ISCCM Elections 2013 Appeal
Please update your Email ID and
Register your mobile phone no with ISCCM

Dear members

Free and fair elections are the foundation of any democratic society. ISCCM elections are now held online only. It is therefore, imperative that ISCCM has email ids and mobile phone nos. of all its members for registering them on the electoral rolls. You are therefore, requested to please update your email ids and mobile numbers as soon as possible. Election participation has been only 30% in ISCCM election 2012. Please visit our website www.isccm.org for downloading the membership update form. All branches have special duty for following this task. I will be in touch with all branch secretaries for continuing this important work for ISCCM election 2013.

Dr. Shivakumar Iyer
Chairperson Election Commission • presidentelect@isccm.org

Dr. Vijaya P. Patil • Dr. Babu Abraham • Dr. Rajesh Pandey
Members Election Commission • drnrungta@gmail.com

Dr. Shivakumar Iyer
Indian Society of Critical Care Medicine, (ISCCM) Pune Branch
Karnik Heritage, Flat No 08, 3rd floor, Sadubhau Kelkar Road, Off F. C. Road, Pune - 411004, Maharashtra
Phone : 020-25532320 (from 11 am to 3 pm)
emails : newsletter@isccm.org

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

Published By :
INDIAN SOCIETY OF CRITICAL CARE MEDICINE
For Free Circulation Amongst Medical Professional
Unit 6, First Floor, Hind Service Industries Premises Co-operative Society, Near Chaitnya Bhoomi, Off Veer Savarkar Marg, Dadar, Mumbai – 400028
Tel. 022-24444737 • Telefax 022-24466348
email : isccm1@gmail.com • isccm1@vsnl.net

ISCCM NewsHeadlines

- World Sepsis Day awareness drive
- ISCCM day hand hygiene program
- News from all over the country’s ISCCM branches - North-East conclave, EZZCON, Launch of Pune Dengue study, DCCS 2012 and more
- ISCCM - ICCM “ICU protocols” a stepwise approach book launched
- Dr. Sameer Jog elected as ESICM Asia-Pacific representative
- Dr. Ramakrishnan conferred ”Best Doctor” award by TN government
- Critical Care in North East India
- Macrophage activation syndrome
- Journal Scan - New ARDS definition, ”Crystalloid or Colloid” and more

ISCCM NewsHeadlines

- ISCCM NewsHeadlines ................. 1
- Editorial ......................................... 2
- Editorial Board 2012-2013 ............. 2
- President’s Desk ............................. 3
- Gen. Secretary’s Desk ................. 4
- College News ................................ 5
- ISCCM Day Celebrations ............ 6
- ISCCM BranchNews (April to August 2012) .......... 7-9
- New Branch Approved ............... 9
- ISCCM Pune Branch launches prospective observational study on dengue .................... 9
- World Sepsis Day in News .......... 10-11
- World Sepsis Day Celebration ....... 12
- General Guidelines for the Award of Fellowship – Fellow of Indian College of Critical Care Medicine (FICCM) .......... 13
- Journal Scan ................................ 14-15
- Macrophage Activation Syndrome .......... 16-17
- Calender of Events ...................... 17
- Development of Critical Care in North East India .......... 18-19
- CRITICARE 2013 .......................... 19-20

EDITORIAL OFFICE

Dr. Shivakumar Iyer
Indian Society of Critical Care Medicine, (ISCCM) Pune Branch
Karnik Heritage, Flat No 08, 3rd floor, Sadubhau Kelkar Road, Off F. C. Road, Pune - 411004, Maharashtra
Phone : 020-25532320 (from 11 am to 3 pm)
emails : newsletter@isccm.org

CONTENTS

VOLUME 7.3 • MAY-AUGUST, 2012

EDUCATIONAL OFFICE

Dr. Shivakumar Iyer
Chairperson Election Commission • presidentelect@isccm.org

Dr. Vijaya P. Patil • Dr. Babu Abraham • Dr. Rajesh Pandey
Members Election Commission • drnrungta@gmail.com

ISCCM NEWSLETTER OF INDIAN SOCIETY OF CRITICAL CARE MEDICINE

www.isccm.org

A BI-MONTHLY NEWSLETTER OF INDIAN SOCIETY OF CRITICAL CARE MEDICINE
Dear ISCCM members,

This issue brings you news from all corners of India & reflects the widening role being played by ISCCM all over the country. The elections are over and the results have been declared. The newly elected office bearers will be announced shortly. A lot of work needs to be done in completing our database & improving members’ participation. Some amendments will be required to the constitution in order to strengthen democratic processes. The next issue will feature the important topic of “conflict of interest”. I hope also to look at ways & means of increasing transparency and streamlining processes by creating standard operating procedures for all activities within the society. An important area is the creation of proposed budgets for various committees that will be presented to the finance committee for approval.

World Sepsis Day activities have been successfully all over the country in raising public awareness about Sepsis an under-recognized killer. Dr. Rajesh Pande is working hard to put together the ISCCM day theme on hand hygiene which is our next big public awarenes drive. This issue also carries two feature articles, one on “Critical Care in North-East India” and one on “Macrophage Activation Syndrome”

Members are earnestly requested to send their contributions & ideas. The editorial board is committed to making critical care communications truly world class. The next issue will also see our newsletter in a new interactive online avatar.

Dear reader and members of ISCCM

It’s a pleasure and pride to communicate with you through the Critical Care Communications, the mouth piece of ISCCM. Over the last five years it has really matured into a very effective and awaited news bulletin of ISCCM.

I have few things to share with you all.

Taking Critical Care to places is really taking off in the Northeast

Our friends in lesser developed (in Critical Care Medicine) areas of country are really responding hard and fast. The Northeast conclave of Intensivists at Guwahati in mid-August followed by East zone conference on Critical Care Medicine at Tata main hospital at Jambshedpur were the real high lights. One in remote east with participation of intensivists from Sikkim, Nagaland, Arunachal, Upper Assam, Manipur and Tripura besides mainstream Assam and West Bengal was very heartening. I wish to congratulate Dr. Arindam Kar and Guwahati branch - Dr. Vandanana and Dr. Deka for doing a wonderful job. Organization of FCCS course in Gangtok may prove to be a milestone for development of Critical Care in Sikkim.

EZCCCON in Jambshedpur (Barkhund) has been a big event and participation of nurses in large number in the meeting was very satisfying. My congratulations to Dr. Samdar and his team. All the three events are glorifying events for Critical Care Medicine.

We have even had feedback from areas of underdeveloped areas of Rajasthan, MP, Gujrat, Punjab, Himachal and JK about similar upcoming events.

Two major events coming up

World Sepsis Day on 13th September - In association with Global Sepsis Alliance under stewardship of Dr. Konrad Reinhart in Germany and Dr. Pravin Amin in India past President of ISCCM who represents ISCCM in USA, ISCCM is an strong partner in observance of the day throughout the country through all its branches and its approved intensive care units where our courses are being run. The whole program is being observed professionally. I am sure a strong message will go to masses, media and professionals about creating awareness on sepsis. Seminars, write ups, press notes, posters and candle marches will be highlights of the day. I must say thank you to all the contributors who are leaving no stone unturned and are sparing their invaluable time in making this as a grand event.

ISCCM day on 9th October is about Hand Hygiene in ICU.

The importance of hand hygiene in ICU does not over emphasise. This is one of the cheapest, easily practised cost effective method of preventing infection spread in ICU. Dr. Rajesh Pande from Delhi is making all the efforts to make this event a grand success. The theme will be observed in the same manner as we would do the World Sepsis Day. Being ISCCM day, I request all intensivists with branches to celebrate this day with pomp and show too and create awareness amongst public and professionals about ISCCM also.

MBBS training programs takes off

This may be one of the major milestone of ISCCM for long years to come. After years of discussions and brainstorming we have come of age and the training program of graduate doctors has seen the light of the day. It is set to succeed, I am sure. The feedback and demand seems to be enormous. With proper protocolled training curriculum it is set to go miles.

Thanks EC and my colleague ISCCM teachers for being forerunners in this program.

Nursing Diploma in Critical care – The program ISCCM wanted to run for last 20 years, is finally being adopted. Thanks to Dr. Prakash Shastri’s efforts for creating a strong acceptable curriculum for nurses for their 2 year diploma course. ISCCM has shown the way that we don’t have to wait for other agencies to take a much needed program forward.

Future is always open for such cooperation. I am sure, folks, the nursing course will start from January 2013.

The society is keen to take ISCCM forward in meaningful manner by increasing its frequency and size: Its H1 Index is a reported to be very exciting at six which means its beginning very, very frequently. We wish to make additional effort for further visible growth of the journal. Release of protocol book by Dr. Chawla and Dr. Todi was another event I must mention and this effort will be very stimulating for younger generation.

ISCCM continues to grow hard and fast. We wish to see it as the largest society of intensivists in the world. With growth we are bound to have new challenges. Challenge of being adhered to it aims and objectives, setting new targets, keeping and taking one and all together. Election reforms are an important agenda which should be looked at through a electron microscope to ensure that we practice the best way. Fair representation of all parts of the country, special consideration for under developed zones of the vast country and creating a spirit of widely distributed representative power and creating space for youth and first timers may go a long way in this direction.

Criticare 2013 is just ahead and the organizing committee is working overtime to make it a grand success. I call upon you to prepare yourself to attend this annual Mecca of Critical Care Medicine in India. Challo Kolkata.

Ladies and gentlemen, we will also try to bid for the big event of ‘World Congress on Intensive Care Medicine in India’ ASP

Thanks
Greetings to all new and old members of ISCCM!

In this issue you might read the result of the electronic elections held from 1st to 7th August 2012. Dr Chawla’s vision of this advanced way of conducting elections has worked smoothly both these years. The saddening part is that out of over 5500 members we had correct contact data (e-mail addresses and mobile phone numbers) for only around 3800 life members. Even of these 400 e-mails bounced. As the years go by ISCCM would really like to “save trees” by going paperless in its communications to the esteemed members. Hopefully one day the Indian Journal of Critical Care Medicine and Critical Care Communications shall only be sent as an e-mail to the members. To move in that direction, we really need completely updated Member Profile. I urge all of you to ensure that our data is complete. We have put up a list of members whose data with us is incomplete; on the website. If you happen to be on that list please contact our office and we will send you an update form.

Dr Shirish Prayag, who did an admirable job as the editor of the IJCCM, for last 2 and half years will be completing his tenure soon and we have invited nominations for this prestigious post. Similarly send in nominations for the ISCCM oration at the Kolkata conference Criticare 2013 if you have a suitable speaker in mind.

This August two universities have started the first-ever MCI-recognized DM (Critical Care Medicine) course. I am sure soon many more universities will offer this course. This will set our people on equal footing with other super-specialities in the coming years.

ISCCM has launched its Post MBBS course this July in the centers which have been accredited for more than 3 years for IDCCM and hopefully this will rectify the woeful shortage of trained manpower in Critical Care in India.

Last but not the least; August 17 will see the release of the “ICU Protocol Book” edited by Dr Chawla and Dr Todi. Those 105 people who became members during the promotional period will get free copies of this wonderful book.

With warm regards

Dr. Atul P Kulkarni
General Secretary, ISCCM

General Secretary’s Desk

Dr. Atul P Kulkarni
General Secretary, ISCCM

Dr. Sameer Jog, Consultant Intensivist from Deenanath Mangeshkar Hospital, Pune got elected as “Asia Pacific Representative” in the council of European Society of Intensive Care Medicine (ESICM). Of the 160 casted votes, 91 votes were in his favour. Dr. Holland Robins, Dr. Sandra Peake and Dr. Sturgess David were the 3 Australians who got 10, 34 and 17 votes respectively. This was possible only due to overwhelming response by Indian Critical Care Consultants who are members of ESICM and voted for him. His tenure as Asia Pacific Representative will start in October this year at Lisbon during Annual Congress of ESICM and his tenure is of 3 years. His presence in the ESICM council will definitely facilitate the meaningful and constructive collaboration between ISCCM and ESICM in future.

College News

Dr. Ramakrishnan AB (Int Med), AB (Crit Care), HMM, FACP, FCCP, FICCM, FICCM
Vice President, ISCCM & Secretary
Indian College of Critical Care Medicine

Dr. N. Ramakrishnan receives “BEST DOCTOR AWARD”

Dr. N. Ramakrishnan, Vice President & Educational Coordinator of Indian Society of Critical Care Medicine was honored by Tamilnadu Dr. MGR Medical University on Teachers Day with “BEST DOCTOR AWARD” for his contributions in the field of Critical Care Medicine & Sleep Medicine. The University has also made him an honorary Professor and member of a special committee to incorporate simulation based curriculum in acute care for undergraduate students (MBBS).

Block Your Dates for CRITICARE 2013

1-6 March, 2012 • Science City, Kolkata

IDCCM & IFCCM

April 2012 IFCCM Exams

Indian Fellowship in Critical Care Medicine (IFCCM) exams were held on April 28, 2012 at three centers - Indraprastha Apollo Hospital (New Delhi), Bombay Hospital (Mumbai) and Apollo Main Hospital (Chennai). For the first time, candidates from ‘alternative pathway’ also appeared for the exam. Five candidates were deemed successful and will be receiving their fellowship certificate during the convocation ceremony to be held during Criticare 2013 at Kolkata.

July 2012 IDCCM Exams

The midyear IDCCM exams were held on July 28 & 29, 2012 at three centers – St. John’s Hospital (Bangalore), Deenanath Mangeshkar Hospital (Pune) and Sir Gangaram Hospital (New Delhi). 51 candidates were deemed successful in the exam and their certificates will be mailed before end of November, 2012. Candidates who were unsuccessful in IDCCM or IFCCM exams may appear for a future exam by formally enrolling for a future exam details of which will be posted in the education section of our website (www.isccm.org)

Post-MBBS Certificate Course

The much awaited two year Post MBBS Certificate Course has been started from July 2012. Candidates may directly contact the accredited institution and enroll for the course certificate. The details of accredited institutions and teachers may be obtained from the link http://www.isccm.org/Edu_Course_Certificate_Institute.htm

The deadline for registration has been specially extended to September 15, 2012. Candidates who meet eligibility criteria are expected to become Associate Members and send the completed student enrollment form before the prescribed deadline.

Honorary Fellowship of Indian College of Critical Care Medicine (IFCCM)

During the first convolution of Indian College of Critical Care Medicine held during the Criticare 2012 in Pune, practitioners, researchers and educators who have contributed significantly to the field of Critical Care Medicine were awarded honorary fellowship (2012). Nominations are now being invited for honorary fellowships to be awarded in 2013. Details of the nomination process have been outlined by the credentials committee being chaired by Dr. G. C. Khilnani and posted in the website.

Honorary fellows whose nominations were accepted (as listed above) but unable to attend the convocation held in February 2012 may receive the honor personally in future convocations within a two year period. Those whose nominations were not accepted this year may either

• Re-apply within a period of three years with any additional documentation as may be appropriate without an additional fee (OR)
• Request a refund of Rs.5,000/- (Ruppees Five Thousand only)

Webinar Series & Protocol Book release

The webinar series has been a wonderful addition to our society’s continued efforts in the field of critical care education. Using current technology, the webinar series will reach more healthcare professionals who are keen on updating their knowledge. The first of the Webinar series was conducted from Tata Memorial Hospital (Moderator; Dr. J. V. Divatia) and focused on topics relating to hemodynamic monitoring. The second one from Apollo Hospitals, Chennai (Moderator; Dr. N. Ramakrishnan) focused on Neurocritical Care issues.

As I prepare this ‘College News’ Update, Indraprastha Apollo Hospital (Moderator; Dr. Rajesh Chawla, Dr. Rajesh Pandye & Dr. Yatin Mehta) is getting ready to host the next program in the Webinar series on August 18, 2012. This webinar is extra special as we will be launching the first book under the auspices of our college & society. The book titled as ‘ICU Protocols : A Stepwise Approach’ edited by Dr. Rajesh Chawla & Dr. S.K. Todi is published by Springer and will be a valuable tool for practical evidence based bedside care of critically ill patients. We will share further details on the book launch in the next newsletter.

Please mark your calendar and plan to join us for future webinars.

September 8, 2012 – Sahyadri Hospitals, Pune (Moderator: Dr. Shivakumar Iyer)
October 6, 2012 – Kolkata (Moderator: Dr. S.K.Todi)

Details of the link to access the webinar will be emailed to all members. Please do update the database if your contact information or email ID has changed.

With warm regards

Dr. Rajesh Chawla, Dr. Rajesh Pande & Dr.

Yatin Mehta) is getting ready to host the next

Dr. Sameer Jog, Consultant Intensivist from Deenanath Mangeshkar Hospital, Pune got elected as “Asia Pacific Representative” in the council of European Society of Intensive Care Medicine (ESICM). Of the 160 casted votes, 91 votes were in his favour. Dr. Holland Robins, Dr. Sandra Peake and Dr. Sturgess David were the 3 Australians who got 10, 34 and 17 votes respectively. This was possible only due to overwhelming response by Indian Critical Care Consultants who are members of ESICM and voted for him. His tenure as Asia Pacific Representative will start in October this year at Lisbon during Annual Congress of ESICM and his tenure is of 3 years. His presence in the ESICM council will definitely facilitate the meaningful and constructive collaboration between ISCCM and ESICM in future.
**ISCCM Day Celebrations**

**9TH OCTOBER, 2012**

**Theme: Hand Hygiene**

**Agra Branch**

Dr. Diptimala Agarwal, Secretary Agra Branch reported the following academic activities of Agra branch, on 5th May Antibiopic Policy release by Dr Prashant Naraong Dr Akhtar Wani (Mumbai) at Pushpanjali Hospital. On 19 May 2012 CRM in Jaislamer with Dr Rakesh Bhatia on “Approach to a child with seizures” and Dr Diptimala on “Seizis Management in the Golden hour”. On 23rd May 2012 BLS training at NTPC (National Thermal Power Corporation) was carried out by Dr Diptimala and Dr Ranvir Tyagi. On 12 July 2012 at Pushpanjali Hospital Dr Diptimala spoke on “Polytrauma case management: TRIAL” and Dr Devender Gupta spoke on Medicolegal aspects. On 18 August 2012 Dr RK Singh made a presentation on “Rational Use of Antibiotics.”

**Bangalore Branch**

Dr. Pradeep Rangappa (Secretary Bangalore branch) reports:

On 30 May 2012 at Columbiasiasa Referral Hospital the following cases were presented:

1. Case series – Dr Shridhar: Unusual cause of recurrent pleural effusion as clinical presentation Dr Vijay Kumar (2) Rare case of hemoptysis – Dr Gayathri (4) Acute abdomen in renal transplant patient – Dr Shankar Kagadgi.

On 27 June 2012 at Baptist Hospital Jain Hospital the following presentations were made:

1. Late presentation of venomous snake bite: Dr Indira Menon, Baptist Hospital (2) Postpartum hemorrhage: Dr Farooq, Jain Hospital (3) Interesting clinical images: Dr Pradeep Rangappa.

**Bhubaneswar Branch**

Dr. Jagadish Chandra Mishra, Secretary - Dr Saroj Kri Patnkaik, Treasurer Dr Jagadish Rath, Members - Dr Acuta Swain, Dr Sanghamitra Mishra, Dr Sarat KR Behera, Dr Pragyan Routray. The new executive members took over charge from 15 June 2012. The following academic meetings were conducted.

25.5.2012 – ABC machine – Mr Jaishankar 15 workshops with the highlight being a preparatory course with invited faculty from overseas Dr. Charles Tripathy, Dr Srijnta Sarangi, Dr Saroj Patnkaik, Dr Pragyan Routray.
20.7.2012 – (1) Case Presentation: Pulmonary Embolism – Dr Pragyan Routray, (2) Ultrasoundography in Critical Care – Dr Rajesh Padih

**Chennai Branch**

Dr. Ritesh Shah, Secretary Baroda Branch reported the following academic activities. In May 2012 Dr. Ritesh Shah presented an overview of the ISICEM Brussels conference. Dr. Ankur Bhavsar presented an update on treatment of ARDS in June 2012. Dr. Keyur Acharya spoke on airway disasters in July and an update on colicosis by Dr. Alok Prasapanna is planned in August 2012.

**Delhi & NCR Chapter**

Dr Rakesh Chawla, Dr Yatin Mehta and Dr Praveen Khurami were conferred the Vishishth Chikitsa Ratan by Indian medical association, Delhi(DMA) for outstanding contribution to services in Critical Care, India on July 1st 2012 by Hon Minister of Health, Dr Ashok Valla. Dr. Rakesh Pande was awarded the prestigious Fellowship of the American College of Critical Care Medicine.

**Bareilly Branch**

Dr. Vimal Bhardawaj reported the following activities from Bareilly. Dr Afzal Azim (Asso professor Critical Care Medicine, SGPIMS, Lucknow) spoke on optimizing use of antibiotics in VAP & newer guidelines. Dr. IM Chugh (Max Pittampura Delhi) spoke on sleep apnea on 10th June. Dr. Vikram Srivasthav (Max New Delhi) presented a case on use of NIV for Acute Respiratory failure on 17th June. In July 2012 Dr Mahesh Gupta in Bareilly presented a case of diabetes in ICU managed with newer analogues of insulin.

**ISCCM Branch News**

(April to August 2012)

**Agra Branch**

Dr. Dipthimala Agarwal, Secretary Agra Branch reported the following academic activities of Agra branch, on 5th May Antibiopic Policy release by Dr Prashant Naraong Dr Akhtar Wani (Mumbai) at Pushpanjali Hospital. On 19 May 2012 CRM in Jaislamer with Dr Rakesh Bhatia on “Approach to a child with seizures” and Dr Dipthimala on “Seizis Management in the Golden hour”. On 23rd May 2012 BLS training at NTPC (National Thermal Power Corporation) was carried out by Dr Dipthimala and Dr Ranvir Tyagi. On 12 July 2012 at Pushpanjali Hospital Dr Dipthimala spoke on “Polytrauma case management: TRIAL” and Dr Devender Gupta spoke on Medicolegal aspects. On 18 August 2012 Dr RK Singh made a presentation on “Rational Use of Antibiotics.”

Dr. Pradeep Rangappa (Secretary Bangalore branch) reports:

On 30 May 2012 at Columbiasiasa Referral Hospital the following cases were presented:

1. Case series – Dr Shridhar: Unusual cause of recurrent pleural effusion as clinical presentation Dr Vijay Kumar (2) Rare case of hemoptysis – Dr Gayathri (4) Acute abdomen in renal transplant patient – Dr Shankar Kagadgi.

On 27 June 2012 at Baptist Hospital Jain Hospital the following presentations were made:

1. Late presentation of venomous snake bite: Dr Indira Menon, Baptist Hospital (2) Postpartum hemorrhage: Dr Farooq, Jain Hospital (3) Interesting clinical images: Dr Pradeep Rangappa.

**Bhubaneswar Branch**

Dr. Jagadish Chandra Mishra, Secretary - Dr Saroj Kri Patnkaik, Treasurer Dr Jagadish Rath, Members - Dr Acuta Swain, Dr Sanghamitra Mishra, Dr Sarat KR Behera, Dr Pragyan Routray. The new executive members took over charge from 15 June 2012. The following academic meetings were conducted.

25.5.2012 – ABC machine – Mr Jaishankar 15 workshops with the highlight being a preparatory course with invited faculty from overseas Dr. Charles Tripathy, Dr Srijnta Sarangi, Dr Saroj Patnkaik, Dr Pragyan Routray.
20.7.2012 – (1) Case Presentation: Pulmonary Embolism – Dr Pragyan Routray, (2) Ultrasoundography in Critical Care – Dr Rajesh Padih

**Chennai Branch**

Dr. Ritesh Shah, Secretary Baroda Branch reported the following academic activities. In May 2012 Dr. Ritesh Shah presented an overview of the ISICEM Brussels conference. Dr. Ankur Bhavsar presented an update on treatment of ARDS in June 2012. Dr. Keyur Acharya spoke on airway disasters in July and an update on colicosis by Dr. Alok Prasapanna is planned in August 2012.

**Delhi & NCR Chapter**

Dr Rakesh Chawla, Dr Yatin Mehta and Dr Praveen Khurami were conferred the Vishishth Chikitsa Ratan by Indian medical association, Delhi(DMA) for outstanding contribution to services in Critical Care, India on July 1st 2012 by Hon Minister of Health, Dr Ashok Valla. Dr. Rakesh Pande was awarded the prestigious Fellowship of the American College of Critical Care Medicine.

**Bareilly Branch**

Dr. Vimal Bhardawaj reported the following activities from Bareilly. Dr Afzal Azim (Asso professor Critical Care Medicine, SGPIMS, Lucknow) spoke on optimizing use of antibiotics in VAP & newer guidelines. Dr. IM Chugh (Max Pittampura Delhi) spoke on sleep apnea on 10th June. Dr. Vikram Srivasthav (Max New Delhi) presented a case on use of NIV for Acute Respiratory failure on 17th June. In July 2012 Dr Mahesh Gupta in Bareilly presented a case of diabetes in ICU managed with newer analogues of insulin.

The ISCCM Day celebrates organized by all participating hospitals of the city during the day. These should be attended by all major stakeholders in the hospital, preferably inaugurated by the CEO/Medical Director with involvement of microbiology & ID, all clinical departments as well as the department of nursing. The HR should be included to make this a pan hospital event, where all HCW and other staff participate.

A Hand Hygiene awareness week can be celebrated which culminates on the ISCCM day.

The activities can include:
1. “Give colour to your ideas” - Hand Hygiene poster competition
2. “Direct diffux” - Poetry, slogan competition, skit on hand hygiene
3. “Let us walk the infection out” - Fashion walk on hand hygiene
4. Hand hygiene awareness drive in patient waiting areas: Patient expectation of hand hygiene campaign
5. Hand hygiene awareness drive among the HCW
a. Housekeeping & GDA: Attitude towards hand hygiene-breaking the barriers
b. Necessity of hand hygiene: Therapists & technicians
c. Nurses role in hand hygiene compliance
d. Physician’s role in hand hygiene compliance
6. Hand hygiene awareness booths to be created outside all wards & ICUs to increase awareness and compliance among the patients and HCW

The respective city branches can organize a central function in the evening of the ISCCM Day. The program may include the following presentations:

1. Nosocomial Infection - A growing menace
2. Preventive Strategies
3. Why Hand Hygiene is so important?
4. The print and electronic media can be invited to cover the event and spread this important message. The members can invite their nursing and medical administrators to this event to further help in implementation of the program in individual hospitals.

DCCS 2012

DCCS 2012 was successfully held at New Delhi from 24th - 26th August 2012 under the able guidance of Dr. Prakash Sharma, Dr. Rakesh Pande, Dr. Rakesh Chawla & the organizing committee. There were more than 15 workshops with the highlight being a preparatory course for fellowship candidates with examiners from overseas Dr. Charles Gomemani & Dr. Rakesh Pande. Dr. RK Mani was awarded the Delhi oration and he delivered an excellent talk on his journey through critical care
Surat Branch

Dr. Mitul Chavada, Surat ISCCM branch, informed that the activities of Surat ISCCM branch in this quarter were:

- Upcoming events: The last day to apply for the diploma and fellowship course was January 2012. The fellowship course is likely to start in May 2012.
- Dr. Shrikant Pardeshi inaugurate the course.

Nagpur Branch

Dr. Deepak Joswarji Secretary ISCCM, Nagpur branch reports ISCCM, Nagpur organized a CME on “TROPICAL & GRAM NEGATIVE INFECTIONS” on 8th July, 2012. Dr. Ashit Hegde, Senior Consultant Infectious Disease, Intensive Care Medicine and Intensive Care Unit (ICU) at Hinduja Hospital, Mumbai, was the chief guest. The day started with a welcome address by Dr. Anand Dongre (Chairman, ISCCM, Nagpur).

Nashik Branch

Dr. Swamrana Tandale from Nashik reports ISCCM Nashik Branch Elections were held in the General Body meeting of ISCCM Nashik Branch on Wednesday 8th August 2012. We received single nominations for the following posts: (1) Chairperson – Dr. Yatindra Dube, (2) Secretary – Dr. Prande Raj and (3) Treasurer – Dr. Dinosh Vagh.

North-east Conclave Report (Gwahati)

The purposes of the conclave were as follows:

- To form a group (email based) amongst the relevant critical care physicians of the seven states of North East and Sikkim in the North-east region.
- Discussing the possibility of formulating a state/city/city branch covering all the seven states of the region.
- Introducing variety of training programs for graduate/post graduate doctors, nurses and paramedical staff under the guidance of ISCCM in the North-east cities/towns.
- To improve interpersonal relationship and communication amongst all members and use this as a medium for the development of new superspecialties.
- To create a common forum and organize academic activities (CME, workshops, certified courses, institutional training programs) within the North Eastern states/towns, bringing together national/international faculties.
- To form a comprehensive database of the people concerned with critical care medicine across all the specialties.
- To form a group (email based) amongst these people to share, discuss, solve, inform and help each other in various situations or problems.

The conclave was divided into two halves, the afternoon session and the evening session. The afternoon session was followed by an introductory session about the ISCCM followed by the information dispatch on various aspects of ISCCM. The afternoon session discussion revolved around the need to open more branches/have more academic interaction, to open for institute recognition for opening diploma and fellowship course conducted by ISCCM. GNRCC, Dispur Hospital and Nemcare Hospital were asked to apply for the course. Dr. Medhi from Dibrugarh pointed out the need to combine few districts to open up a branch as the required no. of members were not sufficient. Dr. P. Bhattacharyya from Shillong conveyed to the group that the starting branch should be formed shortly as the paper work was already done. Dr. Imsu from Nagaland and Dr. Pradeep from Meghalaya, Mizoram, Nagaland, Tripura and Sikkim are still “untapped” in matters relating to Critical Care practitioners in these states. In these states the practitioners in these area are enthusiastic but there has been a lack of training & academic activities in this area in critical care. In order to bridge in this gap and to find solutions of all problems in a common forum the North East conclave was specifically conducted in the Gwahati City branch so as to facilitate representation from all the targeted states. The NE conclave had the glorious presence of the Honorable President, ISCCM, Honorable Vice President, ISCCM, Chairman ISCCM, Gwahati City Branch, Chairman ISCCM Election Commission, Secretary, ISCCM, Gwahati City Branch, Zonal Member, East, ISCCM and various other eminent members.

All the important and the relevant Critical Care practitioners of the North Eastern States were present during the conclave to evenly represent their particular states. The purposes of the conclave were as follows: Re-grouping all the relevant critical care physicians of the seven states of North East and Sikkim in the North-east region.

- Discussing the possibility of formulating a state/city/city branch covering all the seven states of the region.
- Introducing variety of training programs for graduate/post graduate doctors, nurses and paramedical staff under the guidance of ISCCM in the North-east cities/towns.

Nagpur Branch

Dr. Arindam Kar (East Zone Member) who traveled extensively in the last four months in this region meeting doctors & conducting various CME’s with Dr. Vandana Sinha (Secretary Gwahati Branch) report:

This year the theme of the ISCCM is “Taking Critical Care to Places”. And this view in mind we conducted the North East Conclave 2012 at Pragoti Manoir, Gwahati on 2nd July, 2012. In India the states in the North Eastern belt like the Seven Sister states (Assam, Tripura, Meghalaya, Mizoram, Nagaland, Tripura and Sikkim) were specifically conducted in the Gwahati City branch so as to facilitate representation from all the targeted states. The NE conclave had the glorious presence of the Honorable President, ISCCM, Honorable Vice President, ISCCM, Chairman ISCCM, Gwahati City Branch, Chairman ISCCM Election Commission, Secretary, ISCCM, Gwahati City Branch, Zonal Member, East, ISCCM and various other eminent members. All the important and the relevant Critical Care practitioners of the North Eastern States were present during the conclave to evenly represent their particular states.

Intensive care review course. Dr. SV Prayag lighting the lamp with Kayoonosh Kadapatti in the background.

Pune branch conducted the following activities in this quarter. On 27th April case presentations were done by Deenanath Mangeshkar Hospital & Sanjeevan (Shawal) Hospital teams on rabies & Steven Johnson’s syndrome. Sirajuddin hospital & Bharti hospital presented cases on Macrophage activation syndrome & low ICP related subdural hematoma respectively on 29th May 2012. Basic course was conducted at Sanjeevan (Shawal) hospital with Dr. Subhal Dixit as course director in the afternoon session and Dr. Anand Dongre (Chairperson ISCCM Pune) in the evening session.

Intensive Care Review course was conducted on 29th, 30th June 2012, a report by Dr. Kayoonosh Kadapatti (Organizing Secretary) follows:

The Intensive Care Review Course was held at the Courtyard Marriott,Pune City Centre, on the 29th, 30th June and 1st July 2012. We aimed for 75 registrations but had to close just 126 registrations and attended 124 in total.

The course was intense, action packed with a lot of interaction and exchange of data. Our guest faculty included Dr. Vijaya Patil (Mumbai), Dr. Suhasir Tirimula (Hyderabad), Dr. RameshVenkattaram (Chennai) and Dr. Nayana Amin (Mumbai). There were 20 lectures and 25 small group teaching stations. Topics focused on were those not covered in the Mechanical Ventilation Workshop, The Basic Course and ACLS and TETAMATIC. We included a session on pathophysiology of disease processes which was excellent.

The young enthusiastic local faculty from different hospitals in Pune taught extremely well and the work stations were all conducted from an exam point of view.

A mock exam was held covering all topics for that day and all the students sincerely solved the paper at the end of each day.

A novel course on patient safety and care in the organ support therapies was conducted by Dr. Samser Jorg managing the protocol & data collection as trial coordinator.

Background

Dengue infection is a common tropical infection in western Maharashtra. There has been an increase in the occurrence of severe dengue infection in the last few years in this region. Though the overall mortality of the infection is reported between 1.5 to 10 %, the case fatality rate of classical dengue (predominantly from non Indian centres) as we Indian physicians really do not know the exact numbers. The manifestations of Severe Dengue infections are varied and include Shock, ARDS, Hepatitis, Encephalopathy, Myocarditis, Polyserositis and coagulopathy. Unfortunately exact morbidity and mortality in terms of organ dysfunction is still not well studied in the Indian context. One pediatric study and several epidemiological studies in patients with severe dengue have shown that the development of multiple organ dysfunction in these patients is associated with higher mortality rates. Unfortunately precise diagnostic and management guidelines of this disease are lacking especially in the era of Modern Intensive Care. Hence on this background Indian Society of Critical Care Medicine- Pune Branch has taken an initiative in this study. Data from 3 of the ICUs from Pune has been published in Journal of Critical Care in 2010 but that study was more of retrospective data collection and interpretation. The proposed study will be prospective observational multicentric study.

Aims and Objectives

1. To study the morbidity and mortality of Severe Dengue Infection related MODS, especially in the setting of Modern ICU care in the organ support therapies

2. To study the risk factors associated with morbidity and mortality

3. To study the effect of various treatment strategies commonly recommended and practiced on the morbidity and mortality

Study Details

This is prospective observational multicentric study planned to be conducted in 17 ICUs in Pune from 20th July 2012 to 1st December 2013

Inclusion Criteria

1. Adult > 18 years

2. Confirmed diagnosis of Dengue Infection by IgM positive OR Dengue PCR positive OR Dengue PCr positive

3. At least one Documented Non Hematological Organ Dysfunction by SOFA criteria

Exclusion Criteria

1. ICU admission or study enrollment after 1st hour of NHO (e.g. treated with NS-1 antigenic strategy)

2. Exclusion Criteria

3. To study the effect of various treatment strategies commonly recommended and practiced on the morbidity and mortality

Dr. PK Joshi (Chairperson ISCCM Pune) and Dr. Shirinbag Godbole (Endocrinologist) spoke on diabetic ketoacidosis & Nephritis the implications at the meeting on 27th July 2012.

A novel course on patient safety and care in the organ support therapies was conducted by Dr. Samser Jorg managing the protocol & data collection as trial coordinator.

Dr. Ashit Hegde from Hinduja Hoop, Mumbai, made a presentation on Gram negative complications. This was followed by an excellent presentation on Gram negative infections in ICU by Dr. Ashit Hegde from Hinduja Hospital Mumbai.

North-east Conclave Report (Gwahati)

ICUSCM Pune Branch launches prospective observational study on Dengue

Bilaspur Branch

Bilaspur branch received approval from the ISCCM executive committee in August. The Bilaspur branch is as follows -

Chairman: Dr. Manoj Kumar Rai
Secretary: Dr. Neela Shrivastava
Treasurer: Dr. Rakesh Nigam

Executive Committee Members

Dr. K.K. Tiwari • Dr. Rakesh Solgell
Dr. P. Kalita • Dr. Rakesh Pandey
Dr. Rajesh Agarwal • Dr. Vijay Kapilkar

Jamshedpur Branch

Dr. PK Joshi (Chairperson ISCCM Pune) and Dr. Shirinbag Godbole (Endocrinologist) spoke on diabetic ketoacidosis & Nephritis the implications at the meeting on 27th July 2012.

A novel course on patient safety and care in the organ support therapies was conducted by Dr. Samser Jorg managing the protocol & data collection as trial coordinator.

Dr. Poora Hospital conducted the August monthly meeting by presenting interesting cases.
World Sepsis Day in News
World Sepsis Day Celebration

The book was released by Dr. N. Subhash Todi, President of ISCCM, and Dr. J Divita Chanceller, Indian College of Critical Care Medicine on 18th August at India Habitat Centre New Delhi. The function was attended by more than 130 physicians.

The goal of this book is to provide Residens, Fellows, Critical Care Practitioners and allied health care professionals, with a current and comprehensive stepwise algorithm for bedside diagnosis and management of the most frequently encountered problems in the Intensive Care Unit (ICU).

This book is neither a condensed text book as some of the current hand books are nor is it an elementary primer. Although it is small enough to carry around yet it is big enough to contain all essential elements of ICU care. The management of various conditions has been described in a stepwise fashion to avoid missing any important step in both the work up and treatment.

It is a multi-author book, written by well known practitioners in the field of critical care in India. We have included contributions from other specialties that bring a complementary perspective to the multidisciplinary management of critically ill patients. We have avoided the didactic style of writing and have made it more algorithmic with bulleted points to highlight important steps. Each chapter starts with a typical case scenario followed by stepwise management of diagnostic workup and treatment of that condition. Flow sheet, tables, charts, figures and illustrations have been added at appropriate places. Each chapter ends with current authoritative references with annotations to guide the reader about more in-depth reading and important web resources. To prevent the manual from becoming voluminous we have restricted the details of the pathophysiology of each condition. We have included an appendix that has drug doses, ICU formulas, normal values and ICU syllabus for the trainees.

The chapters of this book follow a uniform format and are divided on the basis of organ system and special topics (trauma, toxicology, metabolic problems, and procedures). It is important to understand that the field of critical care, like everything else, is not static but changes constantly. This book does not purport to define standard of care but is only a guide to current clinical practice in intensive care medicine. It is generally presumed that multi-author books are only superficially edited and their chapters reflect the styles of its authors. In this book we have tried to give a uniform format to all the chapters reflecting the purpose of the book. We have worked together as a team for more than a year and reviewed each chapter to ensure the authenticity of the information.

This is an important educational venture of ISCCM, and we hope the book will be read not only in India but also regionally and internationally. Last but not the least, we sincerely hope that this manual will be used by the residents, wherever they are, for better bedside care of critically ill patients.

The book is available from ISCCM office in Mumbai at a very nominal price for members. Happy Reading!

Release of Book “ICU Protocols A Stepwise Approach”

General Guidelines for the Award of Fellowship – Fellow of Indian College of Critical Care Medicine (FICCM)

1. Essential Criteria: Candidates applying for fellowship should meet the following criteria:
   - Candidates should be Life Member of ISCCM for 5 yrs.
   - Physicians should have sub-specialty certification in Anesthesia, Chest medicine, Internal Medicine, Pulmonary Medicine, Surgery, Critical Care or Pediatrics. This also includes diploma in the same subjects.
   - Candidate must be spending at least 50% of his practice time in the field of Critical Care Medicine at the time of application (A letter to that effect should be obtained from appropriate authority such as Medical Superintendent or Dean/Principal of college)

2. With the above mentioned qualifications on those who fulfill AT LEAST one of the following criteria may apply:
   - Candidates who have cleared Indian Fellowship in Critical Care Medicine (IFCCM), Fellowship of National Board (FNB) in Critical Care or Members who are honorary fellowship of Indian Society of Critical Care Medicine (FSCCM)
   - Candidates who have cleared Indian Diploma in Critical Care Medicine (IDCM) and have demonstrated continued involvement in practice of CriticalCare research, publication and outstanding dedication and leadership in the practice of critical care sufficient to recommend election
   - Candidates who also are American board certified in Critical Care Medicine.
   - Candidates who have cleared European Diploma in Critical Care Medicine or FICCCM from Australia

3. In addition to having one of the above certifications:
   - Candidates should demonstrate continued involvement in the practice of Critical Care by research, publication, and workshops and conferences in critical care.

4. Following scoring system would be followed by the Credential Committee for election to the fellowship:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of experience in critical care</td>
<td>10</td>
</tr>
<tr>
<td>Duration of Teaching experience</td>
<td>10</td>
</tr>
<tr>
<td>Publications</td>
<td>20</td>
</tr>
<tr>
<td>Examinership</td>
<td>10</td>
</tr>
<tr>
<td>Contributions to society</td>
<td>20</td>
</tr>
<tr>
<td>National/local fellowships</td>
<td>10</td>
</tr>
<tr>
<td>Awardsism</td>
<td>10</td>
</tr>
<tr>
<td>Membership in Professional Societies</td>
<td>10</td>
</tr>
</tbody>
</table>

Application Process:

- Application in prescribed form should be accompanied by a statement in a plain paper by the candidate describing his credentials supporting his claim for award of fellowship (up to 300 words)
- The candidate should submit a list of publications
- Research work
- A recommendation letter from an IDCCM, IFCCM, or Clearing house fellow or an INCCM
- A list of papers presented in national and international conferences and workshops

This should include nature of work, training, contribution to society programs and any research work

- All applications should be accompanied by a Demand Draft for Rs.10000/- (Rupees Ten Thousand Only) in favour of Indian Society of Critical Care Medicine’ pay able at Mumbai. The application fee is non-refundable.
- Last date of application – September 30, 2012. Any application received after 5 pm on September 30, 2012 will not be considered.
- All applications should be sent to ISCCM Headquarters in Mumbai
- Indian College of Critical Care Medicine
- Unit 6, First Floor, Hind Service Industries Premises Co-operative society, Near Chaitya Bhoomi, Off Veer Savarkar Marg, Dadar, Mumbai 400 028
- The Credential Committee would examine each application for award of fellowship. The decision of the Credential Committee would then be put to approval by the College Board. Candidates will be informed the decision before December 31, 2012
- Fellowship would be awarded during the Annual Conference of Indian Society of Critical Care Medicine to be held in March 2013 in Kolkata
- The candidate is unable to attend the conference and collect the award certificate in the same has to be personally received during one of the conferences held in 2014 or 2015 failing which a fresh application would have to be made for the award

Secretary
Indian College of Critical Care Medicine
The CriTiC al Care CommuniC aTions
a Bi-monthly newsletter of indian society of Critical Care medicine

Hydroxyethyl starch is widely used for fluid resuscitation in intensive care units, but its safety and efficacy have not been well studied. Permeability and permeability of hydroxyethyl starch has been associated with sepsis to fluid resuscitation in the ICU with either 6% HES 130/0.4 (Terarase) or Ringer’s acetate. The use of hydroxyethyl starch is associated with increased mortality and nosocomial infection and increased mortality (due to dependence on dextran) at 90 days after ICU admission.

Of the 804 patients who underwent randomization, 785 completed the study (19 patients did not receive hydroxyethyl starch because they died or were transferred out of the ICU). There were 372 patients in the control group and 213 patients in the hydroxyethyl starch group. The use of hydroxyethyl starch was associated with increased mortality (12%) compared to the control group (7%). In addition, hydroxyethyl starch was associated with increased nosocomial infection rates (28%) compared to the control group (18%). The use of hydroxyethyl starch was also associated with increased incidence of acute renal failure (20%) compared to the control group (15%).

In conclusion, hydroxyethyl starch is not recommended for fluid resuscitation in intensive care units because it is associated with increased mortality, increased nosocomial infection rates, and increased incidence of acute renal failure.

Candida spp. airway colonization could promote antibiotic resistant bacteria selection in patients with suspected ventilator-associated pneumonia

Mail Hatem, Arneet Pauw et al. Pages:1272 – 1279 Wane, 38 Number:8 August 2012

Objectives: The objective of this study was to evaluate if the occurrence of Candida spp. airway colonization in patients with suspected ventilator-associated pneumonia (VAP) could promote antibiotic resistant bacteria selection in patients with suspected ventilator-associated pneumonia (VAP).

Methods: In this retrospective study, we included hospitalised patients with suspected VAP who underwent bronchoscopy for airway colonization testing. Patients were excluded if they had received antibiotics within the last 48 hours prior to bronchoscopy or had a history of antibiotic use within the last 6 months prior to ICU admission. The study included 50 patients who met the inclusion criteria.

Results: Of the 50 patients included in the study, 33 (66%) had Candida spp. airway colonization (11 Candida albicans, 12 Candida glabrata, 2 Candida tropicalis, 2 C. dubliniensis, 4 C. parapsilosis, and 2 C. lusitaniae). The remaining 17 patients (34%) were classified as non-colonized. The presence of Candida spp. airway colonization was associated with a significantly higher rate of antibiotic resistant bacteria selection (19.4%) compared to the non-colonized group (2.9%). The most common antibiotic resistant bacteria isolated were Pseudomonas aeruginosa (8.0%), Acinetobacter baumannii (6.8%), and Stenotrophomonas maltophilia (3.9%).

Conclusion: This study suggests that Candida spp. airway colonization may promote the selection of antibiotic resistant bacteria in patients with suspected ventilator-associated pneumonia. Further research is needed to confirm these findings and to evaluate the clinical implications of this association.

The New Berlin Definition of Acute Respiratory Distress Syndrome

JAM, 2012;30(7):23

Following the initial description of acute respiratory distress syndrome (ARDS) by several multiple definitions were proposed and used until the 2012 Berlin Definition of ARDS (Acute Respiratory Distress Syndrome) Conference (AECC) definition. The AECC definition was developed to strike a balance between the need for a definition that is easy to use in clinical practice and the need for a definition that is based on scientific evidence. The AECC definition was developed by a group of international experts who met in Berlin, Germany in June 2012. The definition includes the following criteria:

1. Acute onset of respiratory failure
2. Bilateral infiltrates on chest X-ray
3. PaO2/FiO2 ratio ≤ 300 mmHg

This definition has been shown to be superior to previous definitions in terms of specificity, sensitivity, and clinical utility. The AECC definition is widely used in research and clinical practice and has been shown to be superior to previous definitions in terms of specificity, sensitivity, and clinical utility.
Macrophage Activation Syndrome

1st CASE
Middle aged male, a case of PUO presented with history of fever 5 days and recurrent pyrexia for 1 week. His investigations done 1 month back showed pancyclopenia, mild hepatosplenomegaly, hypogammaglobulinaemia, low brucella antibodies positive for which he was started on appropriate antibiotics with no relief. In the present admission due to MODS, the autopsy report showed macrophage activation in the liver.

2nd CASE
40 year old female, presented with 8-10 days history of high grade fever, severe headache, 2 episodes of seizures and breathlessness. On admission patient was febrile, irritable, tachypnoeic. Laboratory examination showed normal coagulation profile, CSF examination showed normal nucleic cell count and normal opening pressure. Serological test for neisseria meningitides and brucella antibodies positive, Serum Ferritin levels 4662ng/ml, total bilirubin 5.65mg/dl, Hemoglobin 9.8g/dl, WBC count 12,000, platelets 145,000, LFTs showing functional arrest of all three series of enzymes. Other investigations showed hepatomegaly with ascitis. She was evaluated for possible causes of high ferritin. She presented with febrile neutropenia with liver dysfunction, pericarditis, osteoarthritis, and brucella antibodies positive for which he was started on appropriate antibiotics with no relief. In the present admission due to MODS, the autopsy report showed macrophage activation in the liver.

Hemophagocytic lymphohistiocytosis

The pathological hallmark of this disease is the aggressive proliferation of activated macrophages and histiocytes, which phagocytose other cells, namely, RBCs, WBCs, and platelets, leading to the clinical symptoms. The uncontrolled growth is nonapoptotic and does not appear clonal in contrast to the lineage of cells in Langerhans cell histiocytosis. The spleen, lymph nodes, bone marrow, liver, skin, and membranes that surround the brain and spinal cord are preferential sites of involvement. This disorder may be viewed as a highly stimulated, but ineffective, immune response to antigens, which results in life-threatening cytokine storm and inflammatory reaction.

Diagnosis clinical presentation

The most typical findings are hepatosplenomegaly and cytopenias. Other common findings are lymphadenopathy, increased serum levels of ferritin and serum transaminases and neurological symptoms that may be associated with a spinal fluid hypoproteinaemia and a moderate protein pleocytosis.

With as many as 65% patients have a nonspecific rash that is often vaguely termed maculopapular although it has been described as arrangement from erythrocyanosis to generalized purpuric macules and papules to morbilliform eruption.

Diagnostic guidelines

The diagnostic guidelines for HLH were published by the Histiocytic Society in 1999, based on common clinical, laboratory and histopathological findings. These guidelines were then revised in 2004 with additional 3 criteria.

Revised diagnostic guidelines for HLH

The diagnostic HLH can be established if one of either 1 or 2 below is fulfilled

1. A molecular diagnosis consistent with HLH
2. Diagnostic criteria for HLH fulfilled (five out of the eight criteria below)

A. Initial diagnostic criteria (to be evaluated in all patients with HLH)

Fever

Cytopenia (affecting >2 of 3 lines in the peripheral blood)

Hemoglobin <90g/L (in infants <4 weeks: hemoglobin <100g/L)

Platelets <100x10^9/L

Neutrophils <1x10^9/L

Hypertriglyceridemia and/or hyperlipoproteinemia

Fasting triglycerides >5.0mmol/L (i.e., >265 mg/dl)

Fibrogen <1.5 g/L

Hemophagocytosis in bone marrow or spleen or lymph nodes

No evidence of malignancy

B. New diagnostic criteria

Low or absent NK-cell activity (according to local laboratory reference)

Ferritin >500 g/l

Soluble CD25 (i.e., soluble IL-2 receptor) >4200IU/ml

Note:

If hemophagocytic activity is not proven at the time of presentation, further search for hemophagocytic activity is encouraged. If the bone marrow specimen is not conclusive, material may be obtained from other organs: Serial marrow aspirates over time may also be helpful.

The following findings may provide strong supportive evidence for the diagnosis:

(a) spiral fluid pleocytosis (mono-nuclear cells) and/or elevated spinal fluid protein, (b) histological picture in the liver resembling chronic persistent hepatitis (biphasic).

3. Other abnormal clinical and laboratory findings consistent with the diagnosis are cerebroenzymal symptoms, lymph node enlargement, jaundice, edema, skin rash. Hepatic enzyme abnormalities, hyperproteinaemia, hypothrombinaemia, VLDL, HDL, cholesteroic, and moderate pleocytosis.

Imaging Studies

No specific imaging patterns are diagnostic of hemophagocytic lymphohistiocytosis. CT or ultrasoundography findings may include adenopathy, wall thickening, pericardial effusion, peripertenal echogenicity, lymphadenopathy, and pleural effusion.

MIBI may show CNS involvement, but the diagnosis is clinical and molecular, is discussed below.

Laboratory Studies

Because natural killer (NK) cell function or activity is decreased in as many as 90% of patients with HLH, it is one of the most useful laboratory tests. NK cell number is usually not diagnostic.

In addition to pancytopenia, hypofibrinogenemia, and hypertriglyceridemia, coagulopathy with hypofibrinogenemia, and hypertriglyceridemia as previously mentioned, other laboratory abnormalities have been linked to HLH.

Hemophagocytosis is a marker for hemophagocytic lymphohistiocytosis, with the serum levels paralleling the course of the disease. Liver damage has also been reported as evidenced by elevated ALT, AST, and alkaline phosphatase. Elevated findings on liver function tests including aspartate aminotransferase (AST) and alanine aminotransferase (ALT).

The presence of a PRF1 gene mutation can be determined based on flow cytometry by staining peritoneal cells in lymphocytes.

Treatment

If not recognized and promptly treated, the uncontrolled inflammation associated with HLH leads to life-threatening neutropenia, increased systemic complications and organ damage. Initial clinical management of patients with HLH aims to suppress this excessive immune response and treat its underlying cause.

In familial HLH, the ultimate aim should be to establish the diagnosis to replace the defective immune system with normal functioning immune cells, eradicating the sporadic nature of HLH in adults has impeded investigations of the efficacy of immunosuppressive drugs for this indication. Corticosteroids, cyclosporine, IVIG, antithymocyte globulin and TNF antagonists have induced remission in HLH in the past, but the optimal approach to managing HLH in adults has yet to be established.

Patients with secondary HLH, immunosuppressant and effective treatment of its underlying etiology is often sufficient to induce a durable remission.

The International Histiocytic Society has recommended that children with hyperferritinaemia, hypofibrinogenemia, and HLH and unexplained fever should undergo secondary HLH activation syndrome MAS should be treated with the same immunosuppressant/cytotoxic therapies used to treat primary HLH.

Summary of the HLH 2004 protocol

The HLH 2004 is a revision of the HLH-1994 developed by the Histioctytic Society. The treatment included in the HLH-2004 research protocol is intended to achieve stability of the disease symptoms so that a patient can then receive a stem-cell transplant, which is necessary for a cure. The protocol is designed for patients with familial or genetic disease, who do not show evidence of familial or genetic disease, regardless of suspected or documented viral infection.

Initial therapy (1-8 weeks) based on Eto- poside, Desamethasone and Cyclosporine. The initial dose of etoposide is 100mg/m2 daily for 2 weeks, then 50mg/m2 daily for 2 weeks, then 25mg/m2 daily for 2 weeks. Cyclosporine, dosed to achieve a serum trough level of 200 g/l.

Continuation therapy (until patients can undergo allogeneic stem-cell transplantation)

Cyclosporine, dosed to achieve a serum trough level of 200 g/l.

Calender of Events

October 2012
5-7 October, 2012 3rd Annual UP & Uttarakhand chapter (ISCCM) CRITICON-2012
13-17 October 2012 LIVES 2012, 25th ESICM Annual Congress CCL-Lisbon, Lisbon – Portugal
3rd Annual UP & Uttarakhand chapter (ISCCM)
November 2012
6-8 November 2012 10th Doppler-Echoangiography in Intensive Care Medicine
December 2012
12th German Interdisciplinary Congress for Intensive Care Medicine
1st February 2013 8th Annual Refresher course

Notes:

Corticosteroids are continuously administered as prophylaxis for pneumocystis jirovecii because of immunosuppression.

HLH-2004 PROTOCOL Initial therapy (8 weeks)

Desamethasone 10 mg/m2 daily for 2 weeks, then 5mg/m2 daily for 2 weeks, then 2.5mg/m2 daily for 2 weeks, then 1.25 mg/m2 for 2 weeks.

Etoposide 150mg twice weekly for 2 weeks, then 150mg once weekly for 6 weeks. Cyclosporine, dosed to achieve a serum trough level of 200 g/l.

Continuation therapy (until patients can undergo allogeneic stem-cell transplantation)

Cyclosporine, dosed to achieve a serum trough level of 200 g/l.

Mortality / Morbidity

Familial hemophagocytic lymphohistiocytosis is uniformly fatal if not treated; the median survival time reported in various studies is 2-6 months after diagnosis. The historical series collected by the International Hema- topoietic Lymphohistiocytosis Registry reports a loss of 10% probability that the patient will survive 3 years. Even with treatment, only 21-26% can be expected to survive 5 years. The survival rates on the HLH2004 are high during which time a BMT donor can usually be identified. Bone marrow trans- plantation is the only hope for cure. One study found that 50% of deaths from FHL were due to invasive fungal infections, which are poorly understood. The outcome of secondary hemophagocytic lymphohistiocytosis varies.

Conclusions

Though the survival of patients has improved dramatically during the last decade with the available treatment options it is utmost important to treat HLH at the earliest. With the continuing rise, this high index of suspicion is required when a patient presents with fever, hepatosplenomegaly and cytopenias.
Development of Critical Care in North East India

Indian Scenario

Dr. F. E. Udwha, pioneer of Critical Care Medicine was the first to organize ICU of this country in Beach Candy hospital at Guwahati in early 1971. Then 10 beds were equipped in a corporate way with self fund generation & management. The unit was totally under the care of Anaesthesiology department. It was the first training ground for the students and graduate students in critical care. It rose to a high level and was renovated again to begin again as a prominent intensive of the country.

The advantages we enjoyed in this joint venture

To a great extent it was free of official hassles. It has a better financial position – so better maintainance & better purchase of consumables. Though patients are not so many but less expensive than private ICUs.

First medical College of North-East was establish here in 1947. Government hospitals provide only 10 ICU beds against 50,000 beds. Those include 5 ICU beds in railway hospital. In private hospitals 52 ICU beds exist against 900 total beds.

Sylhet

The most important city of Barak valley which also caters to the needs of Assam, Nagaland, Mizoram & Manipur. It started in Progoti hospital in 2007 (total 4 bedded ICU) and in 2010. Building & space wise this is one of the best ICUs in the region.

Kohima first government ICU of Nagaland was opened in 2007 with 10 beds, commissioned in August, 2007.

Mizoram

In the year 2008 Mizoram entered into Critical Care Service in its capital city of Aizawl. There were 3 ICU beds. In 2009 three bedded ICU. Presbyterian hospital (300 beds) also started three bedded ICU.

Assam Medical College hospital, in the year 2008 an 8 bedded ICU was commissioned. In newly established Jorhat Medical College hospital in 2010. A four bedded well organized ICU was started in Progoti hospital (2007) total hospital beds 110).

Manipur

Critical care is available only in the capital city of Imphal. Regional Institute of Medical Sciences (RIMS) established a 12 bed ICU in 2004 to cater to the needs of 296 bedded academic hospital of the state. In 2010 another 2 bedded ICU is commissioned in newly established Jorhat Medical College hospital in 2008.

Silchar

A four bedded well organized ICU was opened in 2008. Building & space wise this is one of the best ICUs.

State of Meghalaya

Critical care facilities are available, but only in the capital city of Shillong. In government sectors other than NEIGRMS there are two more ICUs (1 bedded) in army hospital and Shillong civil hospital started 6 bedded ICU in 2009. In total against 250 beds in civil hospital there are 46 ICU beds. In private sector there are 5 ICUs comprising total bed strength of 90 beds.

Future of critical care medicine in North-East

Critical Care in North-East region is in a fast developing state. The development in the last seven years are very encouraging. But there is a long way to go. The field is full of dynamics, opportunities & challenges. With more & more young, bright post-graduates doctors of Anaesthesiology & critical care showing interest in Critical Care, we can definitely hope that Critical Care will flourish & prosper in North-Eastern region.

CRITICARE 2013

19th Annual Congress of the Indian Society of Critical Care Medicine & International Critical Care Congress 2013

1-6 March, 2012 • Science City, Kolkata

WEB SITE: www.criticare2013kolkata.org

Indian Scenario

It was the pioneer medical town of Assam. Dibrugarh

Common concerns of the public

• Too-expensive to accept the service.
• As so expensive, anyone who gets admitted to ICU must survive.

Dr. Ajit Kumar Deka

Director & Head Dept. of Anaesthesiology & Critical Care, Guwahati Medical College

Concerns of the Intensivists of the region :-

• too expensive to accept the service.
• As so expensive, anyone who gets admitted to ICU must survive.

Common concerns of the public

• Too-expensive to accept the service.
• As so expensive, anyone who gets admitted to ICU must survive.

Critical concerns of the Intensivists of the region :-

• too expensive to accept the service.
• As so expensive, anyone who gets admitted to ICU must survive.

Crises & remedies

Hospital public relation department and ICU staffs are often not honest & frank enough in the presentation of patients’ prognosis and about expense. Also not enough public awareness is created about intensive care. As mentioned earlier the so called ICUs are basic ICU like the cockpit of a modern Jet aircraft with absolute pre-determined result.

Concerns of the public

• Too-expensive to accept the service.
• As so expensive, anyone who gets admitted to ICU must survive.
Conference Secretariat

Dr. Bibhu Kalyani Das
Chairman, Reception Committee
Mobile: +91-9830006409

Dr. Subhash Todi
Organizing Chairman
Mobile: +91-9831202040

Dr. Susruta Bandyopadhyay
Organizing Secretary
Mobile: +91-9831079453

Dr. Ajoy Sarkar
Treasurer
Mobile: +91-9830006644

CRITICARE 2013
KB-25 Building, 2nd Floor, Salt Lake City, Sector - III, Kolkata - 700098, West Bengal, India.
Mobile: +91-9810084342 • +91-8017984305 • e-mail: secretariat@criticare2013kolkata.org • criticare2013@gmail.com

for more Details & Online Registration please visit www.criticare2013kolkata.org