ISCCM News Headlines

- ISCCM to run training programs for graduate doctors soon. Syllabus, protocols etc are being prepared by expert committee.
- ISCCM new office likely to start its operations in one months time.
- ISCCM elections round the corner.
- ISCCM elections to be held electronically online. Have you updated your email ID and mobile phone numbers.
- Pune getting ready for Criticare 2012 Mark your dates in your calendar.
- Branch conferences being organized by Delhi, Uttar Pradesh-Uttranchal and East zone.
- New branches opened at Akola, Solapur and Ludhiana - Congratulations.
- More than 100 members added to the ISCCM family during the last quarter.
- Prem Bhyahatti and Dhyaneshwar Mukule top ISCCM courses- Congratulations.

Your Attention Please

- Please take active part in election.
- Election window will remain open from 1st to 7th August 2011 for voting.
- Keep an eye on your mobile (sms) and email id (authorized in ISCCM).

In this issue

- ISCCM News Headlines .............. 1
- Editorial ..................................... 2
- From the Desk of the President..... 3
- Guidelines for Air Transport........ 4
- Branch Activity ......................... 5-7
- New Branches Approved .......... 5
- Branch Update ........................... 5
- IDCCM Toppers .................... 5
- DCCS 2011 ......................... 5
- 7th Jaipur Conference on Critical Care Medicine - A Report ..................... 6
- ISCCM to run training course in Critical Care Medicine for MBBS doctors .......... 7
- 3rd EZCCCON 2011 .................. 7
- Agra Criticare 2011 .................. 7
- Reader’s Views ......................... 7
- Journal Scan ........................... 8-9
- Table of Events for conduct of ISCCM Elections – August 2011 ................. 10
- Welcome New Members to the ISCCM family .......................... 11
- Events Calender 2011-2012 ........ 12-13
- I.C.U. Care : Communication and family satisfaction ...................... 14
- CRITICARE 2012 ..................... 15
- Advertisement .......................... 16

We request our esteemed readers to send their valued feedback, suggestions & views at drnrungta@gmail.com
Dear Reader,

ISCMM will, now, train graduate MBBS doctors in Critical Care Medicine through a structured / protocolised course. This decision will go a long way in making available a sizable force of medical professionals trained in Critical Care. They will be able to take care of critically sick patients even outside major cities and towns. The ICUs will no more starve of man power that they need. This has been a long drawn dilemma for the national executive of the society - Will it produce less qualified individuals through such courses, many of us thought. However, serious thought process and discussions have led to this milestone decision making. It will certainly give some hope to a graduate doctor on whom door for further useful structured training in Critical Care Medicine has been shut so far. This will also prevent exploitation of these doctors by banners, glamorous names and organizations in name of Critical Care Training. At the same time, it is very important that apprehensions of some of our members that this may bring down standards of Critical Care training must be well addressed while implementing this programme.

Society is entering a new paradigm by deciding to carry out its elections electronically online this year. The complete calendar of events related to this election process is being published in this edition of the bulletin (page no. 10). This should be helpful in giving very useful information to the member voter. Those who had got their email IDs corrected before 2nd July will be able to vote. Members are requested to update their email IDs and mobile numbers in ISCCM records. There has been significant loss of posted Journals, Bulletins and other information material sent to members because their addresses have not been updated. This is a national waste and should be prevented. This is possible only by two methods – (1) updating addresses and (2) stop sending material to wrong addresses from where there is sustained rebound of such material.

Society is likely to move into its new office in Dadar very soon, probably before the next bulletin is in your hands. New senior executive officer has been appointed in the office. I am sure, the work of the society will be streamlined sooner than later and we will be able to keep our archives intact. Communication and information sharing with members will also become better. I will be too pleased to put few pictures of well furnished and occupied new office in the next bulletin. The national executive is likely to meet in the new premise in its next meeting.

The society continues to grow and grow at a encouraging rate. It does not have any impact of inflation or emergence of lots of other professional societies of doctors. The programmes and meetings of the society are extremely well attended and patronized by the industry. This speaks only volumes about the society’s endeavor to bring the best to its members in terms of knowledge and skill in Critical Care Medicine. 15% + growth has become a norm. More than 100 new members of the Society were approved during the last quarter – Congratulations. Dr Prayag, Dr Zirpe and their team is working overnight to bring us the best during the Pune CRITICARE 2012 meeting. Carry on guys. TUM AAGE BADHO HUM TUMHARE SAATH HAIN.

Jaihind

World is becoming a bad place to live in, not because of bad people but due to silence of good people.

- Shakespeare

Editorial Board

Dr. Narendra Rungta MD, FISCCM, FCCM
Editor, The Critical Care Communications • President-Elect, ISCCM • drnrungta@gmail.com

Dr. Samir Sahu
Bhubneshwar
Dr. Rajesh Pandey
New Delhi
Dr. P Gopal
Hyderabad
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Indore
Dr. Prateek Bhutalecha
Bhopal
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Rohtak (Pediatric Section)
Dr. YP Singh
Meerut
Dr. Rajesh Mishra
Ahmedabad
As you know, from 2011 onwards, elections of the society are going to be held by electronic mail and we will need your help to make this conversion successful. This change is not possible without your support. I have been writing to you repeatedly to update your database. To be able to vote it would be essential for you to check your personal details including your correct e-mail ID from the database at the website or at the society office. You may also contact your branch secretary on this matter. If you have changed your e-mail ID recently or your ID at ISCCM is incorrect, you can correct it either by sending a signed request with your new e-mail ID on plain paper or download the form from the ISCCM website and send it to the central office at Mumbai. We will change your e-mail ID in our records only if your signature matches that with the signature in our records. Please do it today. This will not only help in conducting the next elections but also enable us to send you information of various activities of the society.

We will also hold mock elections so that you can get acquainted with the whole process of election.

Indian college of critical medicine.

Society through its college will award fellowship to those who meet the following criteria:

Candidates should be member of ISCCM for 5 yrs., Physicians with sub-specialty certification in anesthesia or chest medicine, internal medicine, pulmonary medicine, surgery, critical care, pediatrics or equivalent as approved by the board can apply. This also includes diploma in the same subjects.

In addition to their basic specialities as mentioned above, those who fulfill the following criteria can apply:

1. Candidates who have cleared Indian fellowship of critical care medicine OR who have cleared Fellowship of National Board in critical care (FNB) OR members who are honorary fellow of Indian society of critical care medicine (FISCCM)
2. Candidate who have cleared Indian diploma in critical care medicine and have demonstrated involvement in the practice of critical care by research, publication and outstanding dedication and leadership in the practice of critical care sufficient to recommend election
3. Candidates who are American board certified in critical care medicine
4. Candidates who have cleared European diploma in critical care medicine or FJICCM from Australia and are practicing in India for the last 2 yrs

AND

Demonstrated involvement in the practice of critical care by research, publication, OR involvement in national and community for and demonstrated outstanding dedication and/or leadership in the practice of Critical Care

The Credentials Committee of the College shall examine the application to substantiate the applicant meets the established criteria for fellowship.

Fellowship will be awarded in the convocation ceremony held in conjunction with the ISCCM Annual Meeting. No member of the Society elected to Fellowship shall be designated Fellow in Critical Care Medicine (FiCCM) until they have attended the induction convocation ceremony held in conjunction with the ISCCM Annual Meeting.

Detailed procedure for application will be announced soon on the website

New office

We have completed the formalities of purchasing our new office at Dadar. The place is being renovated. We should be able to move in the new office by August this year. We will also have more staff to streamline various activities.

Research

Regarding the Indian Intensive Care Case Mix and Practice Patterns Study (INDICAPS) the last data entry is getting completed. I take this opportunity to thank all those who have contributed to make this a great success. Data from INDICAPS would help us in identifying problems as well as ICUs that could participate in future research. MOSER, an observational study on nosocomial infections will start in June.

ISCCM has more than 45 branches. Only few out of these are active and doing some scientific activity. We have decided this year to encourage and support all these branches to organize scientific programme.
Guidelines for Air Transport

Efficient transport of seriously ill or trauma victims will always have better outcome. Patients are lifted in emergencies from home and accident scene. Transport may be either ground level or air transport depending on the need, availability, and feasibility. It is also important to know that acutely ill or injured patients are at more risk of morbidity and mortality during transport.

**Problems encountered during any type of transport can be related to:**

a. Machinery and equipment’s
b. Transfer facility – physicians not clear and transfers without stabilization (scoop and run) and selection of wrong facility.
c. Transport Team: Team composition not appropriate or competent
d. Wrong decision to transfer
e. Inadequate communication before or during and after transfer
f. Environmental conditions and or transport vehicle

**What are the targets of safe transport?**

a. To reach patient in need as quickly as possible with trained personnel to higher center
b. Stabilization of patient’s condition before transport to prevent further deterioration.
c. To move the patient to a facility capable of providing more extensive care or additional services that will enhance patient outcome
d. To offer the level of care equal to or better than the referring level of care or additional services that will enhance patient outcome
e. No further harm during transport

**What can go wrong if transfer is not proper?**

If the transport of critically ill or injured patient is not proper due to any reason it can lead to increased morbidity and mortality. Various problems encountered are:

1. Hypoxia (especially in air transport and in ventilated patients): This follows the principle of Dalton’s law.
2. Seizures
3. Hypercarbia: Henry’s law
4. Hypotension/hypertension
5. Arrhythmias
6. Myocardial infarction
7. Pulmonary embolism
8. Raised intracranial pressure: Patient should be kept towards the rear side of aircraft
9. Potential risk of migration of catheters
10. Cardiac arrest and death if not stabilized before transfer
11. Hypothermia specially in children due fall in temperature (large body surface area)
12. Hypoglycaemia (decreased glucose store and increased demand) is concern in neonates and small children
13. Risk of intracranial bleed

Air transport can be either by fixed wing aircraft or helicopter. Helicopter are the most common mode of transport in an acute setting.

**Concerns during air transport:**

a. Stress related: Air transport puts an extra stress leading to changes in vital signs.
New Branches Approved

**ISCCM - Akola Branch**

**PRESIDENT**
Dr. Giridhar Panpalia MBBS, MD anesthesia
Devaki nursing home, Ramdas Peth Akola-444001
email: gpanpalia@yahoo.co.in • Mobile: 9823264301

**HON. SECRETARY**
Dr. Rahul Pingle MBBS, MD anesthesia
Near railway station, Ramdas Peth, Akola-444001
email: prahul14@hotmail.com · Mobile: 9823077064/9881477064

**ISCCM - Solapur Branch**

**CHAIRMAN**
Dr. Shirish Valsangkar M.D.; M.R.C.P.
Mobile: 9823900012
email: shirishvalsangkar@hotmail.com

**SECRETARY**
Dr. Mahendra Joshi M.D.
Mobile: 9850489980
email: drmmjoshi@gmail.com

**TREASURER**
Dr. Nitin Toshniwal M.D. • Mobile: 9422066022

**EXECUTIVE MEMBERS**
Dr. Sidheshwar Rudraikshi M.D. • Mobile: 9822072101
Dr. Yatin Joag M.D. • Mobile: 9850831613
Dr. Harshwardhan Joshi M.D. • Mobile: 9420492490
Dr. Harshwardhan Joshi M.D. • Mobile: 9420492490
Dr. Gundeli Ravindra M.D. • Mobile: 9822818158

**ISCCM - Ludhiana Branch**

**CHAIRMAN**
Dr. Anupam Shrivastava
email: shrivastava_anupam@rediffmail.com

**SECRETARY**
Dr. P. L. Gautam

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**Branch Update**

**ISCCM - Ludhiana Branch**

**CHAIRPERSON**
Dr. Devdatta Chafekar
email: nchafy@hotmail.com • Mobile: 9822432736

**SECRETARY**
Dr. Suwarna Tambde
email: isccmnashik@yahoo.com • Mobile: 9420592188

**TREASURER**
Dr. Pankaj Rane
email: dr.pankajrane@yahoo.com • Mobile: 9881158794

**EXECUTIVE COMMITTEE MEMBERS**
Dr. Yatindra Dube • Dr. Vijay Ghatge • Dr. Shirish Deo
Dr. Sudershana Patil

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**IDCCM Toppers**

**Toppers Anand Memorial Award**

Dr. Prema Byahatti
drpremavinod@yahoo.com

Dr. Dnyaneshwar Mutkule
drdnyanesh79@yahoo.com

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**DCCS 2011**

9th Annual Conference of Indian Society of Critical Care Medicine (Delhi & NCR Chapter)

19th-21st August 2011
Hotel Le Meridien, New Delhi, India

**Theme: Achieving Critical Excellence**

**CONFERENCE SECRETARIAT:**

Dr. Prakash Shastri
Chairman, Organising Committee
Dept. of Critical Care Medicine, 4th floor ICU, Super Speciality Block, Sir Ganga Ram Hospital, Rajinder Nagar, New Delhi-110060
Ph: 91-9810937295, Tel: 91-11-42252401
email: delhicriticalcare2011@gmail.com • www.dccs2011.com
The 7th Jaipur Conference on Critical Care Medicine held from April 9th-10th, 2011 at Hotel Clarks Amer, Jaipur was very successful with attendees departing openly enthusiastic about the sharing and learning that had taken place over the three days of the event. Pre-conference courses were also organized from 8-9 April, 2011.

During Pre-conference courses, Pediatric Fundamental Critical Care Support (PFCCS) Course were held first time in India.

Over 300 attendees were provided with a rich overview of the developing field of Critical Care Medicine and had the opportunity to network and share views, research & findings.

Following courses (as a part of Pre-Conference Programme) were also held:

a. Fundamental Critical Care Support (FCCS) Course – FCCS Course was prepared under the auspices of the Society of Critical Care Medicine, USA. The course is a standardized two-day course providing critical care information to non-critical care specialists. The course consists of standardized lectures referenced to syllabus material plus interactive skill stations. Individuals who successfully complete the required provider will receive a certificate of successful completion.

i. FCCS Instructor Course – 2 candidates participated in the course.

ii. FCCS Provider Course – 40 candidates participated in the course.

b. Pediatric Fundamental Critical Care Support (PFCCS) Course – A two-day comprehensive course addressing fundamental management principles for the first 24 hours of pediatric critical care.

PFCCS will disseminate fundamental pediatric critical care concepts to professional providers who may be involved in the initial management and transfer of critically ill or injured infants and children.

i. PFCCS Instructor Course – 5 candidates participated in the course.

ii. PFCCS Provider Course – 25 candidates participated in the course.

Dr. Ellen Pringle, USA was the Course Consultant & Dr. Kundan Mittal, Rohtak was the Course Director.

c. Advanced Cardiac Life Support (ACLS) Course – A two-day course that imparts training to healthcare providers who either direct or participate in the resuscitation of a patient, whether in or out of the hospital. 20 candidates participated in the Course.

d. Critical Care Workshop for Nurses – 75 candidates participated in the Workshop from various cities of the country such as Rohtak, Meerut, Jodhpur, Bikaner, Kota, Alwar, Ajmer etc. Dr. Prakash Shastri, New Delhi was the Workshop Director.

CONFEERENCE ON CRITICAL CARE MEDICINE

The main Conference was held on the 9th April, 2011. Sh. B. N. Sharma, Principal Secretary (Health & Family Welfare) Jaipur inaugurated the conference.

Jaipur Oration was delivered by Dr. Rajesh Chawla, President Indian Society of Critical Care Medicine. His topic of talk was “To decades of Non Invasive Ventilation”.

Social Programmes was also organized during the Conference period.

The following faculty participated in the Conference:

- Dr. Anupam Sharma
- Dr. Pravin Amin
- Dr. G.C. Khilnani
- Dr. Shrirish Prayag
- Dr. Sunit Singh
- Dr. Prakash Shastri
- Dr. Kundan Mittal
- Dr. Manish Munjal
- Dr. Narendra Rungta
- Dr. Neena Rungta
- Dr. Rajesh Chawla
- Dr. Rajiv Lochan Tiwari
- Dr. Deepak Yaduvanshi
- Dr. Sudhir Khunteta
- Dr. Vinay Malhotra
- Dr. Deepak Govil
- Dr. Dhruba Chaudhary
- Dr. Sanjay Dhanuka
- Dr. YP Singh
- Dr. Dhebashish Dhar
- Dr. Rajesh Pande
- Dr. Babita Gupta
- Dr. Ellen Pringle
- Dr. Suresh Bhardava
- Dr. Sushma Khunteta
- Dr. GC Khilnani
- Dr. S Sitaraman
- Dr. Rashmi Kapoor
- Dr. Rashmi Shukla
- Dr. Samresh Das
- Dr. Sanjay Shukla
- Dr. Sheila Nainan

There was also a good participation by pharma companies as sponsors, adverters and exhibitors of the conference. All the participants were fully satisfied with the academic session and enjoyed other activities a lot.
The executive committee of ISCCM, in its meeting held on 8th May 2011 at Mumbai decided to run training courses for graduate doctors. It was a long standing demand from different parts of the country, particularly from non-metropolitan cities and smaller towns. It has been felt that we cannot fill the large vacuum that exists about requirement of critical care professionals in the country. We need to create large work force to fill this vacuum. Graduate doctors after rigorous training for two years in accredited centers and going through a screening examination in both theory and practical may serve the critically sick patients a long way where there is no hope of super specialist intensivist to reach for decades.

The modalities are being worked out by a committee appointed by the president for this purpose and soon this training programme should be in place. Those who have been looking at ISCCM for such programmes can now look forward to having one such program very soon.

Mark Your Dates for

CRITICARE 2012 | 15-19 February 2012 • Pune

Reader's Views

Dr. Rungta

Thank you for sending this along. It is very impressive and the article with Mitchell Levy is very much appreciated. We look forward to a long and mutually beneficial relationship.

Regards,

David J. Martin, CAE
CEO/Executive Vice-President, Society of Critical Care Medicine
500 Midway Drive, Mount Prospect, IL 60056 USA
email : dmartin@sccm.org

Reader's Views

Hi Narendra

This looks excellent. This e-newsletter is unique in editing. The members would be delighted to be aware of the new things happenings in the society through this e-news.

best wishes

Abhiram Mallick
Abhiram.Mallick@leedsth.nhs.uk

Branch Activities

3rd Eastern Zonal Critical Care Conference

3rd Eastern Zonal Critical Care Conference - 2011

19th & 20th November 2011
Venue : Hotel The Crown, Bhubaneswar

Organised by:

ISCCM

INDIAN SOCIETY OF CRITICAL CARE MEDICINE
Bhubaneswar Branch

CONFERENCE SECRETARIAT:
Dr. Samir Sahu - 9437005552
Mr. Subrat Mohanty - 9437178735

3rd EZCCCON 2011
1st Floor, MICU, Apollo Hospitals, 251, Sainik School Road, Bhubaneswar 751005
email : samirsahu_kal@yahoo.co.in
Website : www.isccm-bbsr.org

Agra Criticare 2011

2nd Annual Conference of
Indian Society of Critical Care Medicine
UP & Uttrakhand Chapter

Agra Criticare 2011

2-4 September 2011
Hotel Orient Taj, Fatehabad Road, Agra

Theme

CONFEREENCE SECRETARIAT:

Organising Secretaries
Dr. Ranvir Singh Tyagi • Dr. Rakesh Tyagi

Scientific Secretary
Dr. Diptimala Agarwal
1276, Sec-11-A, Avas Vikas Colony, Sikandra, Agra - 282 007 (U.P.)
email : info@agracriticare2011.com • agracriticare2011@gmail.com
Website : www.agracriticare2011.com

Dear Narendra,
Congratulations on a great publication.

Regards

Andrew Argent
Professor, School of Child and Adolescent Health, University of Cape Town, Medical Director PICU, Red Cross War Memorial Children’s Hospital
email : andrew.argent@uct.ac.za

Mark Your Dates for

CRITICARE 2012 | 15-19 February 2012 • Pune
The deteriorating ward patient: a Swedish–Australian comparison

Author: Jäderling G, Calzavacca P, Bell M
Reference: Int Care Med 2011;37:1000-1005

The authors have tested whether patient characteristics and deterioration patterns of deteriorating patients are different between two health-care systems, separated by distance and culture. Data from 3,063 Rapid Response Teams (RRT) calls: 815 calls at Karolinska University Hospital (Sweden) and 2,248 calls at Austin Hospital (Australia) were collected and the demographics and clinical data was compared. The demographic and clinical data, as well as outcomes for patients were reviewed by a Rapid response team. The age was 66.5 ± 19.4 yrs, sex, unit of admission (surgical vs medical) 49.1%/50.9% versus 48.8%/51% and percentage of odd hours calls (1700-0800 hrs) (57.7-55.8%) were similar. There was a predominance of respiratory triggers at both centers and the “worried” criterion was frequently used in both hospitals (17.2% versus 14.4%) as a trigger for RRT activation. Overall, 30-day mortality was 27.7% versus 29.4%. The study highlights that in two different health-care systems separated by geography, language, culture and organizational features, the characteristics of deteriorating ward patients, their disposal and outcomes were similar, suggesting that the care of the deteriorating ward patient is a global problem in modern hospitals and confirming that their hospital mortality is high. Overall: The profile of critically ill patients necessitating a rapid response trigger is similar across the globe.

Mottling score predicts survival in septic shock.

Author: Quella HA, Lemoine S, Boelle Y
Reference: Int Care Med 2011;37:801-807

A prospective observational study from a tertiary teaching hospital that included all consecutive patients with septic shock during a 7-month period. After initial resuscitation, hemodynamic parameters were recorded and their predictive value on mortality was analyzed. The mottling score (from 0 to 5), based on mottling area extension from the knees to the periphery: Score 0 indicates no mottling; score 1, a modest mottling area (coin size) localized to the center of the knee; score 2, a moderate mottling area that does not exceed the superior edge of the kneecap; score 3, a mild mottling area that does not exceed the middle thigh; score 4, a severe mottling area that does not go beyond the fold of the groin; score 5, an extremely severe mottling area that goes beyond the fold of the groin. An increase in the mottling score was associated with increasing lactate levels (p<0.0001) and decreasing urinary output (p<0.0001). There was no such trend for the cardiac index according to mottling. The SOFA score also displayed a positive correlation with the level of mottling (p = 0.0002). The study showed that the mottling score is reproducible and easy to evaluate at the bedside. The mottling score as well as its variation during resuscitation is a strong predictor of 14-day survival in patients with septic shock. Overall: An interesting score.

The Crystalloid versus Hydroxyethyl Starch Trial: protocol for a multi-centre randomised controlled trial of fluid resuscitation with 6% hydroxyethyl starch (130/0.4) compared to 0.9% sodium chloride (saline) in intensive care patients on mortality

Author: The Crystalloid versus Hydroxyethyl Starch Trial (CHEST) Management Committee.
Reference: Int Care Med 2011;37:816-823

The intravenous fluid 6% hydroxyethyl starch (Molecular weight/molar substitution: 130/0.4) (6% HES 130/0.4) is used widely for resuscitation but there is limited information on its efficacy and safety. A large-scale multi-centre randomised controlled trial (CHEST) in critically ill patients is currently underway comparing fluid resuscitation with 6% HES 130/0.4 vs 0.9% sodium chloride on 90-day mortality and other clinically relevant outcomes including renal injury. The study protocol is discussed. CHEST will recruit 7,000 patients to concealed, random, parallel assignment of either 6% HES 130/0.4 or 0.9% sodium chloride for all fluid resuscitation needs in the intensive care unit (ICU). The primary outcome will be all-cause mortality at 90 days post-randomisation. Secondary outcomes will include incident renal injury, other organ failures, ICU and hospital mortality, length of ICU stay, quality of life at 6 months, health economic analyses and in patients with traumatic brain injury, functional outcome. Subgroup analyses will be conducted in four predefined subgroups. All analyses will be conducted on an intention-to-treat basis. Overall: An interesting study to follow. Results will be keenly awaited.

Biomarkers of Sepsis

Author: Marshall J, Reinhart K

It is difficult to identify patients with severe sepsis and sepsis syndrome who might benefit from either conventional anti-infective therapies or from novel target specific therapies. Use of validated biomarkers of sepsis may improve diagnosis and therapeutic decision making for these high-risk patients.

A small group meeting of experts in clinical epidemiology, biomarker development, and sepsis clinical trials; selective narrative review of the biomarker literature was used to develop a methodologic framework for the identification and validation of biomarkers of sepsis.

The group identified needs for greater standardization of biomarker methodologies, greater methodologic rigor in biomarker studies, wider integration of biomarkers into clinical studies (in particular: early phase studies), and increased collaboration among investigators, pharmaceutical industry, biomarker industry, and regulatory agencies.

The review concludes that biomarkers promise to transform sepsis from a physiologic syndrome to a group of distinct biochemical disorders, which could aid therapeutic decision making, and improve the prognosis for patients with sepsis, but will require an unprecedented degree of systematic investigation and collaboration. Overall: Excellent review on role of biomarkers in sepsis for the postgraduates.

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Functional disability 5 years after Acute Respiratory Distress Syndrome

Author: Heridge M, Tansey CH, Matte A

The study evaluated 109 survivors of ARDS at 3, 6, and 12 months and at 2, 3, 4, and 5 years after discharge from ICU. At each visit, patients were interviewed and examined; underwent pulmonary-function tests, the 6-minute walk test, resting and exercise oximetry, chest imaging, and a quality-of-life evaluation; and reported their use of health care services. At 5 years, the median 6-minute walk distance was 436 m (76% of predicted distance) and the Physical Component Score on the Medical Outcomes Study 36-item Short-Form Health Survey was 41 (mean norm score matched for age and sex, 50). With respect to this score, younger patients had a greater rate of recovery than older patients, but neither group returned to normal predicted levels of physical function at 5 years. Pulmonary function was normal to near-normal. A constellation of other physical and psychological problems developed or persisted in patients and family caregivers for up to 5 years. Patients with more coexisting illnesses incurred greater 5-year costs. Exercise limitation, physical and psychological sequelae, decreased physical quality of life, and increased costs and use of health care services are important legacies of severe lung injury.
Qualitative analysis of an intensive care unit family satisfaction survey

Author: Natalie JH, Peter D, Daren H

This study used three open-ended questions about strengths and weaknesses of the intensive care unit, based on the family members’ experiences and perspectives, tried to identify and describe strengths and weaknesses of the intensive care unit, and this knowledge can be used to improve the intensive care unit and this knowledge can be used to improve the intensive care unit for the patients.

The impact of enhanced cleaning within the intensive care unit on contamination of the near-patient environment with hospital pathogens: A randomized crossover study in critical care units in two hospitals

Author: Peter WA, Deborah S, Ginny M

This prospective, randomized, crossover, 1 year study from UK was aimed at determining the effect of enhanced cleaning of the near-patient environment on the isolation of hospital pathogens from the bed area and staff hands. It was carried out in the ICUs of two teaching hospitals and involved a total of 1252 patients staying during enhanced cleaning and 1311 staying during standard cleaning. In each of six 2-month periods, one unit was randomly selected for additional twice-daily enhanced cleaning of hand contact surfaces. Agar contact samples were taken at five sites around randomly selected bed areas, from staff hands, and from communal sites three times daily for 12 beds per week. Patients were analyzed for hospital-acquired contamination and infection. Over the course of 1152 bed days, 20,736 samples were collected. Detection of environmental MRSA, per bed-day was reduced during enhanced cleaning phases from 82 of 561 (14.6%) to 51 of 559 (9.1%). Other targeted pathogens (Acinetobacter baumannii, ESBL producing Gram negative bacteria, VRE, and Clostridium difficile) were rarely detected. Enhanced cleaning reduced environmental contamination and hand carriage, but no significant effect was observed on patient acquisition of MRSA. Enhanced cleaning as defined in this study was not cost or clinically effective. Overall: Aggressive ICU cleaning is not cost effective.

Routine prone positioning in patients with severe ARDS: feasibility and impact on prognosis

Author: Charron C, Bouffrache K, Caillé V
Reference: Int Care Med 2011;37:785-790

Authors in a French Hospital have routinely used prone positioning since 1997, in patients who have a PaO2/FiO2 < 100 mmHg after 24–48 h of mechanical ventilation and who are ventilated using a low stretch ventilation strategy.

Tiotropium versus Salmeterol for the prevention of exacerbation of COPD

Author: Vogelemer C, Hedeker B, Glaab T

Treatment guidelines recommend the use of inhaled long-acting bronchodilators to alleviate symptoms and reduce the risk of exacerbations in patients with moderate-to-very-severe COPD but do not specify whether a long-acting anticholinergic drug or a β2 –agonist is the preferred agent. This 1-year multicentric, randomized, double blind, double dummy, parallel group European study investigated whether the anticholinergic drug tiotropium is superior to the β2 –agonist salmeterol in preventing exacerbations of COPD. The effect of treatment with 18 μg of tiotropium once daily was compared with that of 50 μg of salmeterol twice daily. A total of 7378 patients were randomly assigned to and treated with tiotropium (3707 patients) or salmeterol (3669 patients). Tiotropium, as compared with salmeterol, increased the time to the first exacerbation (187 days vs. 145 days), with a 17% reduction in risk (P<0.001). Tiotropium also increased the time to the first severe exacerbation (P=0.001), reduced the annual number of moderate or severe exacerbations (0.64 vs. 0.72, P = 0.002), and reduced the annual number of severe exacerbations (0.09 vs. 0.13; P<0.001). The incidence of severe exacerbations and of serious adverse events leading to the discontinuation of treatment was similar in the two study groups. There were 64 deaths (1.7%) in the tiotropium group and 78 (2.1%) in the salmeterol group. These results show that, in patients with moderate-to-very-severe COPD, tiotropium is more effective than salmeterol in preventing exacerbations.

Decompressive Craniectomy in diffuse traumatic brain injury

Author: Cooper JD, Rosenfeld J, Murray M

It is unclear whether decompressive craniectomy improves the functional outcome in patients with severe traumatic brain injury and refractory raised ICP. This ANZICS study group randomly assigned 1252 adults with severe traumatic brain injury and intracranial hypertension that was refractory to first-tier therapies to undergo either bifronto-temporoparietal decompressive craniectomy or standard care. The original primary outcome was an unfavorable outcome (a composite of death, vegetative state, or severe disability), as evaluated on the Extended Glasgow Outcome Scale 6 months after the injury. The final primary outcome was the score on the Extended Glasgow Outcome Scale at 6 months. Patients in the craniectomy group, as compared with those in the standard-care group, had less time with ICPs above the treatment threshold (P<0.001), fewer interventions for increased ICP (P=0.02 for all comparisons), and fewer days in the intensive care unit (ICU) (P<0.001). However, patients undergoing craniectomy had worse scores on the Extended Glasgow Outcome Scale than those receiving standard care and a greater risk of an unfavorable outcome. Rates of death at 6 months were similar in the craniectomy group (15%) and the standard-care group (12%). The study concluded that adults with severe diffuse traumatic brain injury and refractory intracranial hypertension, early bifrontotemporoparietal decompressive craniectomy decreased intracranial pressure for the length of stay in the ICU but was associated with more unfavorable outcomes.

Recommended reviews:
2. Hypoxia & inflammation. NEJM 2011; 364:655-65
3. Point of Care Ultrasonography. NEJM 2011; 364:749-57

Recommended journal issues & Guidelines:
1. Critical care Medicine 2010 Vol. 38, No. 8 (Suppl.)
2. Emergency Clinics of North America 2010; 28
Table of Events for conduct of ISCCM Elections – August 2011

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Activity Description</th>
<th>Responsibility</th>
<th>Target Date for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Email to be drafted to be sent to all Voters by the Chairman elections</td>
<td>Chairman elections_ISCCM &amp; MCA</td>
<td>28/June/2011</td>
</tr>
<tr>
<td>2.</td>
<td>Identification of authorized personnel for communication from ISCCM for all electoral activities – candidates info., voters database etc.,</td>
<td>Chairman elections_ISCCM</td>
<td>28/June/2011</td>
</tr>
<tr>
<td>3.</td>
<td>Emailler to all voters for intimation of election period</td>
<td>Chairman_ISCCM</td>
<td>29/June/2011</td>
</tr>
<tr>
<td>4.</td>
<td>Firming up of voters list / follow-up for corrections - name, email-id, mobile nos. etc</td>
<td>ISCCM_Mumbai Office Staff</td>
<td>27/June/2011 to 02/July/2011</td>
</tr>
<tr>
<td>5.</td>
<td>Upload of candidate Information in website of ISCCM</td>
<td>MCA</td>
<td>03/July/2011</td>
</tr>
<tr>
<td>6.</td>
<td>Emailler to all voters about candidates information and explaining the process of online voting</td>
<td>MCA / Chairman elections_ISCCM</td>
<td>07/July/2011</td>
</tr>
<tr>
<td>7.</td>
<td>Creation of admin users for election monitoring</td>
<td>MCA</td>
<td>21/July/2011</td>
</tr>
<tr>
<td>10.</td>
<td>Cleanup of final database</td>
<td>MCA</td>
<td>27/July/2011</td>
</tr>
<tr>
<td>11.</td>
<td>Password changes and modifications &amp; necessary access controls modifications on the final FTP site which is to be used to voting</td>
<td>MCA</td>
<td>29/July/2011</td>
</tr>
<tr>
<td>12.</td>
<td>Confirmation by ISCCM poll observer that the database has zero voting before the commencement of elections - 31 night 11.30 p.m.</td>
<td>Chairman elections_ISCCM</td>
<td>31/July/2011</td>
</tr>
<tr>
<td>15.</td>
<td>Election Window Closure</td>
<td>MCA</td>
<td>07/Aug/2011 – 5 p.m.</td>
</tr>
<tr>
<td>16.</td>
<td>Election Results Tabulation &amp; Announcement to Chairman elections_ISCCM / General Secretary_ISCCM by MCA</td>
<td>MCA</td>
<td>07/Aug/2011 before 6 p.m.</td>
</tr>
<tr>
<td>17.</td>
<td>Placing of the election results by the General Secretary before the executive committee for approval of results before final declaration</td>
<td>General Secretary_ISCCM</td>
<td>07/Aug/2011 around 6 p.m.</td>
</tr>
<tr>
<td>18.</td>
<td>Announcement of results by Chairman in the AGM</td>
<td>Chairman elections_ISCCM</td>
<td>07/Aug/2011 around 7 p.m.</td>
</tr>
<tr>
<td>19.</td>
<td>Upload of results on the ISCCM website</td>
<td>ISCCM</td>
<td>07/Aug/2011</td>
</tr>
</tbody>
</table>
Welcome New Members to the ISCCM family

1. Hemant Patil, Mumbai
2. Anshul Wadhwa, Delhi
3. Sanjay Walkle, Mumbai
4. Navin Dalal, New Delhi
5. Kodeganti Sreedhar, Tirupathi
6. Anand Malani, Sangli
7. Sanjai Tripathi, Gonda
8. Kingsuk Kar, Kolkata
9. Raminder Batra, Amritsar
10. Bhavneet Arora, Amritsar
11. Yogesh Kushwaha, Delhi
12. Jayendra Aghara, Gujar
13. Saumitra Bhattacharya, Kolkata
14. Praveen Kulkarni, Miraj
15. Sachin Kumar Ambapkar, Kolhapur
17. Rajesh Deshmukh, Nagpur
18. Anrita Parekh, Mumbai
19. Krishna Thambuluru, Bangalore
20. Madhuri Shingade, Pune
21. Nehali Shettar, Pune
22. Bhushan Khinolkar, Pune
23. Jagannath Khandagale, Old John
24. Rahul Guhahasw, Kolkata
25. Subrata Barai, Kolkata
26. Ram Narayan, Dist Srikar
27. Sheetal Diwanji, Valsad
28. Rajesh Toshniwal, Nanded
29. Rajan Ranjan, Delhi
30. Pelli Sitarama Rao, Chennai
31. Mohd Irfan, Nagpur
32. Nived K, Thrissur
33. Manjunath M, Mandy
34. Mouali Hadimani, Chennai
35. Ashok Kumar R, Chennai
36. Anup Bansal, Roorkee
37. Mahesh Nerkar, Mysore
38. Dipankar Dey, Karnopur
39. Srinivasan Swaminathan, Bhopal
40. Chakravarthy Sandur, Chennai
41. Kapil Patwardhan, Pune
42. Ajit Kulkarni, Pune
43. Pravin Taje, Nishik
44. Bhargav Mundlapudi, Mangalore
45. Parul Katarya, Rajkot
46. K. Baby Sailaja, Chennai
47. Kailash Balar, Surat
48. Anil Sonawane, Dist Dhule
49. Umesh Ojha, Dhanbad
50. Madhukar Dhomdi, Aurangabad
51. Manav Pagare, Aurangabad
52. Samir Desai, Valsad
53. Kiwi Manthan, Bikaner
54. Parul Dubey, Mysore
55. Girish Kumbhekar, Beed
56. Kolli S. Chalam, Boreilly
57. Rajiv Yeravdekar, Pune
58. Satish Virmani, Pune
59. Bibha Mahanta, Guwahati
60. Gnanavel Rajan A, Tirunelveli (Dist)
61. Rajiv Dhumna, Chandigarh
62. Jithesh Kizhakkveleppadi, Calicut
63. Pallivalappil Bhargavan, P.O Chevayur
64. Kanchan Saraf, Pune
65. Vineet Mahajan, Jalandhar City
66. Swapna Khanzode, Nagpur
67. Lalit Kumar, Gupta, Chandigarh
68. Monica Kohli, Lucknow
69. Zia Arshad, Lucknow
70. Santosh Ghalme, Dist Pune
71. Sharmili Sinha, Cuttack
72. John George, Emukulam Dist
73. Kondie Raghul, Hyderbad
74. Saurabh Mukhopadhyay, Kolkata
75. Gaurav Bhatia, Ludhiana
76. Vijay Anand D'Silva, Mumbai
77. Darshana D. Rathod, Mumbai
78. Shishir Chandra Jethi, Jabalpur
79. Mohammad Haque, Patna
80. Rajiv Patra, Bhubaneswar
81. Somnath Longani, Lucknow
82. Aparna Amrit Sagari, Thane
83. Antara Gokhale, Pune
84. Srinivas Rajagopal, Chennai
85. Padma Prakash Gandhiiraj, Virudhunagar
86. Mohamed Ibrahim S., Dimdigul
87. Antony Paul, Thrissur
88. Manender Singh, Ludhiana
89. Rakesh Kumar Patel, Dist Navsari
90. Chandrashekar Kulkarni, Dist Raigad
91. Labani Ghosh, Karamsad, Anand
92. Gouri Diwan, Nashik
93. Majrama Jaykumar, New Delhi
94. Sujan Dey, New Delhi
95. Ajay Sinha, Ranchkhula
96. Yogesh Pralhad Patil, Dist Jalgaoon
97. Leelabati Toppo, Bhubaneswar
98. Savita Choudhary, Udaipur
99. Rahul Anil Pandit, Mumbai
100. Madhusmita Patnaik, Cuttack
101. Pravin Patil, Akola
102. Prashant Waichal, Akola
103. Nikhil Kibe, Akola
104. Pradip Chandak, Akola
105. Kishor Pachkor, Akola
106. Prashant Mulawkar, Akola
107. Sadanand Bhusari, Akola
108. Deepak Lote, Akola
109. Shirish Ambekar, Akola
110. Rahul Pingle, Akola
111. Chandini Singh, Kanpur
112. Lakshmipriya Kasarajan, Madurai
113. Amol Benike, Dist Pune
114. Mercy Mbom Ekanem N, Bangalore
<table>
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<tr>
<th>DATE</th>
<th>CONFERENCE NAME</th>
<th>CONTACT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd-3rd July 2011</td>
<td>Pediatric Fundamental Critical Care support Course (PFCCS), Ahmadabad</td>
<td>Dr. Abhishek Bansal Mob No.: + 919909903537 Email id: <a href="mailto:drabhishek@gmail.com">drabhishek@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td>Medicine Phratumwan, Bangkok, Thailand</td>
<td></td>
</tr>
<tr>
<td>8th - 9th July 2011</td>
<td><strong>Critical Care Review course, ISCCM</strong>, Deenanath Mangeshkar Hospital, Pune</td>
<td><a href="mailto:isccmpune@gmail.com">isccmpune@gmail.com</a></td>
</tr>
<tr>
<td>13th-15th July 2011</td>
<td><strong>5th National Conference: Critical Care 2011</strong>, British Journal of Hospital</td>
<td><a href="http://www.mahealthcareevents.co.uk">www.mahealthcareevents.co.uk</a> Phone: 020 7501 676</td>
</tr>
<tr>
<td></td>
<td>Medicine, CBI Conference Centre, First Floor, Centre Point Tower 102 New Oxford</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Street, Camden Town, London WC1A 1DU, UK</td>
<td></td>
</tr>
<tr>
<td>13th-14th August 2011</td>
<td><strong>Fundamental Critical Care support Course FCCS</strong>, Chirayu Medical College &amp;</td>
<td>Dr. Pradip Bhattacharya, Cell no. 09893181555 Email id : <a href="mailto:drpradipkb@gmail.com">drpradipkb@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td>Hospital, Bhopal</td>
<td></td>
</tr>
<tr>
<td>19th-21st August 2011</td>
<td>**Ninth Delhi Critical Care Symposium, The Annual Conference of ISCCM Delhi &amp;</td>
<td>Dr. Prakash Shastri, Department of Critical Care Medicine, Sir Gangaram Hospital</td>
</tr>
<tr>
<td></td>
<td>NCR Region Theme: Achieving Critical Excellence Hotel Le Meridien, Janpath, New</td>
<td>Email: <a href="mailto:prakashshastri@live.in">prakashshastri@live.in</a></td>
</tr>
<tr>
<td></td>
<td>Delhi</td>
<td></td>
</tr>
<tr>
<td>19th-20th August 2011</td>
<td><strong>Fundamental Critical Care support Course (FCCS), DCCS 2011</strong>, New Delhi</td>
<td>Dr. Prakash Shastri, Cell no. +91 9810937295, Email id: <a href="mailto:prakashshastri@live.in">prakashshastri@live.in</a></td>
</tr>
<tr>
<td>27th-28th August 2011</td>
<td><strong>THEMATIC '11 (Haemodynamic Workshop)</strong> Rustom Choksey Auditorium, Tata</td>
<td>Dr. Vijaya Patil, Professor, Dept of Anaesthesiology &amp; Critical Care Tata</td>
</tr>
<tr>
<td></td>
<td>Memorial Hospital, Parel, Mumbai</td>
<td>Memorial Hospital, Mumbai Ph: R - 00 91 22 24451118 M - 0 9819883535 Fax: 00 91 22 24146937 email: <a href="mailto:vijayapatil@yahoo.com">vijayapatil@yahoo.com</a></td>
</tr>
<tr>
<td>2nd-4th September 2011</td>
<td>**UP/ UK Criticare 2011 Pediatric Fundamental Critical Care support Course</td>
<td>Dr. Ranvir Tyagi Mobile No. +91 9837047812 Email: <a href="mailto:drranvir@yahoo.com">drranvir@yahoo.com</a></td>
</tr>
<tr>
<td></td>
<td>(PFCCS), Ahmadabad, Agra</td>
<td></td>
</tr>
<tr>
<td>10th-11th September 2011</td>
<td><strong>AP CRITICON 2011</strong>, ISCCM AP Visakhapatnam, AP, India</td>
<td>Dr. Kuchela Babu (<a href="mailto:kuchelababu@yahoo.com">kuchelababu@yahoo.com</a>) Dr. Mohan Maharaj (<a href="mailto:dramohanmaharaj@gmail.com">dramohanmaharaj@gmail.com</a>)</td>
</tr>
<tr>
<td>13th-15th September 2011</td>
<td><strong>22nd International Congress of the Israel Society of Anesthesiologists (ICISA), Israel Society of Anesthesiologists, Tel Aviv, Israel</strong></td>
<td>Phone : + 972 3-5767711 Email: <a href="mailto:team7@congress.co.il">team7@congress.co.il</a></td>
</tr>
</tbody>
</table>
13th-15th October 2011  ANZICS/ACCCN Intensive Care Annual Scientific Meetings

22nd-23rd October 2011  Fundamental Critical Care support Course (FCCS), Amritsar, Punjab
Dr. Raman Chaitrath
Email: raman69@gmail.com • Mob.: 9815799881

27th-28th October 2011  Sepsis- 2011, Bejing, China
ISF, 7024 Palmetto Pines Ln
Land O’Lakes, FL 34637. Telephone: 813-235-9813 (US) Fax: 813-235-9014 (US) mail id: elaine@sepsisforum.org

12th-13th November 2011  Fundamental Critical Care support Course (FCCS) & Pediatric Fundamental Critical Care support Course (PFCCS), Ahmadabad, Rohtak
Dr. Dhruba Chaudhary (FCCS)
Dr Kundan Mittal (PFCCS)
Email: kundanmittal@yahoo.co.in

19th-20th November 2011  3rd EZCCCON 2011
3rd Eastern Zonal Critical Care Conference
Hotel The Crown, Bhubaneswar
Dr. Samir Sahu - 9437005552
Mr. Subrat Mohanty - 9437178735
1st Floor, MICU, Apollo Hospitals, 251, Sainik School Road, Bhubaneswar 751005
email : samirsahu_kal@yahoo.co.in
Website : www.isccm-bbsr.org

18th-20th November 2011  National conference on Paediatric critical care
Indian Academy of Paediatrics, Paediatric Critical care
Hyderabad, India
Dr.VSY Prasad & Dr. Dinesh Chirla
Mob: +91 917779185

10th-11th December 2011  Fundamental Critical Care support Course (FCCS) & Pediatric Fundamental Critical Care support Course (PFCCS), New Delhi
Dr. Maitree Pande
Dr Rajesh Pande
Email : rajeshmaitree2000@yahoo.com

12th-14th December 2011  The Intensive Care Society Annual State of the Art Meeting 2011, London, ICS (Intensive Care Society) UK
ICC London, East ExCel, Royal Victoria Dock, London
Phone : +44 2072804350
Email : events@ics.ac.uk

4th-8th February 2012  SCCM Congress 2012, George R. Brown Convention Center, Houston, Texas, USA
George R. Brown Convention Center & Society of Critical Care Medicine Headquarters (Map), 500 Midway Drive, Mount Prospect, Illinois 60056 USA
Phone: +1 847 827-6869 • Fax: +1 847 827-6886
Web site: www.sccm.org • Email: info@sccm.org

15th-19th February 2012  CRITICARE 2012: 18th National conference of Indian Society of Critical Care Medicine, Pune
Dr. Kapil Zirpe, Organizing Secretary,
Mobile : +919822844212 • Email id: kapilzirpe@gmail.com

16th-17th February 2012  Fundamental Critical Care support Course (FCCS), Criticare 2012, Crystal Hall, Hotel Mariott, Pune
Dr. Kapil Zirpe
Cell No.: +91 9822044212 • Email: kapilzirpe@gmail.com

20th-23rd March 2012  32nd ISICEM (International Symposium on Intensive Care and Emergency, SQUARE - Glass Entrance, rue Mont des Arts,1000 Brussels, Belgium
ISICEM
Marie-Rose Andre,Secretary. Ph. +32 (0)2 555 3380
E-mail: secrjiv@ulb.ac.be • http://www.intensive.org/
Quality of care is defined as safe, timely, effective, efficient, equitable and patients-centered care. ICU setting is a stressful environment where there is uncertainty at all times. It includes complex technology in disciplinary decision making and high mortality. Since, critically ill patients usually cannot take their own decisions due to illness or delirium, family members play an essential role in decision making for the patient. On the other hand, the expectations of the family are ever so high, which are difficult to satisfy. In Indian settings, most decisions for the critically ill patients are taken by family members. For this reason, the perspective of the family is specially relevant. In fact, rating of the quality of critical care is also determined by family satisfaction.

In intensive care units, families of patients express high level of emotional stress. Outcome of a given patient is almost always guarded and sudden untoward complications do occur, quite often, at most unexpected time. An effective communication, access to information and a cordial relations with family members is a primary responsibility of an intensivist along with other staff. It is important to include family members in decision making, which is quite often, omitted. However, only currently ICU physicians have been realizing their responsibility towards the family members.

Critical decisions such as endotracheal intubation, tracheostomy are usually discussed with the family in detail before obtaining written consent. Other important aspects are emotional support, respect and compassion shown to the family and consideration of family needs. In India, growing economy and social status has led to better quality of medical care. The new hospitals are allocating more and more area to intensive care units. Almost every small hospital (as called nursing Home) in expected to have cardio-respiratory monitoring and facility of mechanical ventilation. Quite often, the physician’s focus is expert care to the patient, and therefore finds very little time for communication with the family. A very important duty of the intensivist is to provide family member with appropriate, clear and compassionate information as they need to cope with their distress and participate in making decisions about patients. A good understanding of disease process, severity and expected outcome helps the family cope with psychological stress.

Several factors determine the quality of communication between health care provider and the family of the critically ill. Besides the sensitivity and communication skills on the part of physician and nurses, it is the staffing of the ICU which determines the family satisfaction. The family satisfaction improves where there is a good nurse patient ratio (less than 1:3), where there is no contradictory information and when the interview time with the family is increased. The satisfaction is further improved when it is by the usual physician providing the care.

Most of the literature available regarding comprehension and family satisfaction have generated from Western countries. In India, the level of education or literacy is variable and ‘living wills’ and ‘advanced directives’ are non-existent. This further increases the importance of communication with the family. In the developed world there are respiratory therapists, pharmacists and psychologists to assist in various aspects of care. In India, the primary responsibility of giving expert medical care remains with physicians. In fact, all the family members expect a word of comfort from treating physician in ICU rather than from other health care workers.

In conclusion, communication on the part of physician and other health care providers with the family of critically ill patient is an important part of comprehensive care. Depression and anxiety are common among family members. Information helps family members to cope with their distress, to build reasonable expectations about patient's outcome, and to perceive ICU as a welcoming place, where they can wait with relative peace of mind for events to unfold. Frequently decisions regarding invasive investigation and treatment require involvement of family members. For that, comprehension of the family members is very important. All this effort leads to better satisfaction of family members which is an important aspect of outcome parameters of critical care.

References


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Your Attention Please

- Please take active part in election.
- Election window will remain open from 1st to 7th August 2011 for voting.
- Keep an eye on your mobile (sms) and email id (authorized in ISCCM).
Dear Colleagues,

On behalf of ISCCM Pune Branch, & the Organising Committee of CRITICARE Congress 2012, it is a pleasure & privilege to invite you all to the “18th Annual Congress of the Indian Society of Critical Care Medicine & International Critical Care Congress 2012″, being held in at Marriott Hotels & Convention Centre, Pune from February 15th to 19th, 2012.

ISCCM Pune branch was the first city branch of ISCCM, formed in 1993 and has been at the forefront in the ISCCM in various activities. The 4th National Congress held in Pune in 1998 is still remembered by the attending delegates as one of the most outstanding ones.

The theme of this year’s conference is, ‘Critical Care in India – Coming of Age’. This event will bring together an international audience with an interest in critical care & emergency medicine. The scientific program will consist of three adult Critical Care Sessions, one Pediatric Critical Care Session & eleven pre conference workshops till date. There will also be an exciting and varied scientific program that will include plenary and thematic sessions, presentation of research papers, workshops and ‘Meet the Expert’ sessions, didactic lectures and smaller group sessions, promoting dialogue, debate and healthy controversy. Adhering to the philosophy of the practice of Critical Care, the sessions will be of interest to all practitioners who care for the critically ill.

Hailed as India’s “Knowledge Capital” and a class metro, Pune has it all ….. Beauty, sophistication and above all, a friendly welcome for everyone! The city proudly stands by its reputation as a true “people city” where its residents live, work and play. Fantastic shopping, breathtaking views and pleasant climate all year round are just a few reasons why residents and visitors alike will tell you that there is no place quite like Pune! The city has the best of both worlds, modern sophistication with neighborhood values.

We offer you not only a very high quality scientific program but also an ambiance where you can relax, meet friends, exchange ideas and improve your networking.

Come discover the excitement that Pune has to offer.

Come back to Pune, where it all began

Dr. Shirish Prayag
ORGANIZING CHAIRMAN

Dr. Ajit Yadav
CO-ORGANISING CHAIRMAN

Dr. Kapil Zirpe
ORGANISING SECRETARY

Dr. Subhal Dixit
CO-ORGANISING SECRETARY

Website : www.criticare2012.org
email : criticare2012@gmail.com

Dr. Kapil Zirpe 09822844212 email : kapilzirpe@gmail.com

Dr. Subhal Dixit 09822050240 email : subhaldixit@yahoo.com
**Fast Acting Local Mucolytic**

3 times more potent & 5 times faster acting than N-acetylcysteine (NAC)¹

- Fluidifies bronchial secretions and facilitates aspiration²
- Disintegrates blood clots by its lytic action upon the mucus embedded in the fibrin network³⁻⁴
- Effective on blood clots alone and on mixed blood and mucus clot²⁴
- Improves patient status by reducing post-bronchoscopy complications⁵
- Can be co-administered with bronchodilators, such as salbutamol and with corticosteroids like methylprednisolone⁶

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**77% increased solubilisation of structured mucus by Mistabron® unlike NAC, Saline**

<table>
<thead>
<tr>
<th>Inhaled substance</th>
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<tr>
<td>Saline</td>
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<tr>
<td>Propylene glycol</td>
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<tr>
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<tr>
<td>Arginin</td>
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<td>NAC</td>
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</tr>
<tr>
<td>Alpha - chymotrypsin</td>
<td>55</td>
</tr>
<tr>
<td>Hyaluronidase</td>
<td>67</td>
</tr>
<tr>
<td>Mesna (Mistabron)</td>
<td>77</td>
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</tbody>
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**Indications:**

- Via nebulisation:
  - during the post operative period to prevent pulmonary complications
  - in chronic bronchitis
  - in bronchial emphysema
  - in bronchiectasis

- Via instillation:
  - in bronchoscopy
  - in tracheostomy
  - in resuscitation

**Dosage:**

- **Nebulizer:** 3 – 6 ml per day in 1 to 4 sessions (maximum of 26 ml per day)¹
- **Instillation:** 1 – 2 ml every hour until fluidification is achieved (maximum of 26 ml per day)³