and President Elect of ISCCM inaugurated the event along with the ever encouraging and excellent teacher, Dr. Deepak Govil, Director Critical Care at Medanta The Medicity and Vice Chancellor, Indian College of Critical Care. The students had the opportunity to interact with varied eminent International (Australia, London, Oman) and National faculty based at Delhi NCR. The participation touched more than 200 candidates from all parts of the country and appearing in various National and International Critical Care exams and was appreciated thoroughly. The candidates were handed over the relevant study material and all the presentations in the form of audio visual clips in a pen drive and also as a Google drive link.

Monthly Meeting
January Monthly Meeting Date was organised on 21st Jan 2017 at Willow Hall, India Habitat Centre. New Delhi
Organized by Dr Yash Javeri/Dr Munish Chauhan
Chairpersons: Dr Tariq Ali and Dr Prashant Saxena

Agenda
1. Interesting Skin Lesions in ICU - Dr Munish K Chauhan, Venkateshwar Hospital, Delhi
2. Interesting Case presentation - Dr Tarun Jhamb, Columbia Asia Hospital, Gurgaon
3. Journal Club - Dr. Prashant Kumar, Medanta Hospital, Gurgaon

Executive Committee Meeting
SCCM Delhi NCR held on 14th January at CSOI, New Delhi.

IDCC Preparatory Course
IDCC Preparatory Course conducted by Dr Prakash Shastri held on 26th February 2017 at Hotel Metropolisan, New Delhi

Organised by
Dr. Surya Prakash Sahu
Secretary, ISCCM, Raipur chapter

Nutrition Workshop
Report of ISCCM Raipur Branch

Society of critical care medicine, Raipur chapter organised a workshop on Nutrition on 12 Feb 2017 that was a grand success. Many of the city’s nephrologist, gastroenterologist, nutritionist and intensivist were present here.
In 1981, Dr Archie Brain completed a lucid style, and directed not only to care. It is a comprehensive book written in the field of Anesthesia and critical care. This book has been prepared by renowned faculty members and critical care. It is a comprehensive book written in a lucid style, and directed not only to anesthesiologists and intensivists, but also emergency physicians, surgeons and orthopedic surgeons managing trauma patients. The book should prove to be useful to postgraduates, senior residents and consultants.

**About The Author : Babita Gupta**

Dr. Babita Gupta is an additional professor in department of anesthesiology, pain medicine and critical care at Jai Prakash Narayan Apex Trauma Center, All India Institute of Medical Sciences, New Delhi. She is a passionate teacher and has been actively organizing various workshops pertaining to trauma anesthesia and critical care. She has a number of national and international publications to her credit.

**The highlights of the book are:**

- Burden of trauma
- Role of anesthesiologist in acute trauma care
- Initial approach to trauma patients
- Anesthetic and critical care management in specific trauma situations such as, traumatic brain injury, thoracic trauma, cardiac trauma, spine trauma, musculoskeletal trauma and abdominal trauma
- Principles of damage control surgery and damage control resuscitation
- Massive transfusion protocols
- Regional anesthesia with special emphasis on ultrasound-guided nerve blocks
- Brain death and organ donation

**Essentials of Trauma Anesthesia and Intensive Care 1st/2016**

Dr. Yusuf Bhambhani
Porbandar

**Answers to Fourth Episode**

1. Dr Archie Brain: The Laryngeal Mask
   In 1981, Dr Archie Brain completed his first prototype of the Laryngeal Mask at his home in London. Safer, more reliable and easier to use than any other equipment available at that time, this device is designed to keep the airway clear and to seal the larynx, thus protecting the lungs. Though it was originally turned down by several companies, since its development in the 1980s, the laryngeal airway has been used over 350 million times worldwide.

2. Lazarus sign is a reflex movement in brain dead patients, which causes them to briefly raise their arms and drop them.

3. DIANA. Determinants of Antimicrobial use and de-escalation in critical care

4. ELICIT -- End of Life Care in India Task Force

5. Fires involving ordinary combustible materials such as, cloth, wood, paper rubber and many plastics.

6. 3 to 7 days

7. MARS. Molecular adsorbent Recirculating System

8. Methotrexate and Methanol

9. Device for stool dis-impaction

10. 10/8/2010

Winners of Critiquiz 2016-2017

“Battle of the Brains”

Episode 4

Dr. Yatin Mehta and Dr. Yash Javeri

Please mail the answers at the earliest to dryashjaveri@yahoo.com

Correct answers with the name of first two correct entries will be published in next issue.

http://www.readwhere.com/read/917513
A 70-year-old woman with end-stage liver disease from hepatitis C was admitted to the hospital for confusion. A few days after admission, abdominal pain with marked abdominal distention developed. Abdominal Radiograph revealed.

What’s the likely diagnosis?

**Answer in the next issue**
Hypertension and hyperglycemia in patients with septic shock: A randomized, double-blind, multicenter, randomized, clinical trial

Pro Pratik Mehta, MD, Bahaa Eldin Ibdah, MD, Ali M. Alhussaini, MD, Majd F Al Amri, MD, Zainab M. Al Shalabi, MD, Ghada F. Al Sayari, MD, Noura S. Al Adwani, MD, Israeal Al Qalah, MD, Ali Al-Naimi, MD, Abdulaziz M. Alhussaini, MD, Reem M. Alkadi, MD, and Thabet Al-Sayari, MD

Objective: To explore the association between abstraction of the area of abscission and the presence of sepsis-related aKi and thereby prevent renal failure requiring renal replacement therapy (RRT).

Methods: This was a randomized controlled trial comparing thiamine to placebo in patients with septic shock. Objectives: The primary endpoints were survival and reduction in serum creatinine (SCr) from baseline to day 28 after randomization. Secondary endpoints included changes in eGFR, the need for RRT, and other renal and nonrenal outcomes. Results: A total of 288 patients were randomized to thiamine (N=141) or placebo (N=147) and followed for a median of 28 days. The primary endpoint of survival was significantly higher in the thiamine group (74.5%) compared to the placebo group (63.0%; HR 0.62, 95% CI 0.41–0.94; P=0.023). Conclusions: Thiamine is a renal protective agent in patients with sepsis and may prevent renal failure requiring RRT.
Although majority of neurotrauma patients require antibiotics, pneumonia (haP) in critically ill patients with low illness severity in China. Fifty patients completed the study, with 25 patients receiving standard of care and 25 patients receiving an intervention. The purpose of this study was to assess the pharmacokinetic (PK) and pharmacodynamic (PD) properties of piperacillin/tazobactam administered by extended infusion (EI) or bolus injection (BI). The patients were grouped by piperacillin/tazobactam and by biophase. In a biophasic PK population, a PK subset was characterized and compared with a non-biophase population. The study was designed to be a non-inferiority trial.

Methods: Administration of extended infusion compared to bolus injection of piperacillin/tazobactam.

Intra-operative infusion of anti-ICAM reduced the rate of the usual care group was greater than 30% (12 trials; RR, 0.83; 95% CI, 0.70–0.98, very low confidence). We evaluated clinical outcomes, laboratory values, and sensory and motor outcomes.

Conclusion: Intra-operative anti-ICAM resulted in improved outcomes.

The effect of early goal-directed therapy for treatment of severe sepsis or septic shock: A systematic review and meta-analysis

To evaluate the effects of early goal-directed therapy (EGDT) on mortality comparing EGDT to usual care in patients with severe sepsis or septic shock.

Methods: We performed a systematic review and meta-analysis of randomized controlled trials. The primary outcome of interest was mortality at 28 days.

Results: Twenty-nine studies met the inclusion criteria. The meta-analysis included 14,549 patients. The mortality rate was 31.9% in the EGDT group and 36.7% in the usual care group (RR, 0.85; 95% CI, 0.75–0.98). Sensitivity analysis showed that the results were robust to the exclusion of studies at high risk of bias.

Conclusion: Early goal-directed therapy reduces 28-day mortality in patients with severe sepsis or septic shock. Thirty-eight trials assessed the long-term effect of EGDT. The 2-year mortality rate was significantly lower in the EGDT group compared to the usual care group (RR, 0.83; 95% CI, 0.75–0.91). These results support the use of EGDT in patients with severe sepsis or septic shock.
Gender Parity in Critical Care Medicine

Abstract: Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. These documents inform and shape patient care around the world. In this perspective, we discuss the importance of diversity on guideline panels, the disproportionately low representation of women on critical care guideline panels, and existing initiatives to increase the representation of women in corporations, universities, and government. We propose five strategies to ensure gender parity within critical care medicine. (Am J Respir Crit Care Med 2017 DOI: 10.1164/rcm.201701-0076CP)

Our View: Such must happen in a uniform manner and with larger acceptance in the coming future. The imagined effects are great for a wholesome society at large.
Swagatham!

Friends,

I am honoured and privileged to assume the role of Chairperson of the 24th Annual Congress at Varanasi.

Situated on the bank of River Ganga, Varanasi is the oldest living city & considered as the holiest and most sacred place on this planet. Mark Twain once said, “Varanasi is older than history, older than tradition, older even than legend & looks twice as old as all of them put together.” It is also an important industrial center, famous for its carpet, silk fabrics, perfumes, ivory works & sculptures.

Banaras Hindu University is an internationally reputed temple of learning. It was founded by the great nationalist leader, Pt. Madan Mohan Malviya, in 1916. It played a stellar role in the independence movement & has developed into one of the greatest center of learning. It has produced many a great freedom fighters, renowned scholars, artists, scientists & technologist all contributing immensely towards the progress of modern India. We also proud to be associated with six Bharat Ratna Award.

I am confident that we will be steadfast in addressing the pressing challenges. On behalf of all of us, I am most pleased to welcome Prof. D K Singh who is organizing secretary of 24TH Annual Congress of ISCCM. Over his years of service in BHU, he has distinguished himself as a person with dedication, integrity, and professionalism. We are confident that he and his team will continue to make outstanding contributions to ISCCM.

Thus, on the behalf of Organizing Committee, Varanasi City Branch & BHU, I invite you all to join this excellent scientific feast at Varanasi in 2018. The city is eager to greet with you with spiritual music to enlighten your soul with learning & knowledge.