Critical Care Communications

A BI-MONTHLY NEWSLETTER OF INDIAN SOCIETY OF CRITICAL CARE MEDICINE

VOLUME 14.5 September-October 2019

Welcome to Criticare 2020 Hyderabad

Theme: Precision in Intensive Care

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

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

Message from President Elect

It has been an eventful quarter. Team of ISCCM presented its bid under the able leadership of Dr. Subhal Dixit, President ISSCM, in Melbourne for the year 2025 world congress, and has been allotted to India. It is a milestone in the history of our organisation. We are in the process of closing the scientific programme for CRITICARE 2020. Salient feature of scientific program will be reduction in number of halls and to have a post graduate corner/hall for the benefit of students and members pursuing training in critical care. Besides workshop in trauma and simulation have been added to fill the GAP between knowledge & skills. Highlight will be panel discussions, case discussions, introduction of CPC, sessions on skill training besides thematic & plenary sessions. In nutshell program planned is innovative, practical and skill based keeping the theme of “PRECISION IN CRITICAL CARE MEDICINE” in right.

As promised nearly 1/3 of the faculty will be of young rising intensivist working both in medical schools, NBE accredited institutions and in practice. We have tried our best to maintain a balance between experience & youth. Leadership of ISCCM has taken a principle decision to not to be faculty in the Criticare2020 except workshops & official engagements, to fulfil its dream to Ensure active participation of young turks and members.  
I am sure with active participation of members we will be able to make society more vibrant and criticare 2020 a success.  
I wish you all a happy new year with a hope that majority of us will attend the National Congress 2020 in Hyderabad and make it a great success.
Long live ISCCM

Dr. Dhruva Chaudhry  
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Dear friends

Greetings from President!

It’s been 10 months since my team has taken over in Mumbai, and it’s my pleasure to inform you that the team is doing a great job.

Executive meetings were held since February has been productive, and proactive decisions were planned and taken in college and ISCCM.

College Board was kind to accept and relax the second teacher criteria, national and various international conferences were approved for poster and paper presentations.

The direct exam rule to appear for IFCCM was approved, and many more new hospitals and teachers were recognised for training.

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I'm very happy to announce that the World Federation has accepted our bid presentation and has allotted the World Congress 2025 to India, ISCCM. It was a very tough call as we had to compete with other countries like Oman, Mexico, Sweden. Myself, Shrikant Sahatraoubddhe and Kalpana Uberoi from Meetings and More attended the bid meeting. Special thanks to Dr Kapil Zirpe for his help support to prepare the bid as a World Federation Council Member. Our video and presentation was very well appreciated!

I thank Meetings & More to help us prepare the bid for world congress. Thanks for all your support and well wishes!

National:
1) New members and branches have been added to the ISCCM family. I welcome all new members and branches and encourage them to spread critical care. The branch management systems will continue to connect them to the Centre.

2) The ISCCM DAY Committee planned the ISCCM Day on 9th October with its theme “Precise Nutrition with Precision”. This year we have planned a great show which needed tremendous cooperation and coordination.

3) The preparation for the most awaited event CRITICARE Hyderabad 2020 is in full swing and I’m sure Rajesh is not leaving any stone unturned to make it a grand show. The SC under Dhruva and Srinivas has been working hard to have an excellent academic festival. This year we have invited new faces on the international and national front. The Scientific program is almost ready covering all aspects of critical care. This year we have introduced new sessions like PG SECTION, INNOVATION SECTION, HANDS ON SESSIONS etc. and request you all to see the uploaded Scientific program.

4) The update book topics have been handcrafted by Dr Todi and the work on this is progressing rapidly and is now in its final stages of publications. I urge all young colleagues to register and send original papers and posters to be presented in CRITICARE. Top new faces have been invited as faculty on international front and as well as the national level where new dynamic faces will be unveiled.

5) The research wing, the HERMES study and Study on Percut V/S surgical tracheostomy DISSECT have been started and we plan to present its results in Hyderabad. Many more new studies have been submitted to ISCCM Research Committee which are in the pipeline. I request young dynamic researchers to come forward and do research on behalf of ISCCM which can be published at national and international level.

The INDICAPS 2 study of ISCCM was successfully conducted by Dr JV Divatia and I thank him on behalf of the Executive committee. ISCCM also supported the Mosaic Study.

5) Books: ISCCM will come out with 4 books and work on it is in progress. NIV, RRT, USG, TRAUMA books will be released in Criticare Hyderabad 2020. Sincerely Appreciate the efforts of Rajesh Mishra, Deepak Govil Sir; Simant Zha in publications of these respective books.

6) ISCCM has started its original research though the research wing, the HERMES study and Study on Percut V/S surgical tracheostomy DISSECT have been started and we plan to present its results in Hyderabad. Many more new studies have been submitted to ISCCM Research Committee which are in the pipeline. I request young dynamic researchers to come forward and do research on behalf of ISCCM which can be published at national and international level.

The INDICAPS 2 study of ISCCM was successfully conducted by Dr JV Divatia and I thank him on behalf of the Executive committee. ISCCM also supported the Mosaic Study.

6) ISCCM has submitted its antibiotic guidelines to ICMR and has got endorsement from the same from APCI, ICS, IAS, Surgical Society. ISCCM has joined hands with these societies and will be happy to have joint sessions with them in Criticare.

7) ISCCM has reached out to ICMR and NLEM Committee Govt Of India, and for the first time has got ISCCM on its board represented by President, President Elect on its committee. ISCCM will opine on the list of drugs to be included in NLEM.

8) Social Media: platform of ISCCM has been very active now with ISCCM shining on Twitter, Facebook, Instagram, Linked In. Thank you Suresh Ramasubam, Manish Munjal, Jayesh Dobariya, and Rahul Pandit for looking after the Social Media.

I welcome you all to CRITICARE HYDERABAD 2020, and request you to register for this grand event.

With Best Wishes,

Dr Subhabal Dixit
MD, FCCM, IDCCM, FICCM, FICP
• Director ICU Sanjeevan & MJM Hosp • President, ISCCM • Chancellor; ICCCM
• Address: 123/1 ApluGhar, Apte road Pune 411004, Maharashtra, India, Tel: +91-20-25331539/ 25339538
• Mobile: +91-9822050249, Email: president@isccm.org
Respected members,

Greetings from your General secretary!!

At the outset, I wish to congratulate you all for getting WFSICM 2025 to India; a dream which we all were looking for since 2013. Persistence and patience have finally paid and credit goes to all the leaders who successfully chased the dream and were able to bring this prestigious event to our country.

We are gearing up for our signature event, Criticare 2020 at Hyderabad. Criticare app has been made. All the members are being regularly updated. 2nd announcement brochure has been sent to you and please feel free to send us your feedback. Very soon you all will get a call to update your correspondence address, please do verify it.

This year we have added few new segments in our congress:

• Eighteen interesting original cases will be selected this year and those selected will get free registration and faculty status.
• A new student corner is being created where day to day issues will be discussed. Students will be able to interact with their mentor on one to one basis.
• Court room is being created to address common issues in real scenario
• We have come up with robust conference app this year. It will be a one-point solution for all your queries. This will guide you for registration, complete program and it will be GPS enabled. You will get an option to vote and give feedback after each lecture and session. Discussion, debate and interaction is our focus and you will find lots of it.

• We are planning to have a memorable Gala dinner. And if you are an entertaining enthusiast, we are going to give you an opportunity to perform at the Presidential night dinner.

I wish all of you be a part of the academic extravaganza and the mega event. Hope to see you all in Criticare 2020 at Hyderabad.

Thanks & Regards,

Dr Rajesh Chandra Mishra
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Theme: ‘Precise Nutrition with Precision’

Activity and Location

Fifty one city branches celebrated ISCCM Day (9th October). The theme ‘Precise Nutrition with Precision’ was celebrated with short and crisp power point presentation along with message from president. This ISCCM Day celebration will go a long way to built up the concept of nutrition in various cities. Overall it was a well appreciated programme. Fresenius Kabi was the principle sponsor.

**ISSCM Day Celebrated At Various Branches**

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ISSCM Day Celebrated At Various Branches

Imphal  Indore  Jabalpur  Jaipur
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Kolkata  Ludhiana  Madura  Mysore
Mysore  Nagpur  Nashik  Nellore
Panvel  Patiala  Pune  Ranchi
### ISSCM Day Celebrated At Various Branches

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Workshop 22 Nov ’19
Conference 23 - 24 Nov ’19

Venue: Aerocity Delhi

HIGHLIGHTS OF COURSE

- Basic Physiology
- Case Based Lectures
- Reputed National Faculty
- Simple to Advanced Haemodynamics
- Simulation Based Case Scenarios on Haemodynamics

- ECHO Workshop: 22 Nov
  Dr Rahul Pandit

- Ultrasound in Critical Care Workshop 22 Nov
  Dr Puneet Khanna

- Interactive Case Discussions
WEBINAR Report

Dr G C Khilnani, M.D, FCCP (USA), FAMS, FICCM, FICP, FNCCP, FISDA
Chairman, Institute of Pulmonary, Critical Care and Sleep Medicine, PSRI Hospital, N. Delhi
Ex: Professor & Head, Dept. of Pulmonary Medicine and Sleep Disorders, AIIMS, N. Delhi
Past President, National College of Chest Physicians
Member, Council of International Governors and Regents, ACCP
Member Executive council, Indian Chest Society
Chairman, Credential Committee, ISCCM

A Webinar titled ‘ISCCM Antibiotic guidelines: A case based discussion’ was conducted on 12th September, 2019 between 3-4 pm and following faculty participated:

Dr. G C Khilnani (Moderator)
Dr. Subhal Dixit (Pune)
Dr. Kapil Zirpe (Pune)
Dr. Dhruva Chaudhry (Rohtak)
Dr. Rajesh Chandra Mishra (Ahmedabad)
Dr. Subhash Kumat Todi (Kolkata)
Dr. Srinivas Samvedam (Hyderabad)

This webinar was a case based discussion and antibiotic prescription for following clinical cases were discussed in details

► Community Acquired Pneumonia
► Ventilator Associated pneumonia
► Severe sepsis in a young man
► Catheter related blood stream infection

The webinar also had questions and comments from audience which were received by emails. This activity was supported by M/S Cipla. More than 1400 doctors logged on and participated.
Early Neuromuscular Blockade in the Acute Respiratory Distress Syndrome
The National Heart, Lung, and Blood Institute PETAL Clinical Trials Network.

Synopsis: Dr. Inderpal Singh Sehgal

BACKGROUND: Whether use of early continuous neuromuscular blocking (NMB) agents in patients with acute respiratory distress syndrome (ARDS) improves outcomes remains unclear.

METHODS: Subjects with moderate to severe ARDS (ratio of the partial pressure of arterial oxygen [PaO2] to the fraction of inspired oxygen [FiO2] of <150 mm Hg with a positive end-expiratory pressure [PEEP] of ≥8 cm H2O) were randomized 1:1 to a continuous 48-hours infusion of cisatracurium with concomitant deep sedation or usual care using light sedation and without routine use of NMB agents. All subjects were ventilated using similar ventilatory strategy using high PEEP. The primary outcome was in-hospital death from any cause at 90 days.

RESULTS: The trial was stopped at the second interim analysis for futility. 1006 patients were early after the onset of moderate-to-severe ARDS (median, 7.6 hours after onset). In the intervention arm, 486 of the 501 patients (97.4%) received a continuous infusion of cisatracurium (median duration of infusion, 47.8 hours; median dose, 1807 mg), and 86 of the 505 patients (17.0%) in the control group received a NMB agent (median dose, 38 mg). There was no difference in the mortality at 90 days between the two study arms. 213 patients (42.5%) in the intervention group and 216 (42.8%) in the control group had died before hospital discharge (between group difference, −0.3 percentage points; 95% confidence interval, −6.4 to 5.9; P = 0.93). While in the hospital, patients in the intervention group were less physically active and had more adverse cardiovascular events than patients in the control group. There were no consistent between-group differences in end points assessed at 3, 6, and 12 months.

CONCLUSION: The use of NMB agent during the initial 48 hours in subjects with moderate to severe ARDS did not improve mortality at 90-days compared to the usual care of light sedation.

The use of neuromuscular blocking (NMB) agents during mechanical ventilation reduces the work of breathing by improving patient-ventilator interaction. The use of NMB agents also reduce the alveolar fluid accumulation. Thus, theoretically neuromuscular blockade should improve clinical outcomes including mortality in subjects with moderate to severe acute respiratory distress syndrome (ARDS). However, the prolonged use of NMB agents could also hamper the recovery due to a higher risk of persistent neuromuscular weakness. A previous trial comparing the routine use of NMB during the initial 48-hours of mechanical ventilation in subjects with moderate to severe ARDS had demonstrated better survival compared to deep sedation and without routine neuromuscular blockade.[1] Whether the use of NMB agents compared to lighter sedation (the current practice) would also improve the clinical outcomes is not known. The authors hypothesized that the use of NMB agents in the ventilating subjects with moderate to severe ARDS during the initial 48-hours would be associated with better clinical outcomes.[2]

The authors enrolled subjects with moderate to severe ARDS (ratio of the partial pressure of arterial oxygen [PaO2] to the fraction of inspired oxygen [FiO2] of <150 mm Hg) with a positive end-expiratory pressure (PEEP) of ≥8 cm H2O.[2] Patients in the intervention group were deeply sedated within 4 hours after randomization. Subsequently, they received an intravenous bolus of 15 mg of cisatracurium, followed by a continuous infusion of 37.5 mg per hour for 48 hours. The patients in the control arm were ventilated using light sedation (Richmond Agitation Sedation Scale [RASS] of 0 to −1 or Riker Sedation Agitation Scale of 3 to 4, or Ramsay Sedation Scale of 2 to 3). All the subjects were ventilated with the high PEEP and low tidal volume strategy. The subjects were prone ventilated at the physician’s discretion after 12 hours of ventilation. Subjects in the both the arms could be given 20 mg of cisatracurium boluses if they met prespecified criteria. If the end-inspiratory plateau pressure remained ≥32 cm H2O for at least 10 minutes, the patient received the administration of increasing doses of sedatives and decreasing tidal volume and positive end-expiratory pressure (if tolerated) before considering using open-labeled cisatracurium. If the treating physician still wanted to administer a neuromuscular blocking agent, an open-label, rapid, intravenous injection of 20 mg of cisatracurium could be administered for patients in the control or treatment. If this rapid, resulted in a decrease of the end-inspiratory plateau pressure by <2 cm H2O, a second injection of 20 mg of cisatracurium was allowed. If after injection, the end-inspiratory plateau pressure did not decrease or decreased by <2 cm H2O, cisatracurium was not allowed during the subsequent 24-hours. The primary outcome was all cause mortality at 90 days. The secondary outcomes were organ dysfunction, in hospital death at 28 days, ventilator free days, and the long-term outcomes that were assessed at 3, 6, and 12 months (survival, disability, health related quality of life, cognitive function, post-traumatic stress, and return to work). A total of 1408 patients were needed to be enrolled to provide the study 90% power assuming a mortality of 27% in the intervention arm and 35% in the control arm.

The trial was stopped due to futility after the second interim analysis. 1006 subjects were enrolled (501 in the intervention arm and 505 in the control arm). 488 patients in the intervention arm received cisatracurium with a median cumulative dose of 1807 mg; in 74 (14.8%) subjects, it was stopped early due to clinical improvement. In the control arm 86 subjects (17%) received NMB agent in the initial 48 hours. The improvement in oxygenation was similar between the two arms from day 1 through day 7.

There were 213 (42.5%) deaths in the intervention arm and 216 (42.6%) deaths in the control arm. There was also no difference in the secondary outcomes. However, cardiovascular adverse events were higher in the intervention arm. There was no difference in the rates of pneumothorax and barotrauma.

The results are different from the previous trial, the ACURASYS trial addressing the same question.[1] There likely reasons are perhaps the small sample size, use of low PEEP strategy and the use of deeper sedation. The use of deeper sedation in the previous trial in the control group might have increased the risk of reverse triggering and thus higher patient-ventilator dysynchrony.[3] This could result in breathing stacking a higher risk of barotrauma (higher in control arm).[1] The intervention arm was protected from reverse triggering due to use of NMB agents.

So, what are the clinical implications of this trial? The results of this trial suggest that the use of NMB agents in all patients with moderate to severe ARDS does not improve the mortality or the long-term outcomes. The use of NMBs should be restricted only to those in whom the patient ventilator synchrony does not improve despite sedation and adjustment of ventilator settings. The trial however, does not answer the question of using NMB agents during prone ventilation. Perhaps those who are prone ventilated, the best strategy still might be to use NMBs according to the PROSEVA trial.[4]

REFERENCES

Hyperbaric oxygen therapy (HBO) is a method of treatment in tissue hypoxia. HBO modulates the immune system, has anti-inflammatory properties, facilitates wound healing and tissue remodelling. In the acute care setting, HBO is useful in carbon monoxide poisoning, severe soft tissue injury, ischemic traumatic injury, infectious disease refractory to antibiotic treatment, diabetic foot, and gas gangrene. This book contains eight chapters divided into two parts. Part one has three chapters mainly focus on stress response to hyperbaric oxygen or environment, physiological and molecular mechanism, effects of HBO and HBO induced preconditioning-neuroprotection. Part two has five chapters which primarily discuss indications, rationale of use and disease specific management & recompression therapy. This book is useful to physiologist, primary care physicians, and scientist.
1) Voltaire

2) Andexanet alpha and thrombosis

3) Passengers that were seated either side of the affected individual.
   (This assumes that no household contacts of the affected individual were also on the plane, and that the
   stricken person didn’t join the ‘mile high’ club with anyone en route to Sydney.)
   This advice applies to flights of 8 or more hours duration. Passengers sitting in the row ahead or behind, or
   more than one seat away to the side, do not need chemoprophylaxis.
   Summary of who needs prophylaxis:
   • Household contacts of a case
   • Persons who share sleeping arrangements with the case
   • Persons who have direct contamination of their nose or mouth with the oral/nasal secretions of a case (e.g.
     kissing on the mouth, shared cigarettes, shared drinking bottles)
   • Health care workers (HCWs) who have had intensive unprotected contact (without wearing a mask) with
     infected patients (e.g. intubating, resuscitating or closely examining the oropharynx)
   • Children and staff in child care and nursery school facilities
   • Airline passengers sitting immediately on either side of the case (but not across the aisle) when the total
     time spent aboard the aircraft was at least 8 hours

4) Reactive Arthritis (Reiter’s syndrome)
   The classic triad of arthritis, urethritis, and conjunctivitis, most commonly from chlamydia.
   Arthritis here is a systemic, seronegative spondyloarthropathy secondary to a precipitating infection.

5) Roth spots
   Named after Moritz Roth (1839-1914) who identified the spots in 1872.
   They are retinal haemorrhages with white or pale centers. They can be composed of coagulated fibrin
   including platelets, focal ischemia, inflammatory infiltrate, infectious organisms, or neoplastic cells.
   Roth spots may be observed in leukaemia, diabetes, subacute bacterial endocarditis, pernicious anaemia,
   ischaemic events, hypertensive retinopathy and rarely in HIV retinopathy.

6) Addison’s Disease
   Addison’s disease is named after Thomas Addison, the British physician who first described the condition in
   “On the Constitutional and Local Effects of Disease of the Suprarenal Capsules” (1855).
   All of Addison’s six original patients had tuberculosis of the adrenal glands.

7) Dermatographism
   Dermatographism would allow you to write their number on your arm, and give you 15-30 minutes to find a
   working pen.
   Dermatographism is an uncommon condition also known as physical urticaria. Physical pressure causes the
   skin to become raised and inflamed in the shape of the stimulus.

8) Botulinum toxin
9) *Pneumocystis jiroveci* Frenkel, formally PCP

Pneumocystis organisms were first reported by Chagas in 1909 but he mistook them for a morphologic form of *Trypanosoma cruzi*, later they were noted to be a different protozoan and named *Pneumocystis carinii*. *Pneumocystis* was widely thought to be a protozoan based on several criteria:

1. strong similarities in microbe morphology and host pathology,
2. absence of some phenotypic features typical of fungi
3. presence of morphologic features typical of protozoa
4. ineffectiveness of antifungal drugs,
5. effectiveness of drugs generally used to treat protozoan infections.

The protozoan hypothesis remained predominant until 1988, when DNA analysis demonstrated that *Pneumocystis* is a fungus. It was not until 1999 that the first valid new binomial appeared.

The organism that causes human PCP is now named *Pneumocystis jiroveci* Frenkel 1999, in honor of the Czech parasitologist Otto Jirovec, who is credited with describing the microbe in humans.

10) “When making a diagnosis one should first consider the obvious”

The law is named after Willie Sutton (1901–1980), a bank robber renowned for escaping from prisons. Finally apprehended, Sutton was allegedly asked by a reporter ‘Why do you always rob banks?’ to which he replied ‘Why, that’s where the money is.’

His logic spurred William Dock (1898–1990) in 1960 to coin ‘Sutton’s Law’ as it pertains to medicine…to ‘go where the money is’. On rounds as a visiting professor at Yale, Dock met a young Puerto Rican woman with an undiagnosed liver disorder despite an extensive series of tests. Suspecting the diagnosis of schistosomiasis he said ‘Why don’t you apply Sutton’s Law?’ i.e. in this particular patient, perform a liver biopsy. The biopsy confirmed ova and the diagnosis.

1961 – Yale physicians Robert Petersdorf and Paul Beeson were on that very teaching round and published a paper examining ‘Fever of Unexplained Origin’ in which Sutton’s Law was first recounted as a footnote.

We are indebted to Dr. William Dock for the term Sutton’s Law. It recommends proceeding immediately to the diagnostic test most likely to provide a diagnosis, and deplores the tendency to carry out a battery of ‘routine’ examinations in conventional sequence…

Sutton’s Law gained immediate popularity because it reminded physicians to bypass unnecessary, inconclusive, and often expensive studies.

1976 – Although Dock was the inventor of the eponym ‘Sutton’s law,’ Sutton himself denied ever saying the phrase:

The credit belongs to some enterprising reporter who apparently felt a need to fill out his copy…I can’t even remember where I first read it. It just seemed to appear one day, and then it was everywhere. If anybody had asked me, I’d have probably said it… Like Dr Dock said, it couldn’t be more obvious. Why did I rob banks? Because I enjoyed it. I loved it!
CRITICAL CARE QUIZ

Dr Tapas Kumar Sahoo
Dr Gunjan Chanchalani

1) What is IDIOT Syndrome?
2) What is Cyberchondria?
3) What is the story behind Cochrane logo?

4) Patients with which disorder, with a very strong HLA association, should not be startled during dinner time?
5) Where did CRP get its name?

6) How can you calculate the A-a gradient at a glance of an ABG?

7) What conditions should be suspected in a woman who makes heavy use of eyebrow pencil when applying her makeup?

8) What is the significance of the temperature -119 Centigrade to the use of medical gases?

9) What condition should you suspect if you shake a patient’s hand and he or she is unable to let go?

10) Your junior comes to you slightly perplexed. They have just given a patient a dose of gentamicin for pyelonephritis and the nurse reports the patient is weak. You suspect a neurological condition and find some neurology outpatient notes confirm your suspicion.
26th Annual Conference of Indian Society of Critical Care Medicine

THEME : PRECISION IN INTENSIVE CARE

WORKSHOP DATE: 26th - 27th FEB 2020 | CONFERENCE DATE: 28th FEB - 1st MARCH 2020 | VENUE: HYDERABAD INTERNATIONAL CONVENTION CENTRE (HICC)

SCIENTIFIC HIGHLIGHTS

► Thought Provoking Thematic Sessions
► Engaging Pro Con Debates
► Problem Solving Sessions
► Innovations and Advances in a Dedicated Hall
► ISCCM Driven Studies and Guidelines Presentation
► Exclusive hall for PG sessions - for the young minds
► Landmark papers and year in review - the past and the present
► Quick review of trick issues in Rapid Fire sessions
► Plenary Session
► Know the Master Talk to Them

YOUNG TALENT HUNT, ABSTRACT SUBMISSION & INTERESTING CASES SUBMISSION CLOSES ON 30TH NOVEMBER 2019

WORKSHOPS

► Mechanical Ventilation Course
► 4C (Comprehensive Critical CareCourse)
► ECHO And USG Course in ICU
► Hemodynamic Monitoring Course
► ENLS (Emergency Neurological Life Support Course)
► Obstetric Critical Care Course
► Airway Management & Bronchoscopy in Critical Care
► Simulation
► Renal Replacement Therapy & ECMO
► Nursing Workshop
► Trauma Workshop
► APICC (Advanced Pediatric Intensive Care Course)

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