ISCCM NewsHeadlines

- Chennai Declaration—A visionary statement from a joint committee of multiple Indian medical societies including the ISCCM to tackle the menace of antibiotic resistance
- ISCCM Hand Hygiene Day – a resounding success all over India
- ISCCM Kolkata 2013 – A curtain-raiser.

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

I will be completing a year as the editor of Critical Care Communications (CCC). At the outset I would like to thank all of you for your support and encouragement. My editorial team especially Dr. Jayant Shelgaonkar with his journal scan has contributed a lot. I hope to elicit a greater contribution from the remaining team and from readers all over the country over the next year. From the next issue the CCC will have an interactive electronic format which will reach all you by email. Please do respond to the various articles with comments. Your contributions in the form of case reports, brief communications, interesting ECG’s, X-rays, CT scans, MRI’s are welcome.

ISCCM day was celebrated all over the country with enthusiasm. There are reports on various events with pictures from all over the country.

The results of the ISCCM election 2012 have been declared at the November EC meeting.

Dr. RK Mani will take over reins of the IJCCM from Dr. Shirish Prayag who did a wonderful job as editor. CCC wishes Dr. Mani all the best in his new endeavour.

In this issue you will also find a book review on “Checklist Manifesto” a best seller on the topic of patient safety by famous Indian-American author, Dr. Atul Gawande. You will also find the detailed scientific program of the ISCCM Kolkata conference. Workshop registrations are almost full and interested members should register ASAP to avoid disappointment.

Looking forward to seeing all of you in Kolkata.
President's Desk

Dr. Narendra Rungta MD, FISCCM, FCCM
President, ISCCM • drnrungta@gmail.com

Dear Reader

Please accept new year Greetings for you and your family. ISCCM is as vibrant and dynamic as you can expect. The activities, growth and innovation continues at a fair pace. With new year starting, we are inundated with new ideas, new programs and fresh vision for future. This all has been possible through participation of all the members of the society and guidance of senior leadership of the society past and present. We are almost completing one year. I am sure the society is ready to move into new era- New era of enhanced accomplishment at national level and ambitious outlook internationally.

Kolkata Criticare 2013 is finally on wheels after few hiccups and I am sure the Organizing committee will leave no stone unturned to make it a memorable event. The journey of success of ISCCM has always been mainly stimulated by our annual conferences. The coming Kolkata conference will only be another feather in cap of ISCCM. I invite you all to this mega event. The Organizing team has made elaborate arrangements to provide you with a feast of Critical Care Medicine and Bangla Hospitality.

Landmark constitutional amendments are being proposed to ensure greater participation by younger generation in the affairs of the society. The Indian Journal of Critical Care Medicine is expected to be more frequent, Webinars by college should become a regular activity of the society, more fellows of Indian College of Critical Care Medicine will be decorated, more funds are being made available for research, education and development of programs in Critical Care Medicine, yet absolute austerity is being maintained at the organizational level. I will be giving you a complete report of year in retrospect in the next bulletin which should be in your hands during the Criticare 13 at Kolkata.

The dream of Taking Critical Care to Places is being coming true. Northeast is vibrant, other areas of the country are being tracked for development of Critical care Medicine.

My special thanks to Dr. Yatin Mehta, Dr. Arinadam Kar, Dr. Sunit Singhi, Dr. Deepak Govil and Dr. Rajesh Pande for going out of way to assist me in performing my Presidential duties. I take this opportunity to thanks my other fellow colleagues, EC members, Past Presidents for being so helpful to me since I took over the Presidency of the society.

News

Dr. RK Mani has been unanimously nominated as editor IJCCM by the credentials committee and this was ratified by the ISCCM EC on 4th November 2012 and will assume office for the years 2013-2014. Dr. RK Mani has a number of publications to his credit and is on the editorial board of various national and international journals. He takes over from Dr. Shirish Prayag who did wonderful job in establishing IJCCM firmly as an indexed journal during his tenure. We wish Dr. Mani every success in taking the IJCCM to ever greater heights.
Greetings to all new and old members of ISCCM and a wish for a great and successful new year! This issue contains the result of the electronic elections held from 1st to 7th August 2012. I congratulate those elected to the National Executive body and wish them luck. It is unfortunate that we had correct contact data (e-mail addresses and mobile phone numbers) for only around 3800 life members out of over 5500 members and out of these 400 e-mails bounced. I urge all members to ensure that their e-mail addresses and mobile phone nos. are correctly registered at the head office. 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 RK Mani will soon take over as the editor of the IJCCM from Dr Shirish Prayag, who did an admirable job for our journal.

The “ICU Protocol Book” edited by Dr Chawla and Dr Todi has been a great success and is very popular. This is available at the head office. Please contact us by e-mail if you want to purchase the book. Similarly the DVDs of first series of Webinars is also available at the office.

We shall soon send you the proposed amendments of the constitution to make the functioning of the society better. Please send in your suggestions to head office by e-mail. These will be discussed in the AGBM at Kolkata Congress.

The preparations for Criticare 2013 at Kolkata are in full swing and I am sure we will enjoy a wonderful scientific feast there at the beginning of March 2013.

With warm regards

Dr. Atul P Kulkarni
General Secretary, ISCCM

Dr. Reshma Ambulkar¹
Dr. Atul Kulkarni²
¹Associate Professor, ²Professor, Department of Anaesthesiology, Critical Care & Pain, Tata Memorial Hospital, Mumbai.

Dr. Gawande is a Professor of Surgery at Harvard Medical School and also a staff writer for the New Yorker magazine. He has written three New York Times bestselling books: Complications, Better and most recently The Checklist Manifesto. The main aim of this book is to drive home the effectiveness of the checklist for preventing mishaps in medicine. We face complex problems in our field of work; the use of checklist can help us tackle them fairly comfortably. Dr Gawande proves his point regarding the usefulness of checklist with not only examples in the field of medicine but also from aviation industry; which pioneered the use of checklist, the hotel industry, the construction business and capital industry. These cases from different fields make an interesting reading especially the emergency landing on the Hudson River being my personal favourite. In today’s world it is not enough to know everything but also to apply it at the right place and in the right order.

In medicine alone; in spite of being an era of superspecialities; simple tasks may be accidently missed or forgotten because of the work pressure and high work load; leading to an increased risk to the patient’s life. This can be avoided by a simple task – Use of a Checklist. In this book Dr Gawande has cited several benefits of using the checklist with supporting data; be it decreasing in line infections, decreasing complications by using the surgical checklists and tackling complex cases of drowning. Dr Gawande ends the book by citing cases where the checklist has made a difference to his practice as a surgeon after the implementation of WHO Surgical Checklist at his hospital.

Notably missing is the mention of the disadvantages of using checklist and the instances where checklist would be detrimental to use. Medicine is a complex arena; the use of checklist at all junctures is not always possible. Each patient is different and may present with many co-existing problems and hence will need treatment tailored to his or her condition. The checklist is rigid and will fail in such circumstances. It is important to give people the freedom to try and invent and to take responsibility which forms an important part of development of self. Sticking to protocols or checklist will kill the initiation and invention of new therapies. On the whole; the book is mentally stimulating and gives perspectives on how checklist can make a difference to patient care and outcome in our practice. The lesson learnt is that by using simple checklists, we can get the basics right in many areas of our work. The hurdle is how to make effective use of checklists without losing efficiency and too much time.

Block Your Dates for
CRITICARE 2013
1-6 March, 2013 • Science City, Kolkata
2012 was a very special year for all of us as Critical Care Medicine was recognized by Medical Council of India as a superspecialty and DM Courses were started. While rejoicing this, our society also reiterated the commitment to education and training by taking a giant leap and creating Indian College of Critical Care Medicine. We are indeed proud that we are one of the few professional societies which such a designated body focusing on education.

As we reflect on the past year, I would like to summarize the activities of the College and thank everyone for making 2012 a very ‘educative’ year.

- The first Convocation Ceremony held during Criticare 2012 at Pune when distinguished peers were honored with fellowship for their commitment and contributions to our society.
- The much awaited Post MBBS Course Fundamental Critical Care support (FCCS) in India at Jeevan Rekha Critical Care & Trauma Hospital, Jaipur on 12th and 13th of January 2013 was launched thanks to efforts from our President Dr. N. Rungta, President Dr. Yatin Mehta who developed the curriculum and selected the Coordinator for the course.
- Efforts were initiated to plan a training program for Critical Care Nurses. Dr. Prakash Shastri has taken the lead to create the curriculum and this program is expected to be started soon.
- We are now proud to have a book from India for India and the rest of the world – Dr. Rajesh Chawla and Dr. Subhash Todi edited a book entitled “ICU Protocols – A stepwise approach” published by Springer. Several thousand copies of the book have already been sold and there have also been several online download of chapters through the Springer website.
- Based on the ICU Protocols book, we are soon planning a two day “Comprehensive Critical Care Course” and the first of these courses would be offered during Criticare 2013 at Kolkata. We are confident that such a program designed to suit our local needs would be a great value addition.
- The use of technology has certainly helped reach more intensivists through our webinars that were well received and attended. Selected lectures have also been released in a DVD format that is available for purchase from ISCCM head office.
- We are initiating the second webinar series from February 2013.
- IDCCM & IFCCM Courses continue to remain popular. A special thanks to Dr. Dhruva Chaudhry, our Accreditation Coordinator who has hastened the process of accreditation. Several new institutions were accredited and we now have over 100 institutions across the country offering our training programs.
- 182 candidates registered for IDCCM in 2012 of whom 107 were successful.
- 14 candidates appeared for IFCCM in April 2012 and five of them were successful. Of note, candidates from ‘alternative pathway’ appeared for the first time this year.

None of these could have been accomplished without the commitment of the College Board under the leadership of Dr. J. V. Divatia (Chancellor) and Dr. Rajesh Chawla (Vice Chancellor) and the entire Executive Committee under the leadership of Dr. N. Rungta. Needless to say that the enthusiasm & requests from our members has been a great source of inspiration to do more.

We look forward to enhancing educational offerings even more in 2013 and would greatly appreciate any suggestions from members of our society.

We congratulate the toppers in 2012 who will be receiving the following awards during the Convocation Ceremony to be held on March 1, 2013 during Criticare 2013 at Kolkata.

1. Dr. Vijayakalashni Kamat Award for topper in IDCCM – Dr. G. Sathyamurthy (Sundaram Medical Foundation Hospital, Chennai)
2. Anand Memorial Award for topper in IDCCM – Dr. Pritesh John Korula (Christian Medical College, Vellore)
3. Anand Memorial Award for topper in IFCCM – Dr. Prashant Walse (PD Hinduja Hospital, Mumbai)

**FCCS Courses at Jaipur & Gangtok**

**JAIPUR**

**Reported by Dr. Manish Munjal, Jaipur**

Indian Society of Critical Care Medicine, Jaipur Chapter organized the 85th Fundamental Critical Care Course (FCCS) in India at Jeevan Rekha Critical Care & Trauma Hospital, Jaipur on 12th and 13th of January 2013.

**GANGTOK**

**Reported by Arindam Kar, East Zone Member ISCCM**

Fundamental Critical Care support (FCCS) Course was held on 29th-30th September 2012 at Sikkim Manipal Institute of Medical Sciences, Gangtok, Sikkim. This was the 70th FCCS course in India, and first in the North-Eastern region.

The course lectures and skill stations were conducted in the CRH Building of the institute. There were a total of 40 provider and two instructor candidates who attended the course. The course participants were from Sikkim, North Bengal, Meghalaya, Orissa, Jharkhand, Madhya Pradesh and Maharashtra. A total of nine faculty members covered 17 lectures and eight skill stations over two full days. The course faculty included intensivists, anesthesiologists and internists across the country.

The course was inaugurated by Brig SN Mishra, Vice chancellor, Sikkim Manipal University, Dr RN Sallhan Dean SMIMS and Pro VC Sikkim Manipal University, Dr Kundan Mittal, National consultant PFCCS Program, and Dr Arindam Kar, Zonal Member East ISCCM executive council, by lighting of lamp. What followed were two days of interesting and useful discussions, teaching and most importantly hands on experience. The course was conducted under able guidance of Dr Manish Munjal, National Course Director of FCCS, and with blessings from Dr Narendra Rungta, President of executive body of ISCCM.

The Course was supported by funds from Medical Council of India, Sikkim Manipal University, and Industry (Alere, Micro-Labs, Lupin Maxter, and United).
Abstract
“A Roadmap to Tackle the Challenge of Antimicrobial Resistance - A Joint meeting of Medical Societies in India” was organized as a pre-conference symposium of the 2nd annual conference of the Clinical Infectious Disease Society (CIDSCON 2012) at Chennai on 24th August. This was the first ever meeting of medical sociesties in India on issue of tackling resistance, with a plan to formulate a road map to tackle the global challenge of antimicrobial resistance. We had representatives from most medical societies in India, eminent policy makers from both central and state governments, representatives of World Health Organization, National Accreditation Board of Hospitals, Medical Council of India, Drug Controller General of India, and Indian Council of Medical Research along with well-known dignitaries in the Indian medical field. The meeting was attended by a large gathering of health care professionals. The meeting consisted of plenary and interactive discussion sessions designed to seek experience and views from a large range of health care professionals and included six international experts who shared action plans in their respective regions.

The intention was to gain a broad consensus and range of opinions to guide formation of the road map. The ethos of the meeting was very much not to look back but rather to look forward and make joint efforts to tackle the menace of antibiotic resistance. The Chennai Declaration will be submitted to all stake holders.

Background and Current Indian Scenario
Antimicrobial resistance is a serious global challenge, with the menace of antibiotic resistant “super bugs”, with possible return to the pre-antibiotic era. There is a dramatic increase in the prevalence of superbugs, and there is an equal drop in the number of new antibiotics available. The need of antibiotic research and development is nearly dry, especially when it comes to antibiotics active against Gram-negative bacteria. Research and development of any antibiotic is a huge investment for pharmaceutical industry.

There is currently no functioning national antibiotic policy or a national policy to contain antimicrobial resistance in India. The policy published in 2011 has been put on hold due to non implementability of major recommendations. There is no restriction on Over The Counter (OTC) dispensing of antibiotics without prescription. Indian hospitals have reported very high Gram-negative resistance (ESBL producers) and carbapenem resistance rates. Increasing carbapenem resistance will invariably result in increased usage of colistin, currently the last line of defence, which is at risk for colistin-resistant and Pan Drug Resistant bacterial infections. There is paucity of published data on the existence of an antibiotic policy in the majority of Indian hospitals or on their compliance with existing policies. There are major international efforts to tackle the challenge of antimicrobial resistance.

Development of Road Map
“A Roadmap to Tackle the Challenge of Antimicrobial Resistance - A Joint meeting of Medical Societies in India” was organized as a pre-conference symposium of the 2nd annual conference of the Clinical Infectious Disease Society (CIDSCON 2012) at Chennai on 24th August. This was the first ever meeting of medical societies in India on issue of tackling resistance, with a plan to formulate a road map to tackle the global challenge of antimicrobial resistance from the Indian perspective. We had representatives from most medical societies in India, eminent policy makers from both central and state governments, representatives of World Health Organization, National Accreditation Board of Hospitals, Medical Council of India, Drug Controller General of India, and Indian Council of Medical Research along with well-known dignitaries in the Indian medical field. The meeting was attended by a large gathering of health care professionals. The meeting consisted of plenary and interactive discussion sessions designed to seek experience and views from a large range of health care professionals and included six international experts who shared action plans in their respective regions.

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Aim of the ‘Road map meeting’ and ‘Chennai Declaration’
Aim of the “Road map meeting” and “Chennai Declaration” was to initiate efforts to formulate a national policy to control the rising trend of antimicrobial resistance (AMR), after consultation with all relevant stake holders and to take all possible measures to implement the strategy.

Executive summary
1. Increasing antimicrobial resistance is a serious global and regional challenge. There is an urgent need to initiate measures to tackle the scenario and join international efforts to control this menace.
2. The Indian Ministry of Health (MOH) will need to take urgent initiatives to formulate a national policy to control the rising trend of antimicrobial resistance, after consultation with all relevant stake holders and then take all possible measures to implement the policy.
3. The Drugs Controller General of India (DCGI) will need to formulate and implement a policy on rationalizing antibiotic usage in the country, both in hospitals and over the counter, after consultation with stake holders and experts in the field.
4. State Departments of Health will need to take initiatives to improve infection control standards and facilities in hospitals and encourage implementation of regional antibiotic policies, pending formulation and publication of a national policy. Once a national policy is formulated, whole hearted support for this policy by the state DOH is needed for implementation.
5. The Medical Council of India will need to make necessary curriculum changes so as to include a structured training on antibiotic usage and infection control at the undergraduate and post-graduate level.
6. An Infection Control Team (ICT) must be made mandatory in all hospitals. Regulatory authorities and accreditation agencies (NABH, ISO) must insist on a functioning ICT, during the licensing and accreditation process.
7. State Department of Health (DOH) should take initiatives in organizing regional and state infection control committees to supervise the functioning of hospital ICT.
8. A National Task Force should be set up to guide and supervise the regional and state infection control committees.
9. The National Accreditation Board of Hospitals (NABH) is required to insist on strict implementation of hospital antibiotic and infection control policy, during hospital accreditation and re-accreditation processes. Hospitals without compliance with the policy should not be given accreditation.
10. The Indian Council of Medical Research should broaden the antimicrobial resistance surveillance network, incorporating hospitals from both the government and private sector. ICMR will need to provide funds for research on antimicrobial resistance, drug development, and vaccines.
11. The Indian division of the World Health Organization should step up interaction with the government on issues related to drug resistance, antibiotic policy, and infection control.
12. There is an urgent need to standardize Microbiology laboratories in India. Hospitals must have good quality Microbiology laboratory or should be willing to outsource specimens, in the absence of a standardized laboratory.
13. Medical societies to take active interest in initiating infection control and antibiotic stewardship awareness activities among the society members, utilizing the extensive network of local branches of all societies.
14. Medical journals should make deliberate attempts to educate readers on infection control and national antibiotic policy-related issues.
15. Electronic and print mass media should take initiatives on public awareness campaigns on the dangers of misuse of antibiotics.
16. Non-Governmental Organizations (NGOs) - national and international- have played a pivotal role in disseminating public information and funding research in diseases like cancer and cardiac diseases. They should come forward with similar enthusiasm to tackle antibiotic resistance issue, with the same vigor.
17. There is a need to evaluate the extent and to regulate the usage of antibiotics in veterinary practice.

**Objectives**

Regulate over the counter sale of antibiotics

It is obvious that ban of ‘Over the Counter’ (OTC) sale of all antibiotics without prescription will be the ideal step, but whether such a strict policy could be implemented is questionable. It is debatable whether we have enough drug inspectors and infrastructure to monitor OTC dispensing of all antibiotics. A practical approach will be to formulate a list of antibiotics with strict monitoring on the dispensing of these drugs. Step-by-step introduction of other drugs to the restricted list could be tried later. [Table 1].

The following strategies can be considered:

**Strategy 1:** Complete ban on OTC sale of antibiotics without prescription throughout the country.

**Strategy 2:** Complete ban of OTC sale of antibiotics without prescription in metros and larger cities with a more liberal approach in smaller cities and villages.

**Strategy 3:** A liberal approach throughout the country to start with, with an initial list of antibiotics under restriction and addition of other drugs to the list in a phased manner.

### In-hospital antibiotic usage monitoring

Surveillance on the usage of all antibiotics will be the ideal way to achieve this aim. This may be an impossible task in the current Indian context, considering the lack of resources in many hospitals. Monitoring higher-end antibiotics will be a more practical and implementable strategy. Monitoring should be more vigilant for third line antibiotics active against Gram-negative bacteria. Strict monitoring on the usage of colistin, must be implemented on an urgent basis. Colistin prescription should be in duplicate, with a copy to be sent to the pharmacy. The prescription must be countersigned by a consultant in 24 hours. In addition, a second opinion by an antibiotic steward within 48-72 hours must be made compulsory. This will allow any doctor to use this life-saving drug in emergencies and at the same time, misuse will be prevented by the compulsory rule of giving a second opinion. Carbenapenem and tigecycline (the other higher-end antibiotics with Gram-negative spectrum) usage should be subjected to similar stringent supervision [Table 2].

A similar approach would be ideal in the case of higher-end antibiotics with Gram-positive spectrum as well, but may be difficult to implement. The hospital infection control committee should monitor compliance to the surgical prophylaxis policy.

### Audit and feedback

Pharmacist should keep track on the usage of higher-end antibiotics and should provide a daily list to the infection control team. The infection control team should follow-up the cases on a daily basis, discuss with the antibiotic steward, and give feedback to the primary consultant.

### Table 1: Rationalizing OTC sale of antibiotics- Step by Step Approach

<table>
<thead>
<tr>
<th>Antibiotics that need a prescription (duplicate) of a registered medical practitioner prior to dispensing</th>
<th>No need of Prescription</th>
<th>Many or may not need prescription *need consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>All injectable Antibiotics</td>
<td>Ampicillin, Amoxicillin, co-amoxiclav</td>
<td>First &amp; second generation cephalosporins cefadroxil, cephalaxin, cefaclor</td>
</tr>
<tr>
<td>Oral antibiotics</td>
<td>Erythromycin, clindamycin</td>
<td>Cefuroxime</td>
</tr>
<tr>
<td>Linezolid</td>
<td>Nitrofurantoin</td>
<td>Cotrimoxazole</td>
</tr>
<tr>
<td>Forepensem</td>
<td>Doxycycline</td>
<td>Azithromycin, clarithromycin</td>
</tr>
<tr>
<td>Newer Quinolones-levofoxacin, moxifloxacin, sparfloxacin, pazufloxacin etc.</td>
<td>Ciprofloxacin</td>
<td>*Pharmacy to retain the duplicate prescription</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd generation cephalosporin- Cefdinir, cefpodoxime, cefixime</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 2: In-hospital higher-end antibiotic usage monitoring*

- Colistin, carbenapenem, and tigecycline needs strict monitoring.
- Usage needs to be endorsed by another consultant within 72 hours.
- Higher-end antibiotics with Gram-positive spectrum (teicoplanin, vancomycin, daptomycin, linezolid).
- Need monitoring (strict regulation may not be practical).
- Need to complete an antibiotic monitoring sheet.
- Prescription in duplicate. Copy to be sent to the pharmacy.
- Pharmacist to maintain records on higher-end antibiotic usage.
- Infection control committee will monitor the data at least every three months.

### National antimicrobial resistance surveillance system

Department of Health and Indian council of Medical Research (ICMR) should establish a national antibiotic resistance surveillance system with representation from all regions in the country. Periodic publication of collated data in a key national journal will serve as a benchmark for antibiotic usage and resistance load in hospitals.

### Role of ministry of health

Ministry of Health should take urgent initiative to formulate a national policy in order to control the rising trend of antimicrobial resistance, after consultation with all relevant stake holders and take all possible measures to implement the strategy. National Antibiotic Policy must have generic domains of agreement but should be subject to local adaptation depending on resistance patterns and resources. Department of Health (DOH) to make regulations to reinforce infection control measures in all hospitals. DOH to support, through the development of a national network, surveillance of AMR (Antimicrobial Resistance) and consumption and quality of prescribing, DOH to conduct public awareness campaigns through media and encourage private
organizations to conduct similar campaigns. Encourage research to develop new antibiotics and vaccines. DOH working in close collaboration with the insurance industry, represented by Federation of Indian Chamber of Commerce and Industry (FICCI), to lay down standard treatment guidelines for diseases after consulting with national experts (including proper antibiotic use), which will be linked to third party payment for the hospitalized patients.

Role of Drugs Controller General of India (DCGI)
Urgent measures are needed to regulate over the counter sale of antibiotics (OTC) and rationalize in-hospital antibiotic usage, especially higher-end antibiotics. DCGI has a significant role to play in the initiation of the OTC regulation. Though this is a major challenge, there should not be any delay in initiation of serious efforts.

Hospital Infection Control Committee (HICC)
All hospitals must have an infection control committee and an antibiotic policy and should initiate or augment efforts towards implementation. Those hospitals with an existing ICC and an antibiotic policy should augment efforts to increase compliance to the policy. ICC should define an annual target for achievement.

Hospital accreditation agencies can assess the compliance to the policy. All hospitals must have an infection control team, under the leadership of an infection control consultant, who can be an infectious diseases specialist, a microbiologist with training in infection control or a physician of any specialty with training in infection control. Wholehearted support of the hospital management is essential for the effective functioning of ICT.

Antibiotic steward
An antibiotic steward is a physician who is trained in infectious diseases and infection control or a microbiologist with training in infection control and antibiotic stewardship. In hospitals without an ID physician or microbiologist, any clinician with special interest in infection control and antibiotic stewardship can function as an antibiotic steward. Antibiotic steward should be responsible for giving a second opinion on higher-end antibiotic usage. Availability of more than one antibiotic steward in any one hospital will provide flexibility and choice.

Regional (District) Infection Control and Antibiotic Stewardship Committees
Regional infection control committees could be established to assist and supervise the infection control activities in the region. All hospitals in the region, both government and private, should be under the guidance of the regional committee.

Central Task Force
A central task force should be formed to supervise the infection control and antibiotic stewardship activities at a national level. The task force should include representatives of all major stake holders: regional and national. Presence of state task forces can bridge the activities of the regional committees with the central task force.

Role of Microbiology Laboratories
Lack of standardization of microbiology laboratories is a serious issue, which needs urgent attention of the policy makers. Microbiology labs should issue hospital antibiogram at pre-defined intervals. Those hospitals without good laboratory support should be willing to outsource samples to better laboratories. Multidrug-resistant bacteria, especially pan-drug-resistant bacteria, must be considered as a notifiable entity. Such a reporting system should complement national antimicrobial resistance surveillance studies. Indian Microbiologists should expand their role from the conventional microbiologist working in a laboratory to an active player in directing interventions in the prevention of HAIs, deciding antibiotic policy and authorizing use of reserve antibiotics, planning and strengthening of diagnostic facility, choosing rapid, sensitive, and specific diagnostic tests, and monitoring antimicrobial resistance [Table 3].

Hospital microbiology laboratories should follow standard protocols for susceptibility testing. Hospitals to send Antimicrobial Susceptibility Testing (AST) to standardized labs to avoid erroneous reporting of organisms and their susceptibility pattern.

Role of National Accreditation Board of Hospitals (NABH)
National accreditation board of hospitals can play a very significant role in implementing infection control and antibiotic stewardship policy in Indian hospitals. There is no published data on the level of compliance of NABH accredited hospitals to the antibiotic policy and infection control guidelines. NABH should formulate more efficient ways of assessing the compliance to the guidelines. NABH to insist on strict implementation of hospital antibiotic and infection control policy, during hospital accreditation and re-accreditation processes.

Role of medical council of India
One of the main reasons for the inappropriate antibiotic usage by Indian doctors is the lack of adequate training on the subject during undergraduate and post-graduate courses.

Curriculum change
Structured training in antibiotic usage and infection control should be introduced in both UG and PG curriculum. Post-MD/DNB (Internal Medicine) sub-specialization in Infectious Diseases, (leading to DM/DNB) should be introduced in all post-graduate centers that offer sub-specialty training. MD microbiology: Compulsory training in infection control and antibiotic stewardship. Antibiotic stewardship and infection control one week rotation-3rd, 4th, and final year MBBS.

Role of medical teachers
Teachers should be role models to their students in wise and appropriate antibiotic
Table 3: Role of microbiologists and microbiology laboratories

1. Constantly changing spectrum of Multi Drug Resistant (MDR) pathogens and the availability of newer technologies calls for the need of regular communication between the microbiologists and clinicians.

2. Microbiology labs need to be strengthened and be proactive with rapid & molecular diagnostics, early identification of emerging pathogens and detecting resistance accurately.


4. Determining molecular epidemiology of resistant strains.

5. Dissemination of data at frequent and regular intervals.

6. Develop networking of institutes, Govt. and private hospitals/labs.

7. Develop standardized laboratory methods & Quality control protocols, for reliable data.

8. Rapid, sensitive, specific and point of care tests - bacterial infections / resistance

9. Taking technology to the field - microarray based, real time PCR based.

10. Mandatory NABL accreditation of the clinical laboratories.

11. Restrictive reporting of antibiotics. Microbiologists should release the sensitivity report on higher - end antibiotics, only if the bacteria are Multi Drug Resistant.

12. government support for capacity building.

13. Identify Institutions in different regions as referral labs which will be responsible for making a repository of bacterial strains of interest / rare resistant markers, undertake genotyping of the resistant isolates and study emergence of new mechanism of resistance.

usage, infection control practices and as rational prescribers.

Role of director of medical education (DME)

State Department of Health and the Directorate of Medical education should take very active initiatives in implementing the national antibiotic policy and the curriculum change recommended by the MCI. DME should support establishment of infection control committee in all medical college hospitals and conduct regular CMEs on proper antibiotic usage.

Role of directorate of public health (DPH) and medical services (DMS)

DPH and DMS will have pivotal role in implementing infection control and antibiotic stewardship policies in government hospitals, and organizing fund for antibiotic stewardship training.

Role of World Health Organization (WHO)

WHO should co-ordinate initiatives in various countries, provide technical support, and organize awareness activities. High quality infection control set-ups in developed countries may not be fruitful unless countries with high resistance rates and less stringent infection control facilities take serious measures to control resistance. WHO can play significant role in helping countries who lack. Indian division of the WHO should be proactive in tackling resistance initiatives and interact with the Indian government. WHO should take initiatives in establishing an international fund to help resource-limited countries, provide technical and monetary help in tackling AMR initiatives.

Role of medical societies in implementing antibiotic stewardship

‘Road map meeting’ and the ‘Chennai Declaration’ are the typical examples of the willingness of medical societies to work together for a common cause. Medical societies in India always took active interest in public health issues and have made significant contributions in all initiatives. Even though the issue of antibiotic resistance existed for long time, serious discussion on the subject started only in recent years. Medical societies should disseminate policy decisions to all society members and public through professional and public and social networking media.

Action plan of all societies for the coming year - Spreading message on rational usage of antibiotics and infection control.

Encourage members of the society to attend short courses to qualify to be an antibiotic steward. Dedicated sessions on infection control, antibiotic stewardship in society conferences and workshops for tackling resistance.

Role of medical journals

Journals must make deliberate attempt to educate readers on infection control and national antibiotic policy-related issues and publish more articles on the subject of antibiotic stewardship and infection control. A joint meeting of journal editors to implement this agenda should be explored.

Role of mass media

International media have played a significant role in the success of public awareness activities on the danger of overuse of antibiotics. Indian media should follow similar examples. Media should take initiatives in public awareness regarding “Bad bugs, no drugs” concept.

Veterinary antibiotic usage

Veterinary antibiotic usage as a growth promoter or for prophylactic and therapeutic indications is a major contribution to the resistance scenario, which might be passed from animals to humans directly or indirectly via food, environment, or during animal husbandry practices. The magnitude of veterinary antibiotic usage is not well-studied in India. There is need to evaluate the extent of antibiotic usage in the veterinary practice, its indications of use and determine the same. There is also urgent need for regular monitoring of residues of antibiotics in food of animal origin and study their role. Formulation and implementation of regulations for withholding periods between the use of antibiotics and animal slaughter or milking have to be evolved.

National antibiotic awareness day

A designated “National Antibiotic Awareness Day” will help in propagating the importance of tackling antibiotic resistance among health care workers and the public, giving opportunity to all stake holders to appraise their previous work and plan future activities.

Where does the road map head?

“Road map meeting” decisions - The “Chennai declaration” will be submitted to all sectors of the relevant governmental and non-governmental bodies, medical societies, and all major stake holders. The road map should form the template for regional and local framework for combating AMR. Progress with the implementation of the Road map will be assessed annually by a joint committee during the annual conference of one of the participating medical societies. Road map committee of medical societies will communicate with all stake holders to collect data on the progress. The central task force can categorise the recommendations into major and minor on priority basis, assess the progress of implementation and the compliance by all stake holders. The road map will be a dynamic process, subject to further adaptation with time, experience, and maturity.

Measurable goals of the road map

First year

Formulation of a national policy to combat antimicrobial resistance.

1. Initiation of efforts to implement major components of the policy.

2. Sixty percent compliance rate to major recommendations by all stake holders.

Second year

Compliance rate to reach 70%.

1. Initiation of efforts to implement minor components of the policy.

2. India achieving the status of a country with a functioning antibiotic policy despite limitations.

Next five years

1. More than 90% compliance rate to major and minor components of the policy.

2. India achieving the status of a country with a functioning antibiotic policy comparable to those countries with high quality infection control and antibiotic policy compliance rates.

Conclusion

Serious concern about the rising trend of antimicrobial resistance in the country has prompted medical societies to hold the joint “Road map meeting” in order to seek practical, implementable solutions to the problem. We have considered the Indian scenario on the ground before making the recommendations. We believe that if we have the will and resolve, the “Chennai Declaration” targets can very easily be achieved.

Disclaimer

The opinions expressed in “Chennai Declaration” are those of the authors. The opinions do not reflect in any way to those of the institutions, to which the authors are affiliated. We express our gratitude to the governmental bodies like DCGI, MCI, NABH, ICMR, and World Health Organization for participating in the “Road map meeting,” but the opinions expressed in “Chennai Declaration” do not, in any way, belong to these organizations. We also express our gratitude to the international representatives for their participation in the meeting and sharing their experience.

Abridged by Dr. Palepu Gopal
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Effectiveness of a multidimensional approach for prevention of ventilator-associated pneumonia in adult intensive care units from 14 developing countries: Findings of the International Nosocomial Infection Control Consortium

Rosenthal, Victor D. MD; Rodrigues, Camilla MD; et al. Critical Care Medicine: December 2012 - Volume 40 - Issue 12 - p 3121–3128

The aim of this study was to analyze the effect of the International Nosocomial Infection Control Consortium’s multidimensional approach on the reduction of ventilator-associated pneumonia in patients hospitalized in intensive care units. A prospective active surveillance before-after study. The study was divided into two phases. During phase 1, the surveillance team at each intensive care unit conducted active prospective surveillance of ventilator-associated pneumonia by applying the definitions of the Centers for Disease Control and Prevention National Healthcare Safety Network, and the methodology of International Nosocomial Infection Control Consortium. During phase 2, the multidimensional approach for ventilator-associated pneumonia was implemented at each intensive care unit, in addition to the active surveillance.

Forty-four adult intensive care units in 38 hospitals, members of the International Nosocomial Infection Control Consortium, from 31 cities of the following 14 developing countries: Argentina, Brazil, China, Colombia, Costa Rica, Cuba, India, Lebanon, Macedonia, Mexico, Morocco, Panama, Peru, and Turkey.

A total of 55,507 adult patients admitted to 44 intensive care units in 38 hospitals.

The International Nosocomial Infection Control Consortium ventilator-associated pneumonia multidimensional approach included the following measures: (1) bundle of infection-control interventions; (2) education; (3) outcome surveillance; (4) process surveillance; (5) feedback of ventilator-associated pneumonia rates; and (6) performance feedback of infection-control practices.

The ventilator-associated pneumonia rates obtained in phase 1 were compared with the rates obtained in phase 2. We performed a time-series analysis to assess the impact of our intervention.

During phase 1, we recorded 10,292 mechanical ventilator days, and during phase 2, with the implementation of the multidimensional approach, we recorded 127,374 mechanical ventilator days. The rate of ventilator-associated pneumonia was 22.0 per 1,000 mechanical ventilator days during phase 1, and 17.2 per 1,000 mechanical ventilator days during phase 2.

The adjusted model of linear trend showed a 55.83% reduction in the ventilator-associated pneumonia rate at the end of the study period; that is, the ventilator-associated pneumonia rate was 55.83% lower than it was at the beginning of the study.

The implementation of the International Nosocomial Infection Control Consortium multidimensional approach for ventilator-associated pneumonia was associated with a significant reduction in the ventilator-associated pneumonia rate in the adult intensive care units setting of developing countries.

Association between systemic corticosteroids and outcomes of intensive care unit–acquired pneumonia

Ranzani, Otavio Tavares MD; Ferrer, Miquel MD, PhD; et al. Critical Care Medicine: September 2012 - Volume 40 - Issue 9 - p 2552–2561

The use of corticosteroids is frequent in critically ill patients. However, little information is available on their effects in patients with intensive care unit-acquired pneumonia. We assessed patients’ characteristics, microbial etiology, inflammatory response, and outcomes of previous corticosteroid use in patients with intensive care unit-acquired pneumonia.

Prospective observational study was conducted at Intensive Care units of a university teaching hospital.

Three hundred sixteen patients with intensive care unit-acquired pneumonia. Patients were divided according to previous systemic steroid use at onset of pneumonia.

Interventions: None.

Measurements and Main Results: Survival at 28 days was analyzed using Cox regression, with adjustment for the propensity for receiving steroid therapy. One hundred twenty-five (40%) patients were receiving steroids at onset of pneumonia. Despite similar baseline clinical severity, steroid treatment was associated with decreased 28-day survival (adjusted hazard ratio for propensity score and mortality predictions 2.503; 95% confidence interval 1.176–5.330; p = .007) and decreased systemic inflammatory response. In past bioscience, steroid treatment had an impact on survival in patients with nonventilator intensive care unit-acquired pneumonia, those with lower baseline severity and organ dysfunction, and those without etiologic diagnosis or bacteremia. The cumulative dosage of corticosteroids had no significant effect on the risk of death, but bacterial burden upon diagnosis was higher in patients receiving steroid therapy.

Conclusions: In critically-ill patients, systemic corticosteroids should be used very cautiously because this treatment is strongly associated with increased risk of death in patients with intensive care unit-acquired pneumonia, particularly in the absence of established indications and in patients with lower baseline severity. Decreased inflammatory response may result in delayed clinical suspicion of intensive care unit–acquired pneumonia and higher bacterial count.

Corticosteroids and intensive care unit–acquired pneumonia*

Editorial by Klompas, Michael MD, MPH

Critical Care Medicine: September 2012 - Volume 40 - Issue 9 - p 2710–2712

Over 50 yrs ago, investigators from Johns Hopkins Hospital published a report describing the impact of hydrocortisone on pneumococcal pneumonia (1). Patients prescribed corticosteroids in addition to penicillin defervesced more quickly and had less pleuritic pain compared to controls. This study suffered from a weak randomization strategy, incomplete blinding, and the selection of questionable outcomes, but the notion that corticosteroids might help patients with pneumonia by attenuating inflammatory cascades still exercises physicians’ imaginations. A steady flow of investigations has continued to probe the relationship between corticosteroids and pneumonia (2). Recent studies have focused on community-acquired pneumonia of moderate severity, defined as requiring admission to hospital, and community-acquired pneumonia of high severity, defined as requiring admission to an intensive care unit (ICU) (3). The study by Ranzani and colleagues (4) in this issue of Critical Care Medicine extends this field of investigation to ICU-acquired pneumonia.

The authors’ decision to evaluate ICU-acquired pneumonia was reasonable, given the signal from the septic shock literature that corticosteroids probably only benefit the sickest of patients (if any). The divergent results of the trial by Annane et al (6) of hydrocortisone for septic shock, which noted lower mortality rates among corticosterin nonresponders, and the Corticus trial, which found no difference in mortality between hydrocortisone and placebo arms regardless of the corticosterin response, continue to stir controversy. The most tenable explanation for the discrepant results between the two trials is that the trial by Annane et al (6) enrolled sicker patients than the Corticus patients enrolled within 8 vs. 72 hrs of shock onset (0%). Patients in the Annane trial had more refractory shock and higher mortality rates overall, thereby raising the possibility that corticosteroids may only benefit the sickest of patients.

And indeed, the literature on corticosteroids and pneumonia also shows that outcomes in critically ill patients might be most impactful in patients with more severe pneumonia. In a randomized controlled trial of dexamethasone vs. placebo among 304 patients hospitalized with community-acquired pneumonia, patients randomized to receive dexamethasone had marginally shorter hospital lengths of stay (median 6.5 days vs. 7.5 days, p = .05) but no difference in hospital mortality or hospital readmission rates (7). This trial specifically excluded patients requiring intensive care. Confalonieri and colleagues (8), however, conducted a trial on patients with severe community-acquired pneumonia specifically requiring ICU admission. They randomized 46 patients to a 200-mg hydrocortisone bolus and daily infusions at 10 mg vs. placebo for 7 days. Patients assigned hydrocortisone required fewer days of mechanical ventilation (median 4 days vs. 10 days, p = .007), had shorter hospital length of stay (median 13 days vs. 21 days, p = .03), and lower mortality rates (0% vs. 30%, p = .009). Confalonieri and colleagues also reported a subgroup analysis of the study by Annane et al (6) of hydrocortisone for severe septic shock refractory to fluids and vasopressors (8, 9). Septic shock was secondary to community-acquired pneumonia for 101 of the 300 patients in the study by Annane et al (6). The 28-day mortality rate was 45% among the 47 hydrocortisone patients vs. 65% in the 54 placebo patients (odds ratio 0.44, 95% confidence interval 0.20–0.98, p = .04).

The study by Ranzani and colleagues now considers the potentially sickest of pneumonia patients, those with ICU-acquired pneumonia. Ranzani and colleagues analyzed prospective, observational data.
on 316 patients with ICU-acquired pneumonia. They divided the population into steroid-exposed and unexposed groups. Steroid exposure was defined as ≥20mg of methylprednisolone or equivalent within the 3 days preceding pneumonia onset. The primary outcome was 28-day survival on a Cox regression. They attempted to adjust for confounding by indication using propensity-to-treat-with-study scores constructed from 33 clinical variables including comorbidities, admission diagnosis, ICU admission, Acute Physiology and Chronic Health Evaluation II and Sequential Organ Failure Assessment scores, and presence or absence of shock at pneumonia diagnosis. They found that steroid-exposed patients had a higher 28-day mortality compared to steroid-unexposed patients (adjusted hazard ratio 2.5, 95% confidence interval 1.2–5.3, p = 0.017). The study’s strengths included prospective data collection, a large number of patients classified using propensity scores to adjust for confounding by indication.

The study by Ranzani and colleagues ostensibly contradicts the hints from previous work that corticosteroids may improve survival for patients with the severest of pneumonias. On closer examination, however, this study’s limitations prevent us from answering the key question of whether the variable indications and timing of steroid exposures, the strong possibility that many patients actually did not have pneumonia, a relatively low proportion of severely ill patients, and some omissions from the propensity scores that raise the possibility of persistent confounding by indication.

Most notably, corticosteroids in this study were not necessarily prescribed as adjuncts for the treatment of pneumonia. The indications for corticosteroids included exacerbation of respiratory disease (33% of the steroid group), neurological disorders (27%), septic shock (14%), and long-term use of corticosteroids (10%). These conditions vary in both their morbidity and responsiveness to corticosteroids independent of pneumonia (27). In addition, patients were classified as steroid exposed as long as they were on corticosteroids within the 2 days prior to pneumonia onset. This leaves open the possibility of significant variability in the duration and dose of steroid exposure prior to and subsequent to pneumonia onset. High doses of corticosteroids for long periods prior to or after pneumonia may have rendered some patients immunologically compromised at pneumonia onset; conversely, corticosteroids may have been abruptly stopped immediately before or after pneumonia onset in other patients, thereby attenuating the possibility of beneficial suppression of the acute inflammatory effects of a severe pneumonia. Pneumonia was considered present in this study if patients met a clinical definition of pneumonia and had a simplified clinical pulmonary infection score ≥6. The positive predictive value of both these criteria for histological pneumonia is only about 60%, making it possible that almost half the patients in this study did not have pneumonia at all (27). Only about a third of patients (98/316) had shock at the time of pneumonia diagnosis, the patient subset theoretically most likely to benefit from corticosteroids. Finally, the propensity scores incorporated Acute Physiology and Chronic Health Evaluation II and Sequential Organ Failure Assessment scores from ICU admission rather than the time of steroid initiation, possibly compromising the adequacy of adjustment for confounding by indication and severity of illness.

The net message of this study is that patients treated with corticosteroids have high morbidity and mortality, but the factors described above, most of which are unavoidable consequences of observational data, leave us wondering whether corticosteroids are markers or drivers for poor outcomes. The possibility that patients with the severest of pneumonias may yet benefit from corticosteroids still stands. In addition, these observational data should not stop clinicians from using corticosteroids for ICU diagnoses for which randomized, controlled trial data do suggest possible benefit such as early acute respiratory distress syndrome, chronic obstructive pulmonary disease flares, and acute spinal cord injuries (6, 9, 10, 13). We continue to need careful, randomized, controlled trials and better pneumonia diagnostics to determine whether severe pneumonias merit corticosteroids and to determine, whether the risk-to-benefit ratio of corticosteroids shifts when patients with other indications for corticosteroids develop pneumonia.

Physical restraint in mechanically ventilated ICU patients: a survey of French practice
Bernard De Jonghe, Jean-Michel Constantin, et al.
To characterize the perceived utilization of physical restraint (PR) in mechanically ventilated intensive care unit (ICU) patients and to identify clinical and structural factors influencing PR use.
A questionnaire was personally handed to one intensivist in 130 ICUs in France then collected on-site 2 weeks later.
The questionnaire was returned by 121 ICUs (response rate, 93 %). 66 % of which were medical-surgical ICUs. Median patient-to-nurse ratio was 2.8 (2.5–3.0). 82 % of ICUs, PR is used at least once during mechanical ventilation in more than 50 % of patients. 65 % of ICUs, PR, when used, is applied for more than 50 % of mechanical ventilation duration. Physical restraint is often used during awakening from sedation and when agitation occurs and is less commonly used in patients receiving deep sedation or neuromuscular blockers or having severe tetraparesis. In 29 % of ICUs, PR is used in more than 50 % of awake, calm and co-operative patients. PR is started without written medical order in more than 50 % of patients in 68 % of ICUs, and removed without written medical order in more than 50 % of patients in 77 % of ICUs. Only 21 % of ICUs have a written local procedure for PR use. This survey in a country with a relatively high patient-practitioner ratio shows that PR is frequently used in patients receiving mechanical ventilation, with wide variations according to patient condition. The common absence of medical orders for starting or removing PR indicates that these decisions are mostly made by the nurses.
Lung water assessment by lung ultrasonography in intensive care: a pilot study
Giacomo Baldi, Luna Gargani, Antonio Abramo, et al.
Volume 39, Issue 1 / January , 2013, Pages 74 – 84
To investigate the accuracy of lung ultrasonography (LUS) in the quantification of lung water in critically ill patients by using quantitative computed tomography (CT) as the gold standard for the determination of lung weight.
Twenty consecutive patients admitted to an intensive care unit who underwent chest CT as a step in their clinical management were evaluated within 4 h by LUS. Lung weight, lung volume, and physical lung density were calculated from the CT scans using ad hoc software. Semiquantitative ultrasound assessment of lung water was performed by determining the ultrasound B-line score, defined as the total number of B-lines detectable in an anterolateral LUS examination.
Good correlations were found between the B-line score and lung weight (r = 0.75, p < 0.05) and density (r = 0.82, p < 0.01), that only marginally increased when the lung density of the first 10 mm of subpleural lung tissue was evaluated (r = 0.83, p < 0.01). Moreover, values of subpleural lung density were not significantly different from values of the whole lung density (0.34 ± 0.11 vs 0.37 ± 0.16 g/ml, p > 0.05). Very good correlations were found between the B-line score and both the weight (r = 0.85, p < 0.01) and the density (r = 0.88, p < 0.01) of the upper lobes. The weight of the lower lobes was not correlated with the B-line score (r = 0.14, p = ns).
Conclusions
Lung ultrasound B-lines are correlated with lung weight and density determined by CT. LUS may provide a reliable, simple and radiation-free lung densitometry in the intensive care setting.

Low-dose steroids in adult septic shock: results of the Surviving Sepsis Campaign
The Surviving Sepsis Campaign (SSC) developed guidelines and treatment bundles for the administration of steroids in adult septic shock. However, it is not clear how this has affected clinical practice or patient outcome. The SSC has developed an extensive database to assess the overall effect of its guidelines on clinical practice and patient outcome. This analysis focuses on one particular element of the SSC’s management bundle, namely, the administration of low-dose steroids in adult septic shock. This analysis was conducted on data submitted from January 2005 through March 2010 including 27,836 subjects at 218 sites.
A total of 17,847 (of the total 27,836) patients in the database required vasopressor therapy despite fluid resuscitation and therefore met the eligibility criteria for receiving low-dose steroids. A total of 8,992 patients (50.4 %) received low-dose steroids for their septic shock. Patients in Europe (59.4 %) and South America (51.9 %) were more likely to be prescribed low-dose steroids compared to their counterparts in North America (46.2 %, p < 0.001). The adjusted hospital mortality was significantly higher (OR 1.18, 95 % CI 1.10–1.26, p < 0.001) in patients who received low-dose steroids compared to those who did not. There was still an association with increased adjusted hospital mortality with low-dose steroids even if they were prescribed within 8 h (OR 1.23, 95 % CI 1.13–1.34, p < 0.001). Steroids were commonly administered in the treatment of septic shock in this subset analysis of the Surviving Sepsis Campaign database. However, this was associated with an increase in adjusted hospital mortality.

Blind Insertion of Feeding Tubes in Intensive Care Units: A National Survey
Norma A. Metheny, RN, PhD, Barbara J. Stewart, PhD and Andrew C. Mills, RN, PhD
Am J Crit Care September 2012 vol. 21 no. 5 352-360
Although most critically ill patients experience at least 1 blind insertion of a feeding tube during their...
stay in an intensive care unit, little is known about the types of health care personnel who perform these insertions or about methods used to determine proper positioning of the tubes.

To describe results from a national survey of critical care nurses about feeding tube practices in their adult intensive care units. The questions asked included who performs blind insertions of feeding tubes and what methods are used to determine if the tubes are properly positioned.

Data were collected from members of the American Association of Critical-Care Nurses via pencil-and-paper and online surveys. Results from both forms were combined for data analysis and were compared with practice recommendations of national-level organizations.

A total of 2298 responses were obtained. Physicians perform more blind insertions of styled feeding tubes than do nurses; in contrast, nurses place more nonstyled tubes. Radiographic confirmation of correct position is mandated more often for blindly inserted styled tubes (92.3%) than for nonstyled tubes (57.5%). The 3 most commonly used bedside methods to determine tube location are auscultation for air injected via the tube, appearance of feeding tube aspirate, and observation for indications of respiratory distress.

Recommendations from multiple national-level organizations to obtain radiographic confirmation that each blindly inserted feeding tube is correctly positioned before the first use of the tube are not adequately implemented. Auscultation is widely used despite recommendations to the contrary.

Randomized Controlled Trial of Chlorhexidine Dressing and Highly Adhesive Dressing for Preventing Catheter-related Infections in Critically Ill Adults

Jean-François Timsit, Olivier Mimoz, et al

Rationale: Most vascular catheter-related infections (CRIs) occur extraluminally in patients in the intensive care unit (ICU). Chlorhexidine-impregnated and strongly adherent dressings may decrease catheter colonization and CRI rates.

Objectives: To determine if chlorhexidine-impregnated and strongly adherent dressings decrease catheter colonization and CRI rates.

Methods: In a 2:1:1 assessor-masked randomized trial in patients with vascular catheters inserted for an expected duration of 48 hours or more in 12 French ICUs, we compared chlorhexidine dressings, highly adhesive dressings, and standard dressings from May 2010 to July 2011. Coprimary endpoints were major CRIs with or without catheter-related bloodstream infection (CR-BSI) with chlorhexidine versus nonchlorhexidine dressings and catheter colonization rate with highly adhesive nonchlorhexidine versus standard nonchlorhexidine dressings. Catheter-colonization, CR-BSIs, and skin reactions were secondary endpoints.

Measurements and Main Results: A total of 1,879 patients (4,163 catheters and 34,339 catheter-days) were evaluated. With chlorhexidine dressings, the major-CRI rate was 67% lower (0.7 per 1,000 vs. 2.1 per 1,000 catheter-days; hazard ratio [HR], 0.328; 95% confidence interval [CI], 0.174–0.619; P = 0.0006) and the CR-BSI rate 60% lower (0.5 per 1,000 vs. 1.3 per 1,000 catheter-days; HR, 0.402; 95% CI, 0.186–0.868; P = 0.02) than with nonchlorhexidine dressings; decreases were noted in catheter colonization and skin colonization rates at catheter removal. The contact dermatitis rate was 1.1% with and 0.29% without chlorhexidine. Highly adhesive dressings decreased the detachment rate to 64.3% versus 71.9% (P < 0.0001) and the number of dressings per catheter to two (one to four) versus three (one to five) (P < 0.0001) but increased skin colonization (P < 0.0001) and catheter colonization rate (HR, 1.650; 95% CI, 1.21–2.26; P = 0.0016) without influencing CRI or CR-BSI rates.

Conclusions: A large randomized trial demonstrated that chlorhexidine-gel-impregnated dressings decreased the CRI rate in patients in the ICU with intravascular catheters. Highly adhesive dressings decreased dressing detachment but increased skin and catheter colonization.

Ventilator-Associated Pneumonia Is Characterized by Excessive Release of Neutrophil Proteases in the Lung

Thomas S. Wilkinson, PhD; Andrew Conway Morris.
CHEST. December 2012;142(6):1425–1432. Et al.

Background: Ventilator-associated pneumonia (VAP) is characterized by neutrophils infiltrating the alveolar space. VAP is associated with high mortality and accurate diagnosis remains difficult. We hypothesized that proteolytic enzymes from neutrophils would be significantly increased and locally produced inhibitors of human neutrophil elastase (HNE) would be decreased in BAL fluid (BALF) from patients with confirmed VAP.

We postulated that in suspected VAP, neutrophile proteases in BALF may help identify “true” VAP.

Methods: BAL was performed in 55 patients with suspected VAP and in 18 control subjects. Isolation of a pathogen(s) at >10^7 colony-forming units/ml of BALF dichotomized patients into VAP (n = 12) and non-VAP (n = 43) groups. Matrix metalloproteinase (MMPs), HNE, inhibitors of HNE, and tissue inhibitors of matrix metalloproteinases (TIMPs) were quantified. Plasminogen activator (PA) activity was estimated by sodium dodecyl sulfate polyacrylamide gel electrophoresis and zymography.

Results: Neutrophil-derived proteases HNE, MMP-8, and MMP-9 were significantly increased in cell-free BALF from patients with VAP as compared with those without VAP (median values: HNE, 2,708 ng/ml vs 294 ng/ml, P < 0.01; MMP-8, 184 ng/ml vs 5 ng/ml, P < 0.01; MMP-9, 310 ng/ml vs 11 ng/ml, P < 0.01). HNE activity was also significantly increased in VAP (0.45 vs 0.01 arbitrary units; P < 0.05). In contrast, no significant differences were observed for protease inhibitors, TIMPs, or PA. HNE in BALF at a cutoff of 670 ng/ml identified VAP with a sensitivity of 93% and specificity of 79%.

Conclusions: Neutrophil proteases are significantly elevated in the alveolar space in VAP and may contribute to pathogenesis. Neutrophil proteases appear to have potential in suspected VAP for distinguishing true cases from “non–VAP” cases.
A REPORT

ISCCM Day Celebrations

9TH OCTOBER, 2012

Theme: Hand Hygiene

Madurai

On 9th-Oct ISCCM Day celebration was observed at the Apollo Specialty Hospital Madurai. On the Theme of “Hand Hygiene” we had awareness programs for the Health Care Workers, patient’s and their relatives. We made it as a Hand Hygiene awareness week from 9th - 15th the Global Hand Washing Day.

Dr Mohamed Ibrahim
M.D.

Cochin

Sir,

Lectures and posture presentations were done at various hospitals in Cochin. Senior colleagues arranged hand hygiene awareness programmes in their respective hospitals. In our hospital (*Lakeshore Hospital, Cochin*) we had an afternoon meeting at our auditorium where *Dr. Nita George M.D Anaesthesia, EDIC, Intensivist* spoke about the importance of hand hygiene followed by a half an hour video presentation. About 200 people attended including both nurses and paramedical staff.

Dr. Mallie George
Secretary, ISCCM Cochin City Branch

Bhopal

Dr. Pradip Bhattacharya from Bhopal reports

Respected sir,

Namaste! I am herewith sending the particulars of I.S.C.C.M. Day celebrations, organised by our branch. The particulars are given below.

Branch : KAKINADA CITY BRANCH
Date : 9th October 2012
Time : 12 noon to 2 p.m
Venue : Anaesthesia Seminar room, Govt. General Hospital, Kakinada
Programme Details : We conducted a special meeting to celebrate I.S.C.C.M Day on 9th October i.e today. Prof. A.S. Kameswara Rao, Chairman of the branch chaired the meeting and welcomed the gathering. He also spoke on - "Critical Care in semi urban areas". Dr. B.V. Mahesh Babu, Secretary of the branch highlighted the importance of I.S.C.C.M. Day and he spoke on the theme - "Wash Hands & Save Lives". Senior members - Prof B. Soubbagya Lakshmi, Dr. S.S.C. Chakra Rao and Dr. S.V. Lakshminarayana. Also shared their opinions regarding I.S.C.C.M. activities and gave suggestions regarding the future projects. The meeting was adjourned for Lunch after a formal vote of thanks by Dr. Atchutharamaiah, Treasurer of the branch.

In the evening Dr. M. Santhisree, Asst. Professor of Anaesthesia and Critical Care conducted an Awareness campaign among the Nursing students and Anaesthesia Technicians regarding the importance of HAND HYGIENE.

Contact Person : Dr. B.V. Mahesh Babu; Contact no: 9848160327.

Thanking you,
With warm regards,
Dr. B.V. Mahesh Babu
Indian Society of Critical Care Medicine, Jaipur Chapter is organizing the 85th Fundamental Critical Care Course (FCCS) in India at Jejevan Rekha Critical Care & Trauma Hospital, Jaipur on 12th and 13th of January 2013. It is a two-day comprehensive course addressing ‘fundamental management principles for the first 24 hours of critical care’ of Society of Critical Care Medicine, USA. The registration will be restricted to 40 delegates (for provider course) and 5 delegates (for instructor course) on first-come first-serve basis. The registration fee is Rs 5500- (including course material) for provider course and 12000 for instructor course which has to be sent by cheque/ bank draft/ cash in favor of “Indian Society of Critical Care Medicine, Jaipur Chapter” and mailed to organizing secretary.

Please find attached registration & course information on attached document

You are requested to confirm your seat before sending registration fee as we have a limited seats and registration is on first-come first-serve basis.

For registration and details, kindly contact.

Course Coordinator
Dr Manish Munjal
Jeevan Rekha Critical Care & Trauma Hospital, Mahal Yojna, Jagatpura, Jaipur - 302025 (India)
• Off.: +91 141 515 50 50 (50 Lines) • Direct +91 515 50 75 • Cell. No.: +91 98290 62550

In Surat, we arranged awareness program on hand hygiene in different hospitals on ISCCM day. Our aim was to encourage nursing staff & other para medical staff about importance of hand hygiene.We all took similar classes based on WHO recommendation.

BAPS Pramukh swami Hospital : Dr. Mitul Chavda
Adventist Hospital : Dr. Chetan Mehta
Nirmal Hospital : Dr. Gaurish Gadbail
Apple Hospital : Dr Alpesh Parmar.

Dr. Mitul Chavda
ISCCM Day Hand Hygiene Surat

We conducted a special meeting to celebrate IS.C.C.M Day on 9th October i.e today. Prof. A.S. Kameswara Rao, Chairman of the branch chaired the meeting and welcomed the gathering. He also spoke on “Critical Care in semi urban areas.” Dr. B.V. Mahesh Babu, Secretary of the branch highlighted the importance of IS.C.C.M Day and he spoke on the theme “Wash Hands & Save Lives”. Senior members - Prof B. Soubhagya Lakshmi, Dr. S.S.C. Chakra Rao and Dr. S.V. Lakshminarayana, also shared their opinions regarding IS.C.C.M activities and gave suggestions regarding the future projects. The meeting was adjourned for lunch after a formal vote of thanks by Dr. Atchutharamaiah, Treasurer of the branch.

In the evening Dr. M. Santhisree, Asst.Professor of Anaesthesia and Critical Care conducted an awareness campaign among the nursing students and anaesthesia technicians regarding the importance of Hand Hygiene.

Dr Mahesh Babu

ISCCM Day was celebrated with lots of enthusiasm here in the city of Taj–Agra.
8 Oct–16hrs--Press conference was organised about the aim of the day and to spread awareness amongst people.
9 Oct-13hrs--Presentation for the Nursing staff,paramedics on Hand Hygiene by Dr Diptimala Agarwal at Pushpanjali Hospital Agra
9Oct--20hrs-Program for the doctors at Pushpanjali Hospital Agra.
1. Prevention of Catheter related Blood Stream Infection : Dr Ranvir S Tyagi
2. Prevention of Catheter related Urinary Tract Infection : Dr Neha Agarwal
3. Prevention of Ventilator Associated Pneumonia : Dr Rakesh Tyagi

Dr. Diptimala Agarwal
ISCCM day on hand hygiene was celebrated at various hospitals in Pune by the respective ISCCM members in those hospitals.

**Dr. Subhal Dixit**

Bangalore ISCCM Chapter commemorated the ISCCM Day on 10 October at Hotel Le Meridian. We were privileged in having Victor Rosenthal who is an ID specialist and pioneer in extensive research work in Infection Control give talk on “Effective interventions to prevent Nosocomial Infections” which was followed by talk on “hand hygiene” by Dr Ajith Kumar, President, Bangalore Chapter ISCCM.

**Dr. Pradeep Rangappa**

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**Calender of Events**

**January 2013**

1. **January 2nd to 6th, 2013**
   - 1st central province Criticon 2013, Nagpur, India
   - Contact: CPCriticon2013@gmail.com

2. **January 19th, 2013**
   - ISCCM, Bangalore Chapter CME, Bangalore
   - www.isccm.org

3. **January 19th to 23rd, 2013**
   - 42nd critical care congress, San Juan, Puerto Rico
   - www.sccm.org

**February 2013**

1. **February 10th, 2013**
   - ISCCM Mumbai Branch Clinical Meeting, “Criticare Update 2013”
   - ISCCM Mumbai branch

**March 2013**

1. **March 1st to 6th, 2013**
   - 19th Annual Congress ISCCM, Criticare 2013, Kolkata, India
   - www.criticare2013kolkata.com

2. **March 19th to 22nd, 2013**
   - 33rd International symposium on intensive care and emergency medicine, Brussels
   - www.intensive.org

**June 2013**

1. **June 8th to 9th, 2013**
   - Basic support and support in intensive care (BASIC), Columbiaasia Referral Hospital, Bangalore
   - Contact: Dr. Pradeep Rangappa, Secretary, ISCCM: Bangalore. email: drpradeepr@aol.com

2. **June 12th to 15th, 2013**
   - 24th Annual meeting of European society of Paediatric and Neonatal intensive care, Netherland
   - www.kenes.com/espnic

**July 2013**

1. **July 9th and 10th, 2013**
   - ISCCM Pune, Intensive Care Review Course, Pune
   - Contact: Ms Vidula- 09011026332; Dr Subhal Dixit- 9822050240

2. **July 11th and 12th, 2013**
   - ISCCM Pune, Workshops on hemodynamic monitoring, Mechanical Ventilation and Ultrasound, ECHO in ICU, Pune
   - Contact: Ms Vidula- 09011026332; Dr Subhal Dixit- 9822050240

3. **July 13th and 14th, 2013**
   - Best of Brussels Conference (Top 50 lectures), ISCCM, Pune
   - Contact: Dr Subhal Dixit- 9822050240, Dr Kapil Zirpe- 9822844212

4. **July 12th to 14th, 2013**
   - Intensive Care in Asia-Opportunities and Challenges, Singapore.
   - www.sg-anzics.com

**August 2013**

1. **August 17th 2013**
   - USG and ECHO workshop, Manipal Hospital, Bangalore
   - Contact: Dr. Pradeep Rangappa, Secretary, ISCCM-Bangalore. email: drpradeepr@aol.com

**September 2013**

1. **September 20th to 22nd, 2013**
   - THEMATICC 2013 and International Conference on Shock, Hemodynamic Monitoring and Therapy
   - Contact person: Dr. Vijaya Patil (09819883353) or Dr Atul Kulkarni (09869077526)

**October 2013**

1. **Oct 5th to 9th, 2013**
   - ESICM LIVES 2013, Paris, France
   - www.esicm.org

**November 2013**

1. **November 9th 2013**
   - Mechanical Ventilation workshop, Narayana Hrudayalaya, Bangalore
   - Contact: Dr Pradeep Rangappa, Secretary, ISCCM, Bangalore. email: drpradeepr@aol.com
10:30 – 10:40 Parallel Session
Chairpersons: Sandhya Talwar & Dr Mitesh Mustafi

10:40 – 11:00 Antimicrobial therapy of septic shock - Speed in Life (4) Speaker: Anand Kumar

11:00 – 11:20 Surgical options in acute spinal cord injury (8) - Pravin Amin

11:20 – 11:40 Acute spinal cord injury: a growing threat (6) Speaker: Jeff Lipmann

11:40 – 12:00 Cardiogenic shock: time is tissue (7) - Anand Kumar

12:00 – 12:20 Ethical issues in ICU (28) - Mrinal Sircar

12:20 – 12:40 Nutrition therapy in critical care (12) - Bibhu Kalyani Das

12:40 – 12:50 Cardiogenic shock: beyond lactate (55) - Bibhu Kalyani Das

12:50 – 1:10 Immunomodulation in sepsis (14) - Pravin Amin

1:10 – 1:30 Antimicrobial therapy of septic shock: Ideal resuscitation fluid for 2013 (18) - George John

1:30 – 1:50 Is chloride resuscitation harmful? - Sumit Ray

1:50 – 2:10 Therapeutic hypothermia: Current guidelines (29) - Manoj Goel

2:10 – 2:30 How I do it: lessons learnt from Therapeutic hypothermia: Current guidelines (29) - Manoj Goel
### Scientific Program Day 1 – (Con’t)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:30-4:50 pm</td>
<td>PREPARATION FOR CONVOCATION</td>
</tr>
<tr>
<td>4:50-5:10 pm</td>
<td>PREPARATION FOR CONVOCATION</td>
</tr>
<tr>
<td>5:10-5:30 pm</td>
<td>PREPARATION FOR CONVOCATION</td>
</tr>
<tr>
<td>5:30 pm -6:30 pm</td>
<td>Convention of Indian College of Critical Care Medicine &amp; Paul President’s Oration</td>
</tr>
</tbody>
</table>

### Cultural Program Followed by Dinner

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</thead>
<tbody>
<tr>
<td>7:30 – 9:15 am</td>
<td>Meet the Expert (Breakfast session)</td>
</tr>
<tr>
<td>9:30-9:30 am</td>
<td>PLENARY SESSIONS – 1 (HALL A)</td>
</tr>
<tr>
<td>10:00-10:20 am</td>
<td>PLENARY SESSIONS – 2 (HALL A)</td>
</tr>
<tr>
<td>10:50 – 11:10 am</td>
<td>Bedside monitoring of lung mechanics during mechanical ventilation (93) – Marco Ranieri</td>
</tr>
<tr>
<td>11:30-11:50 am</td>
<td>Lung imaging in ventilated patient at the bedside (93) – Daniel Talmor</td>
</tr>
<tr>
<td>12:20 – 12:40 pm</td>
<td>Change (5 minutes)</td>
</tr>
</tbody>
</table>

### Q&A

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</thead>
<tbody>
<tr>
<td>12:45 – 1:15 pm</td>
<td>Parallel Session</td>
</tr>
</tbody>
</table>

### SCIENTIFIC PROGRAM DAY 2 – (Con’t)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30 – 1:00 pm</td>
<td>HALL – A THEMATIC RESPIRATORY MONITORING</td>
</tr>
<tr>
<td>11:00 – 1:30 pm</td>
<td>HALL – B PANEL DISCUSSION</td>
</tr>
<tr>
<td>12:30 – 1:00 pm</td>
<td>HALL – C CASE DISCUSSION (AIM)</td>
</tr>
<tr>
<td>12:30 – 1:00 pm</td>
<td>HALL – D THEMATIC NUTRITION</td>
</tr>
<tr>
<td>1:00 – 2:00 pm</td>
<td>HALL – E THEMATIC CARDIOLOGY</td>
</tr>
<tr>
<td>1:00 – 2:00 pm</td>
<td>HALL – F THEMATIC GASTROENTEROLOGY</td>
</tr>
</tbody>
</table>

### Q&A

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:15 – 1:45 pm</td>
<td>Parallel Session</td>
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</tbody>
</table>

### Ancillary Session

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:30-4:50 pm</td>
<td>PREPARATION FOR CONVOCATION</td>
</tr>
<tr>
<td>4:50-5:10 pm</td>
<td>PREPARATION FOR CONVOCATION</td>
</tr>
<tr>
<td>5:10-5:30 pm</td>
<td>PREPARATION FOR CONVOCATION</td>
</tr>
<tr>
<td>5:35-6:05 pm</td>
<td>PREPARATION FOR CONVOCATION</td>
</tr>
</tbody>
</table>

### Q&A

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:15 – 7:00 pm</td>
<td>Parallel Session</td>
</tr>
</tbody>
</table>

### The Critical Care Communications

**A Bi-Monthly Newsletter of Indian Society of Critical Care Medicine**

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**The Critical Care Communications** is a bi-monthly newsletter published by the Indian Society of Critical Care Medicine. It is a platform for exchanging knowledge, experiences, and innovations in the field of critical care medicine. The newsletter covers a wide range of topics, including clinical practices, research findings, and educational content, aimed at enhancing the quality of care and promoting best practices in critical care settings. Contributions come from experts across the globe, reflecting the global nature of critical care medicine. To subscribe or for more information, visit the official website of the Indian Society of Critical Care Medicine.
<table>
<thead>
<tr>
<th>TIME</th>
<th>SESSION</th>
<th>SPEAKERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20:00-20:30</td>
<td>Introduction to the Workshop / Pre Test</td>
<td>Dr Omender Singh</td>
</tr>
<tr>
<td>20:30-21:00</td>
<td>Approach to Acute poisoning in Emergency Department-Toxidromes</td>
<td>Dr Omender Singh</td>
</tr>
<tr>
<td>21:00-21:30</td>
<td>ACLS AHA /AHLIS Toxicology</td>
<td>Dr Yash Javeri</td>
</tr>
<tr>
<td>21:30-22:00</td>
<td>The ABCDs of Poisoning</td>
<td>Dr Omender Singh</td>
</tr>
<tr>
<td>22:00-22:30</td>
<td>Alcohol, Ethanol, and Beyond- Toxic Alcohol Intoxication</td>
<td>Dr Senthil Kumarar</td>
</tr>
<tr>
<td>23:00-00:00</td>
<td>Sedative and Hypnotic Overdose</td>
<td>Dr Praveen Rajput</td>
</tr>
<tr>
<td>00:00-01:00</td>
<td>Alcohol and Anesthesia (Contd.)</td>
<td>Dr Senthil Kumarar</td>
</tr>
<tr>
<td>01:00-02:00</td>
<td>Sedative and Hypnotic Overdose</td>
<td>Dr Praveen Rajput</td>
</tr>
<tr>
<td>02:00-03:00</td>
<td>Alcohol and Anesthesia (Contd.)</td>
<td>Dr Senthil Kumarar</td>
</tr>
</tbody>
</table>

**SCIENTIFIC PROGRAM DAY – 3 (Contd.)**

<table>
<thead>
<tr>
<th>HALL – A</th>
<th>HALL – B THETMIC NEPHROLOGY</th>
<th>HALL – C PANEL DISCUSSION</th>
<th>HALL – D CONTROVERSIES</th>
<th>HALL – E THETMIC OBESTRICS &amp; CRITICAL CARE</th>
<th>HALL – F IMAGING IN ICU WHAT'S NEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairpersons:</td>
<td>A.K. Baronia &amp; Indira Chahal</td>
<td>Chairpersons: Jayanta Bose, Dr V V Lokmanirayas</td>
<td>Chairpersons: Rajesh Roy Deepak Talwar</td>
<td>Chairpersons: Asif Ahmed &amp; Anuradha Saha</td>
<td>Chairpersons:</td>
</tr>
</tbody>
</table>
## WORKSHOP ON INTENSIVE CARE NEPHROLOGY BEYOND BASIC (for Instructor & Provider Course) • 4th & 5th March, 2013

**Course Director:** Dr. Charles Comersall & **Course Co-ordinator:** Dr. Shivakumar Iyer

**Monday 4th March, 2013**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30</td>
<td>Registration</td>
</tr>
<tr>
<td>08:50</td>
<td>Welcome</td>
</tr>
<tr>
<td>09:00</td>
<td>AKI – definitions and epidemiology</td>
</tr>
<tr>
<td>09:30</td>
<td>AKI</td>
</tr>
<tr>
<td>10:00</td>
<td>Chronic kidney disease</td>
</tr>
<tr>
<td>10:30</td>
<td>CRRT part 1</td>
</tr>
<tr>
<td>11:00</td>
<td>Break</td>
</tr>
<tr>
<td>11:20</td>
<td>CRRT part 2</td>
</tr>
<tr>
<td>11:50</td>
<td>Peritoneal dialysis</td>
</tr>
<tr>
<td>12:20</td>
<td>IHD &amp; Hybrid techniques</td>
</tr>
<tr>
<td>12:50</td>
<td>Drug dosing in renal failure</td>
</tr>
<tr>
<td>13:20</td>
<td>Lunch</td>
</tr>
<tr>
<td>14:20</td>
<td>Skill stations/tutorials AKI Chronic kidney disease Peritoneal dialysis CRRT IHD and hybrid techniques Drug dosing</td>
</tr>
<tr>
<td>15:20</td>
<td></td>
</tr>
<tr>
<td>16:35</td>
<td>Lecturing (instructor candidates only)</td>
</tr>
<tr>
<td>17:00</td>
<td>Teaching skill stations (instructor candidates only)</td>
</tr>
</tbody>
</table>

**Tuesday 5th March, 2013**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30</td>
<td>Rhabdomyolysis</td>
</tr>
<tr>
<td>09:00</td>
<td>Abdominal compartment syndrome</td>
</tr>
<tr>
<td>09:30</td>
<td>Break</td>
</tr>
<tr>
<td>09:50</td>
<td>Skill stations/tutorials AKI Chronic kidney disease Peritoneal dialysis CRRT IHD and hybrid techniques Drug dosing</td>
</tr>
<tr>
<td>12:05</td>
<td>Post course MCQ</td>
</tr>
<tr>
<td>12:35</td>
<td>Close</td>
</tr>
</tbody>
</table>

**Instructor candidates only**

13:15 Instructor candidates give allocated lectures with feedback from facilitator

14:15 Instructor candidates teach skill stations with feedback from facilitator

17:15 Close

## WORKSHOP ON RESEARCH & PUBLICATION • 4th & 5th March, 2013

**Course Director:** Dr. Sunit Singhi & **Course Co-ordinator:** Dr. Mahua Bhattacharya

**DAY - I • 4th March, 2013**

### HOW TO START

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>9am – 9:20</td>
<td>Asking right research question and background literature search</td>
</tr>
<tr>
<td>9:20am – 9:40</td>
<td>Study designs (scope &amp; limitations)</td>
</tr>
<tr>
<td>9:40 am – 10:20</td>
<td>Understanding basic statistics</td>
</tr>
<tr>
<td>10:20am – 11:00</td>
<td>Writing a research protocol</td>
</tr>
</tbody>
</table>

### HANDS ON (Group discussion)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:15 am – 1:00</td>
<td>Each Group will be given a clinical problem (New Therapy, Prognosis, Diagnosis)</td>
</tr>
<tr>
<td></td>
<td>One Faculty facilitator for each group</td>
</tr>
<tr>
<td></td>
<td>Groups will be expected to do the following</td>
</tr>
<tr>
<td></td>
<td>Identify research question</td>
</tr>
<tr>
<td></td>
<td>Do literature search, Identify Study design, Identify statistical methods, Write a research protocol</td>
</tr>
<tr>
<td></td>
<td>One spokesperson from each group will present to all groups about their conclusions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00pm – 2:00pm</td>
<td>LUNCH</td>
</tr>
</tbody>
</table>

### RESEARCH RELATED ISSUES

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00pm – 2:20pm</td>
<td>Ethical issues in research</td>
</tr>
<tr>
<td>2:20pm – 2:40pm</td>
<td>Legal issues in research</td>
</tr>
<tr>
<td>2:40pm – 3:00pm</td>
<td>Organisational issues in research</td>
</tr>
<tr>
<td>3:00pm – 3:20pm</td>
<td>Economical issues in research</td>
</tr>
<tr>
<td>3:20pm – 3:40pm</td>
<td>Documentation in clinical research</td>
</tr>
</tbody>
</table>

### PUBLISHING RESEARCH

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:00pm – 4:30pm</td>
<td>Writing abstract and manuscript</td>
</tr>
<tr>
<td>4:40pm – 4:45pm</td>
<td>TEA BREAK</td>
</tr>
<tr>
<td>4:45pm – 4:50pm</td>
<td>Submitting research work for publication</td>
</tr>
<tr>
<td>4:45pm – 5:00pm</td>
<td>Conducting meta analysis</td>
</tr>
<tr>
<td>5:00pm – 5:30pm</td>
<td>OPEN FORUM</td>
</tr>
</tbody>
</table>

**DAY – II • 5th March, 2013**

### LECTURE

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00am – 9:30am</td>
<td>What is Evidence Based Medicine and what it is not</td>
</tr>
<tr>
<td>10:00am – 10:30am</td>
<td>How to search internet for evidence</td>
</tr>
<tr>
<td>10:30am – 10:50am</td>
<td>TEA BREAK</td>
</tr>
</tbody>
</table>

### CASE BASED DISCUSSION

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:50am – 12:50pm</td>
<td>Delegates will be divided into groups. Each group will be given a case scenario and they will formulate right questions and search net for relevant evidence and present to the entire group.</td>
</tr>
</tbody>
</table>

### LUNCH

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30pm – 1:30pm</td>
<td>LUNCH</td>
</tr>
</tbody>
</table>

### LECTURE

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:30pm – 2:10pm</td>
<td>Analysing literature on Diagnosis</td>
</tr>
<tr>
<td>2:20pm – 2:30pm</td>
<td>Analysing literature on therapy</td>
</tr>
<tr>
<td>2:30pm – 2:50pm</td>
<td>Analysing literature on Meta analysis</td>
</tr>
<tr>
<td>2:50 pm – 3:10pm</td>
<td>Analysing literature on prognosis</td>
</tr>
</tbody>
</table>

### CASE BASED DISCUSSION

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:30pm – 4:30pm</td>
<td>Delegates will be divided into groups. Each group will be given an article (therapy, diagnosis, metaanalysis) to critique</td>
</tr>
</tbody>
</table>

**MEETING OF INSTRUCTOR CANDIDATES ONLY**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:30pm – 5:00pm</td>
<td>OPEN FORUM</td>
</tr>
</tbody>
</table>

**MODERATOR :** Sunit Singhi

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**WORKSHOP ON INTENSIVE CARE NEPHROLOGY BEYOND BASIC**

**Indian Society of Critical Care Medicine**

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**THE CRITICAL CARE COMMUNICATIONS**

**A Bi-Monthly Newsletter of Indian Society of Critical Care Medicine**
WORKSHOP ON COMPREHENSIVE TRAUMA LIFE SUPPORT (CTLS) • 4th & 5th March 2013

Course Director & Co-ordinator - Dr. N. Ganapati & Dr. Tanmoy Das

Day – 1 (4th March, 2013)

07.30 Registration
08.30 Course Overview
09.00 Initial Assessment & Primary Survey
09.50 Airway Assessment & Management
10.40 Break
11.00 Workshop: Airway/RSI/Cricothyrotomy
12.00 Hemorrhage Assessment & Management
12.50 Lunch
13.30 Severe Head Injury
14.20 Abdominal Trauma
15.00 Break
15.30 Thoracic Trauma
16.20 - 17.30 Workshop: Chest Tubes/Interosseous

Day – 2 (5th March, 2013)

08.30 Spinal Trauma
09.10 Musculoskeletal Trauma
09.40 Burns
10.00 Trauma in Pregnancy & Children
11.50 The Elderly Trauma Patient
12.30 Lunch
13.30 Definitive Care
14.10 Transport of the Critically Injured
14.50 Break
15.10 Intensive Care: The First 24 hours
16.00-17.00 Evaluation & Concluding Session

The course will emphasize on:
1. Sequence of assessment & management
2. Team roles & preparation
3. Primary survey
4. Simultaneous resuscitation & re-evaluation
5. Secondary survey
6. Planning & definitive care management
7. On-going support to optimize outcome
8. Tertiary survey

The CTLs Educational Format provides:
1. Pre-course materials (A must read)
2. A 2 day course that features
   - A multi disciplinary approach
   - Case audit interactive presentations
   - Group Discussions
   - Interactive Hands On Skill Stations
   - An in course MCQ

CTLS Faculties
International
- Dr. Michael Parr, Australia
- Dr. Gillian Bishop, Australia
- Dr. Maureen McCunn, USA
- Dr. Jeff Berman, USA
- Dr. Arpan Guha, UK
- Dr. Sashi Kumar, Australia
- Dr. Samir Suri, Australia

National
- Dr. J Balavenkat, Coimbatore
- Dr. T Ramakrishnan, Chennai
- Dr. Manish Morheta, Lucknow
- Dr. Debasis Roy, Kolkata
- Dr. Arijit Bose, Kolkata

WORKSHOP ON NUTRITION IN CRITICAL CARE

Course Director - Dr. N. Ramakrishnan & Co-ordinator – Dr. Lawni Goswami

Monday 4th March 2013

6:30 – 9:00 am Registration
9:00 – 9:10 am Welcome, Introduction of faculties, briefing of workshop format
9:10 – 9:30 am Nutrition as adjunctive care or as proactive therapy Dr. N. Ramakrishnan
9:30 – 9:50 am Nutritional screening and assessment Dr. Pravin Amin
9:50 – 10:10 am Current guidelines on enteral nutrition (ASPEN/ISPEN/Canadian) ICU Dr. Mohan Das
10:10 – 10:30 am Current guidelines on parenteral nutrition (ASPEN/ISPEN/Canadian) Dr. Pravin Amin
10:30 – 10:50 am Immunonutrition in critical care Dr. Krishnan Sriram
10:50 – 11:10 am Tea Break (20 mins)
11:10 – 12:10 pm Case based Discussions - 
- Nutrition in Pancreatitis 
- Nutrition in Hepatic Failure
12:10 – 12:30 pm Perioperative Nutrition optimization Dr. Krishnan Sriram
12:30 – 1:30 pm Lunch
1:30 – 2:30 pm Case based Discussion – 
- Nutrition in Renal failure 
- Nutritional issues in EOL care
2:30 – 2:50 pm Monitoring Nutritional Support role of markers and whats new Dr. Mohan Das
2:50 – 3:30 pm Quiz / MCQs
3:30 – 4:00 pm Display of nutritional delivery devices, Nasogastric tubes, Freka Tubes, PEG tubes and their care different pumps and delivery devices

AIRWAY MANAGEMENT WORKSHOP • 4th & 5th March 2013

Course Directors : Dr. Atul Kulkarni & Dr. Saikat Sengupta

DAY 1 • 4th March, 2013

8:00 Registration
8:30 Predicting the difficult airway and their pitfalls in intensive care Dr. Saikat Sengupta
9:00 Airway algorithms and their application critical care scenarios Dr. Pradeep Bhattacharya
9:30 Supraglottic airway devices with special emphasis on the LMA’s Dr. Sheila Nynan Myatra
10:00 Fiberoptic guided intubation in intensive care and other uses of the fiberscope in intensive care Dr. Atul Kulkarni
10:30 – 11:00 Tea Break
11:00 – 13:00 Workstations
13:00 – 13:45 Lunch
13:45 – 15:45 Workstations

Workstations
1. Bag Mask Ventilation, Intubation with MILS, Oxygen therapy, Humidification Dr. D P Samaddar
2. Optimizing laryngoscopy – OELM, BURP, Sellicks, Ramp, different laryngoscope blades, styles, bougies, airway exchange catheters Dr. Prithwis Bhattacharya
3. Supraglottic Airways – LMA etc Dr. Sheila Nynan Myatra
4. Needle cricothyrotomy & TTJV Surgical cricothyrotomy Dr. Sasi Kumar, Australia

WORKSHOP ON NUTRITION IN CRITICAL CARE

Course Director - Dr. N. Ramakrishnan & Co-ordinator – Dr. Lawni Goswami

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3. Supraglottic Airways – LMA etc Dr. Sheila Nynan Myatra
4. Needle cricothyrotomy & TTJV Surgical cricothyrotomy Dr. Sasi Kumar, Australia
DAY 2 • 5th March, 2013

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Faculty</th>
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<tbody>
<tr>
<td>0830</td>
<td>Video Laryngoscope: what have you been missing in critical care</td>
<td>Dr. Moed Ahmed</td>
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<tr>
<td>0900</td>
<td>The subglottic airway – percutaneous tracheostomy: when &amp; how?</td>
<td>Dr. Sheila Nynus Myatra</td>
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<tr>
<td>0930</td>
<td>Maintaining the airway in critical care. Care of the patient</td>
<td>Dr. Drithivas Bhattacharya, Dr. Jayanta Mittra</td>
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<tr>
<td>1000</td>
<td>Extubating the patient with a difficult airway.</td>
<td>Dr. D P Samaddar</td>
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<td>1030 – 1100</td>
<td>Tea</td>
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<tr>
<td>1100 – 1300</td>
<td>Lunch</td>
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<tr>
<td>1305– 1545</td>
<td>Workstations</td>
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<tr>
<td>0830</td>
<td>Neuro Critical Care Workshop</td>
<td>Dr. Atul Kulkarni &amp; Dr. Saikat Sengupta</td>
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<tr>
<td>0900</td>
<td>Course Directors - Dr. Atul Kulkarni &amp; Dr. Saikat Sengupta</td>
<td>4th March 2013 Venue: Institute Of Neurosciences Kolkata (I-NK)</td>
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<tr>
<td>0930</td>
<td>8:30am to 8:40am Introduction</td>
<td>Dr. Kapil Zirpe</td>
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<tr>
<td>0940</td>
<td>8:40am to 9.00am ICP: Physiology / Pathology / Management</td>
<td>Dr. J M K Murthy</td>
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<tr>
<td>1000</td>
<td>9:00am to 9:20am Approach to Comatose Patients</td>
<td>Dr. Pramita Sarathi, Goswami</td>
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<tr>
<td>1020</td>
<td>9:20am to 9:40am Myths and Facts in Neuro Critical Care</td>
<td>Dr. Bibhukalyani Das</td>
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<tr>
<td>1040</td>
<td>9:40am to 10.00am Blood Pressure Management in CVA</td>
<td>Dr. Subhash Arora</td>
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<tr>
<td>1050</td>
<td>10.00am to 10:20am Critical Care issues in CNS infection</td>
<td>Dr. A Shorona</td>
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<tr>
<td>1020</td>
<td>10:20am to 10:40am Current concepts in Management of Status Epilepticus</td>
<td>Dr. Tapas Kumar Banerjee</td>
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<tr>
<td>1040</td>
<td>10:40am to 11.00am Antiepileptic in ICU</td>
<td>Dr. Trinianjan Sarangi</td>
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<td>1050</td>
<td>11.00am to 11.30am Delirium in NeuroICU</td>
<td>Dr. Alakananda Dutt</td>
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<tr>
<td>1110</td>
<td>11.30am to 11.45am TEA BREAK</td>
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<tr>
<td>1145</td>
<td>11.45am to 12.05 pm What is new in Stroke Management</td>
<td>Dr. Jayanta Roy</td>
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<tr>
<td>1205</td>
<td>12:05pm to 12.25pm Recent advances in Neuro radiological interventions</td>
<td>Dr. Sukalyan Purakayaitha</td>
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<tr>
<td>1255</td>
<td>12.25pm to 12.45pm Medical management of SAH</td>
<td>Dr. JMK. Murthy</td>
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<td>1315</td>
<td>12.45pm to 1.30pm LUNCH BREAK</td>
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<td>1345</td>
<td>INVESTIGATIONS IN NEURO CRITICAL CARE/ CASE BASE DISCUSSION (Rotation of 4 batches)</td>
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<tr>
<td>1345</td>
<td>1345 – 1545 Workstations</td>
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<td>1400</td>
<td>1345 – 1545 Lunch</td>
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<td>1430</td>
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<td>1400</td>
<td>1430 – 1545 lunch</td>
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<td>1430 – 1545 Workstations</td>
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</table>

INVESTIGATIONS IN NEURO CRITICAL CARE/ CASE BASE DISCUSSION (Rotation of 4 batches)

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</thead>
<tbody>
<tr>
<td>1.30pm</td>
<td>EEG / EP</td>
<td>Dr. Asish Dutta</td>
</tr>
<tr>
<td>2.00pm</td>
<td>Transcranial Doppler (understanding its role in neurocritical care)</td>
<td>Dr. Indrani Ghosh</td>
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<tr>
<td>2.30pm</td>
<td>CSF and other lab investigations in NCCU</td>
<td>Dr. Hrishikesh Kumar</td>
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<tr>
<td>3.00pm</td>
<td>Neuro Imaging (CT/MRI)</td>
<td>Dr. Mona Tawari</td>
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<td>3.30pm</td>
<td>4.00pm TEA BREAK</td>
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<tr>
<td>4.00pm</td>
<td>4.30pm Traumatic Brain Injury</td>
<td>Dr. Sanamendra Nath Ghosh</td>
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<tr>
<td>4.30pm</td>
<td>5.10pm Therapeutic Hypothermia (when I will do it)</td>
<td>Dr. Apratim Mukherjee</td>
</tr>
<tr>
<td>5.00pm</td>
<td>Management of Post cardiac arrest Syndrome</td>
<td>Dr. Kapil Zirpe</td>
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<tr>
<td>5.30pm</td>
<td>5.00pm Diagnosis of Brain Death and Organ Donation</td>
<td>Dr. Subhash Arora</td>
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<tr>
<td>5.00pm</td>
<td>VALIDATORY FUNCTION</td>
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</table>

Indian Society of Critical Care Medicine

Election Result 2012

I am happy to announce the list of newly elected office bearers and members of the Executive Committee for 2013 - 2015 that was ratified in the ISCCM executive committee meeting on 4th November 2012

VICE PRESIDENTS

Dr Yatin Mehta

Dr Khilnani Praveen

Dr. Kapil Zirpe

SECRETARY

Dr. Prakash Shastri

EXECUTIVE COMMITTEE MEMBERS

Dr. Singh Yogendra Pal

Dr. Khuntea Sudhri

Dr. Nikalje Anand

Dr. Sachdev Anil

PRESIDENT – ELECT AND CHIEF ELECTION COMMISSIONER - ISCCM

Dr. Shivakumar Iyer
CRITICARE 2013

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

Conference highlights:
- More than 250 lectures
- Thematic/Panel/Pro-con/ Guideline/ How I do it / Controversies Sessions
- 200 National Faculties
- 30 International Faculties
- Twenty-eight Workshops
- Adult & Pediatric sessions

WORKSHOP DETAILS
- Advanced Cardiac Life Support Course
- Fundamental Critical Care Support Course
- Fundamental Disaster Management
- Comprehensive Trauma Life Support Course
- Ultrasound in Emergency and Critical Care Unit
- Mechanical Ventilation
- Hemodynamic Monitoring
- Critical Care Nursing
- Antibiotic Stewardship & Infection Control
- Airway Management Workshop
- Learning through Simulations
- Basic Assessment & Support in Intensive Care

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