ISCCM News Headlines

- Meet the candidates for ISCCM Election 2013
  1st - 7th August 2013
- ISCCM Day on 9th October 2013.
- Exercise your franchise in large numbers
- War against Tropical Fever
- President's appeal to join the ISCCM research network
- Generic Drugs – And the fundamental Right to Healthcare!
- Article by Dr. Sumit Ray
- Read the latest from the journals - Dr. Shelgaonkar

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. Manish Munjal • Dr. Kapil Zirpe • Dr. Susruta Bandopadhyay
Members Election Commission

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

This issue of Critical Care Communications brings to you the profile of all the candidates contesting the ISCCM election 2013. I earnestly appeal to all of you to exercise your franchise to elect the best candidates. A democracy is truly representative only when a majority of voters exercise their vote. Despite our best efforts our database is still incomplete. I request all of you to update your contact details so that you are abreast with what is happening in the society and can participate in all societal activities, not least of which are the elections.

The Comprehensive Critical Care course of the Indian College of Critical Care Medicine is shaping up well with Dr. Chawla putting in a lot of effort. Dr. Anand Dongre and Dr. Anand Nikalje are working hard for the “ISCCM Day Campaign” on “Tropical Critical Illness”.

The ISCCM Research Committee is gearing up with its planned study on “Tropical Critical Illness”. Members are requested to register their ICU’s and participate in this study.

This issue also carries two articles, one on “Generics” a much debated issue and the other on Volumetric Capnography.

Members are requested to send their contributions, planned activities and programs already conducted to me on time for inclusion in the “CCC”
Year after year, post monsoon, a large part of our country, suffers from the menace of fevers that are peculiar to many tropical countries. Malaria, dengue, scrub typhus, leptospira, the Japanese encephalitis and typhoid fever are certain kinds of fevers which, because of supportive environmental conditions, prosper during this season in India. The clinical picture and the presentations are so overlapping that it becomes virtually impossible to diagnose one particular disease with conviction even in the best of Critical Care centres. Even after 65 years of independence, on account of political and administrative failures of our leadership, our population remains at a high risk of morbidity and mortality. The incomprehensible attitude of the government agencies to downplay the epidemics or mini-epidemics initially only helps the diseases to aggravate further. What is more astonishing is that when the medical professionals react with the reporting of the disease, the political leadership only reacts with casual contempt. Therefore, not only some of the traditional tropical diseases like malaria and dengue recur every year, even the old forgotten diseases like scrub typhus are re-emerging in varying formats and acute virulence. These cases inundate the ICUs in the form of MOFS, renal shutdown, ARDS, bleeding, or significant thrombocytopenia leading to a panic situation.

The Indian Society of Critical Care Medicine, therefore, chose to declare war on these tropical fevers and take them head on.

What are the war room strategies to tackle this problem?

These consist of declaring this years ISCCM theme “as War against Tropical Fever in ICU”, creating awareness among physicians and interivists about the syndrome, generate mass media awareness, collect data on the diseases in India through a well organized national multi-centric study called “Tropfeind Study “, organizing CME programs in various parts of the country about the need to understand and deal with the syndrome in a protocolised manner and last but not the least, ISCCM will observe “ISCCM Day” on 9 October, 2013 as day of “War against Tropical Fever in ICU”. Dr Anand Dongre of Nagpur and Dr. Nikhalje of Aurangabad have been given the responsibility of motivating and stimulating all branches, groups in ISCCM, ICUs to organize programs on this theme. This will trigger awareness, augment knowledge and skills to manage these diseases effectively in the ICU.

The ultimate aim is to reduce morbidity and mortality in ICU from these diseases. I call upon every single member and branch to seize the opportunity and contribute their bit to achieve the objective of their own organization i.e ISCCM.

The election season of the society is on. This will throw up our future leadership. I am sure the members will vote in large numbers to elect the best leaders for the coming term. The last few years have shown that we can lead other societies through innovation. The online election has already matured and bloomed. The Indian College of Critical Care Medicine has also got a kickstart and high standards have been prescribed. This is the first election after sweeping changes in the constitution of our society. New leadership in college will also be due in the next six months. The nursing courses will have started by the time this bulletin will be in your hands. I am sure our nurses will catch up fast in the speciality and make the most of this opportunity. I appeal to ICU bosses and hospital administrators of all big hospitals to motivate the best nurses to take up to this two year training program.

Forthcoming Criticare 2014 at Jaipur from 14th to 18th February 2014. This will be, by far, the largest Critical Care conference and education feast ever held in this part of world. This is the joint meeting of Asia Pacific Association of societies of Critical care Medicine, ISCCM and Critical Care Nurses Society. We expect almost 4000 delegates joining the proceedings at the majestic Birla Auditorium at Jaipur with almost 300 lectures, 20 skill stations and about 100 industrial exhibits on display. Early registration helps everyone: registrants save money and organizers come to know in advance about the probable numbers and groups participating. On behalf of the Organizing Committee, I invite all of you to join us at Jaipur. We promise to give you a memorable welcome, hospitality and time during your stay at Jaipur. A strong scientific program is being designed to suit the taste of every one – which was reflected in the survey conducted by the Scientific Program Committee. Some of the international celebrities who have consented to be the faculty are Ravindra Mehta, Mitch Levy, Neil McIntyre, Marin Kollef, Tony Maclean, L Gatinoni, Luca Neri and many more. For more details visit our website www.criticare2014.com.

Before I conclude, I wish to request all colleagues who have responsibility of taking care of their committee or subcommittee work, to complete their work in time so that the society achieves its objectives well ahead of time.
Greetings to all new and old members of ISCCM! By the time this newsletter reaches you, the 1st DM (Critical Care Medicine) students to our institute. I have just come to know that the St John’s Hospital in Bangalore and the SGPGI in Lucknow have been recognized by MCI as teaching centers for DM (Critical Care Medicine). Congratulations are due to both these centers. I am sure with time our specialty will grow with leaps and bounds.

I would also like to take this opportunity to welcome all of you to Mumbai to attend the International Conference on Shock, Hemodynamic Monitoring & Therapy along with the annual workshop fixture THEMATICC 2013 from 20-22nd September 2013. We will have with us some prominent international faculty, such as Dr Daniel De Backer from Belgium, Professor Sheldon Magder from Canada, Dr Mahesan Nirmalan from UK, Professor Jean Louis Teboul from France and Professor Azriel Perel from Israel along with our national faculty as well. Please hurry since we have limited (250) registrations.

Last but not the least, the Young Talent Hunt! Please send in your videos on selected topics, if you are young (< 40 years) and have not been a speaker at our National Conference, because this year we have an innovative idea to select young talent in critical care. I have written to all of you regarding this by e-mail and all branches will also hold local competitions to select young talent. I foresee interesting times ahead!

With warm regards

Dr. Atul P Kulkarni
General Secretary, ISCCM

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Dear Friends

Hemodynamic monitoring and interventions to normalise the hemodynamic parameters are one of the most common interventions in critical care. We have long felt that there was no comprehensive course dealing with all aspects of haemodynamic monitoring, interpretation and appropriate therapeutic approach. To overcome this lacuna, Department of Anaesthesiology, Critical Care & Pain, Tata Memorial Hospital and Mumbai branch of Indian Society of Critical Care Medicine started organising a two day workshop on hemodynamic monitoring called Tutorials in Hemodynamic Monitoring & Therapy in Critical Care (THEMATICC) in 2004. Since this year is the 10th year, we have decided to celebrate the occasion by organising an International Conference on Shock, Hemodynamic Monitoring & Therapy along with the annual from 20-22nd September 2013. The registrations for the workshop are now full so we request you to send the registrations only for main conference now.

We look forward to hearing from some eminent international faculty who have done a pioneering work in various areas relating to cardiovascular physiology, hemodynamic monitoring and therapeutic approaches to management of shock. The confirmed speakers include Dr Daniel De Backer (Belgium), Professor Sheldon Magder (Canada), Dr Mahesan Nirmalan (UK), Professor Jean Louis Teboul (France) and Professor Azriel Perel (Israel) along with prominent national faculty. An exciting scientific feast awaits us. Our auditorium is small therefore we can accept only 250 registrations for the main conference and only 60 registrations for the THEMATICC 2013. We have therefore only two categories of registrations ISCCM members and ISCCM non-members and the registration fees will not change as the conference approaches. We shall be unable to accept any spot registrations. The registration form can be downloaded from the ISCCM website – www.isccm.org. We look forward to seeing you in Mumbai during September 2013.

Warm regards

Dr. JV Divatia
Organising Chairperson

Dr. CK Jani
Organising Co-Chairperson

Dr. Vijaya Patil
Organising Secretaries

Dr. Atul Kulkarni
General Secretary, ISCCM

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International Conference on Shock, Hemodynamic Monitoring & Therapy and Tutorials in Hemodynamic Monitoring & Therapy in Critical Care 2013 (THEMATICC’13)

Main Conference : 20-21st September 2013
THEMATICC’13 : 22 September 2013 • Registrations are now full for workshop

Dr. JV Divatia
Organising Chairperson

Dr. CK Jani
Organising Co-Chairperson

Dr. Vijaya Patil
Organising Secretaries

Dr. Atul Kulkarni
General Secretary, ISCCM

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Calender of Events

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

September 2013
September 20th to 22nd, 2013 THEMATICCC 2013 and International Conference on Shock, Hemodynamic Monitoring & Therapy Contact person : Dr. Vijaya Patil (9891983835) or Dr. Atul Kulkarni (09869077526)

October 2013
Oct 5th to 9th, 2013 ESICM LIVES 2013, Paris, France www.esicm.org

November 2013
November 9th 2013 Mechanical Ventilation workshop, Narayana Hrudayalaya, Bangalore Contact : Dr Pradeep Rangappa, Secretary, ISCCM, Bangalore email : drpradeepr@aol.com

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Many prominent intensive care experts and ISCCM members from all over the country presented their lectures for the ISCCM4C course on 15th and 16th July 2013 at New Delhi. The experts were split in small groups with a group co-ordinator and the lectures were fine-tuned on 15th July. These lectures were then presented to all the experts on 16th July. In the next month or so the course will be ready and a roll-out of the ISCCM4C course is planned soon. Dr. Chawla is to be congratulated for spearheading this effort along with Dr. Divatia, Dr. Ramakrishnan and all the others from ISCCM.

ISCCM Comprehensive Critical Care Course (ISCCM 4 C)

This course has been designed for practising physicians, anaesthesiologists, intensivists, postgraduate students in anaesthesia, medicine and critical care. All other specialties including those from surgery, orthopaedics, pulmonology with an interest in Intensive Care will also benefit from this course.

For More Details Please Contact: Mr. Vimal Merchant, Executive Manager - ISCCM • 09819402435

INDIAN SOCIETY OF CRITICAL CARE MEDICINE, Unit 6, First Floor, Hind Service Industries Premises Co-operative Society, Near Chaitya Bhoomi, Off Veer Savarkar Marg, Dadar, Mumbai – 400028 • Tel: 022-24444737 • Telefax: 022-24460348 • email: isccm1@gmail.com • isccm1@vsnl.net
ISCCM Election 2013-2014 - Candidates Profile

President Elect - Number of Post - 1

Dr. Atul P. Kulkarni
Professor & Head, Division of Critical Care, Tata Memorial Hospital, Mumbai.

Qualifications
• Teacher DM (Critical Care Medicine)
• MD (Anaesthesia), Nagpur University, Nagpur
• Overseas Fellow Intensive Care, St George Hospital, Australia, 2002-2003.
• Fellow Indian College of Critical Care Medicine
• Awarded Presidential Citation in 2012 and 2013

Involvement with ISCCM
• Have worked extremely hard for all activities of ISCCM since its inception
• Treasurer, ISCCM National Executive Committee since February 2004-2010
• General Secretary, ISCCM national Executive Committee Since February 2010 - February 2014
• Member of Finance subcommittee and Education subcommittee of the National ISCCM Executive Committee 2004-2014.
• FCCS instructor since 2004, FDM instructor since 2012
• Instructor Winfocus Ultrasound course

Academic activities
• Faculty Member in several Critical Care and Anaesthesia Conferences, CMEs, workshops.
• Central Coordinator for Workshops, 11th Annual Conference of ISCCM Nagpur
• Member National Scientific Committee for past 4 years
• Member Scientific Committee and Coordinator for Haemodynamic workshop during the First Asian Congress on Shock and Sepsis, Nagpur 2006.
• Director of Hemodynamic and Mechanical Ventilation and Airway Workshop during several National Annual Workshop.

Dr. Atul P. Kulkarni

Dr. Yatin Mehta
Currently working as Chairman, Institute of Critical Care and Anesthesiology, Medanta The Medcity, Gurgaon, Haryana. He did his M.D. from All India Institute for Medical Sciences, DNB in 1982 and FRCA (Lon) in 1984 from Queens University Hospital, Nottingham, UK and worked in UK and Denmark before assuming post of Director, Department of Anaesthesiology and Critical Care at Escorts Heart Institute and Research Centre, New Delhi.

He has approximately 200 publications and 250 presentations in conferences and is regular faculty for the National ISCCM conferences.

He was Ex- Chief Editor of Annals of Cardiac Anesthesia besides being member in editorial board of several journals.

He is a teacher and examiner for IDCC, IFCC and FNB in Critical care and Cardiac Anesthesia.

Has served ISCCM in various capacities in National Executive and is currently the vice president of ISCCM.

He has been awarded FAMS by National Academy of Medical Sciences, FIACTA (Honorary) by Indian Association of Cardiovascular Thoracic Anaesthesiologists (IACTA) and FICCM (honorary) by Indian College of Critical Care Medicine. Besides this he has received Vishishta Chikitsa Ratna Award by Delhi Medical Association in 2012 and was nominated Medical Doctor of the Year 2010 by Emednews.

Dr. Yatin Mehta

Dr. Saurabh Kole
Working in Critical Care for more than 20 years, presently ITU in-charge, Belle Vue Clinic, Kolkata

Academic Activities:
Invited Speaker
• World Critical Care Conference, Italy 2009
• Asia Pacific Critical Care Congress, Australia 2008
• 7th Emirates Critical Care Conference, Dubai 2011
• APACCM and JSIM, Japan 2012
• National Congress : ISCCM, APICON, SEMI, ISPEN

Editor & Contributor : Book ‘Ventilation Made Easy’

Field Activities:
• Set up a Rural Critical Care Unit reaching a remote part of rural West Bengal
• Helping Disaster victims for 13 years. Led medical teams to,
  • Gujarat 2001 (Earthquake)
  • Nagapattinam and Andaman 2004 (Tsunami)
  • Bangladesh 2007 (Cyclone)
  • Myanmar 2008 (Cyclone)
• Initiated Basic Life Support training in Police & other institution as early as 1997
• Helped arrange 300 workshops on BLS

Organizing activities:
• ISCCM
  • Founder Secretary, Kolkata Branch
  • Executive Committee Member (1997-2000)
  • Secretary (2001-2)
  • Zonal Member (2004-05)
  • Organizing Secretary, National Congress - ISCCM (1999), ISPEN (2006), SEMI (2012) at Kolkata
  • Organizing Co-Chairman 19th Annual Congress, ISCCM (2013)

Dream:
ISCCM to emerge as a pro-people Critical Care Service and Awareness force reaching deep into rural India.

Dr. Saurabh Kole
Dr. Pradip Kumar Bhattacharya

Believes in Medicine as a scientific discipline based on humanism.

- Presently Director Critical Care & Emergency Medicine at CMCH Bhopal.
- Previously Head, Intensive Care Unit MAX SUPER SPECIALITY HOSPITAL PPG Delhi.
- Established first tertiary level intensive care unit in Madhya Pradesh at BMHRC Bhopal Year 2000.
- Certified FCCS & ACLS Instructor.
- Certified Fellow Indian College of Critical Care Medicine.
- Certified Six Sigma Green Belt for quality control
- Certified Teacher for ISCCM accredited Diploma & Fellowship Course.
- Publications in National & International journals.
- Past National Executive committee member ISCCM.
- Founder secretary ISCCM Bhopal Chapter.
- Presently Chairman ISCCM Bhopal City Branch.
- Conducted three National Conferences at Bhopal.
- Organizing Secretary Criticare 2008 held in Bhopal.
- Felicitated by Health Minister of Madhya Pradesh in the year 2009 for remarkable contribution in the field of critical care to the state.

Dr. Shyam Sunder Tipparaju

MD PDCC

Believes in Medicine as a scientific discipline based on humanism.

- Chief Intensivist and Medical Director of Continental Hospitals, Hyderabad.
- President ISCCM Hyderabad chapter 2013-15.
- Practicing Critical Care for the last 2 decades and responsible for conceptualizing to inceptualizing two major corporate hospitals in Hyderabad.
- Founder member and architect of ISCCM Hyderabad.
- Awarded the Eminent Citizen of India in 1997.
- Invited Speaker and Workshop Coordinator for Annual Conferences of ISCCM, ISA, API, ISPEN.
- National EC Member of ISCCM 2006 – 2012.
- Known for penchant for Nutrition in critically ill.
- Member Sub-Committees of Guidelines and Education.
- Teacher for IDCCM.
- Organizing Secretary for ISPEN 2002.
- Chairperson of landmark Criticare 2010 at Hyderabad, which brought ISCCM and SCCM together.
- Principal Investigator for various clinical trials.
- Participant in various international studies.
- Publications in various journals.
- Presented papers in World Congress of Critical Care, Argentina, Australia.
- Desire to spread and consolidate ISCCM and work towards protocolling Critical Care practice utilizing the tertiary hospitals.

Dr. Dhruva Chaudhry

MD (Medicine), DNB (Medicine), DM (Pulmonary & Critical Care Medicine), RISCCM, FICP

Prof. Dhruva Chaudhry is presently Dean Faculty of Medical Super specialties, Professor & Head, department of Pulmonary & Critical Care Medicine at PGIMS, Rohtak. An alumnus of PGIMER & PGIMS, he is a recipient of Commonwealth Fellowship in Pulmonology & Hansraj Nayyar Memorial Award of ISCCM.

Dr. Chaudhry is a member of National Executive of ISCCM since 2009 & is holding the charge of Accreditation Co-ordinator. He is a founder fellow of Indian College of Critical Care Medicine. He is instrumental in establishing the Rohtak branch of the society & is the branch’s first chairperson.

Prof. Chaudhry established the department of PCCM in his institute, an approved centre for DM in Pulmonary Medicine. He is an inspector for NBE/ MCI, Examiner for Undergraduate, Postgraduate (Medicine & Respiratory Medicine) and Post Doctoral Courses in Pulmonary & Critical Care Medicine. Dr. Chaudhry has written more than 30 papers, 10 Chapters & guided 15 Post graduates & 5 Ph.Ds. Prof. Chaudhry is a regular speaker in International, National & Regional conferences & CMEs. He also is on the editorial board & a regular reviewer in peer review journals in Chest & Critical Care.

Dr. Subhal Dixit

MD (MEDICINE), IDCCM (Indian Diploma Critical Care Medicine)

- Passed IDCCM from the first batch of the ISCCM course
- Director, ICU MJM Hospital and Sanjeevan Hospital Pune
- Consultant in Critical Care, Prayag Hospital & Critical Care Center
- Secretary ISCCM Pune 2012-2013
- Recognized teacher in Critical Care for IDCCM for last 7 years.
- Examiner for IDCCM
- Active member of ISCCM and ISCCM pune since the last 12 years, and have held post of secretary ISCCM Pune for 6 years and 2 years as treasurer ISCCM Pune, and actively worked in the registration of ISCCM Pune with Charity Commissioner
- Joint Org. Secretary of CRITICARE 2012 Pune, one of the most successful ISCCM Congresses.
- Org. Secretary 1st Mechanical Ventilation Conference In Pune.
- Active Member in Organising the Annual Mechanical Ventilation Workshop in Pune for last 10 years.
- Faculty in ISCCM National Conferences and Mechanical Ventilation Workshop Pune.
- Have Good Skills in Organization of Various ISCCM Meetings, Seminars.
- Ex West Zone Member ISCCM For 6 Years
- Executive Committee Member IMA Pune 2010-2013

Areas of interest: Mechanical ventilation, SEPSIS, Nutrition, Organization of Critical Care Unit.

Dr. Subhal Dixit
Dr. Anand Waman Dongre

**Executive member ISCCM Nagpur Branch 2002.**

**Founder Member ISCCM Nagpur Branch since 1997.**

**Chairman ISCCM Nagpur Branch - 2011 -13 -**

**Presentely - Director of Swastik Critical Care, 32 bedded hospital**

**CABG Programme Co-ordinator at Arneja Heart Institute a Nagpur**

**Worked as Specialist Anaesthesiologist and Critical Care in 12 beded**

**Faculty**

- **Organizational Activities:**
  - **Candidate for executive Committee members**
  - **Presently - Director of Swastik Critical Care, 32 bedded hospital**
  - **CABG Programme Co-ordinator at Arneja Heart Institute a Nagpur**
  - **Worked as Specialist Anaesthesiologist and Critical Care in 12 beded**

**Publications:**

- More than 50 published articles, including original article, review article, case report, case series in national and international indexed journals.

**Research:**

- Principal investigator and co-investigator in 10 (intramural and extramural) research projects. Current research on Metabolomics in lung injury and Cidemias in critically ill.

**Reviewer of journals:**

- Reviewer for more than 10 journals including: Respiratory care, Research Society of Anesthesiology and Clinical Pharmacology, HSR proceedings in Intensive Care and Cardiovascular Anesthesia, Journal of Laboratory Physicians.

**Membership of societies:** ISCCM, ISNACC, SCCM, ITACCS

**Awards:** Fellowship of Indian College of Critical Care Medicine - FICCM 2013

**Academic Activities:**

- Examiner for PDCC and DNB exit exam for critical care fellowship, Reviewer for abstracts for SCCM yearly congress, Faculty for Foundation course- SGPGeMs residents, Thesis evaluator (M.D.Anesthesiology - PGIMER Chd)

**Organizational Activities:**

- **Organizational Activities:**
  - **Scientific chairman of UP - Uttarkhand Chapter of- 2010-2011, Scientific advisor of Lucknow branch - 2009-2011, Secretary Lucknow branch (2012-2013), Member of ISCCM-Committee for preparing document for FCCM (Fundamentals of Critical Care Nursing)**

**Presently**

- **Presently writing a book titled Basics of Critical Care Nursing**

**Professional Societies**

- **ISCCM**
- **ISTAC**
- **ESICM**
- **SCCM**
- **Americal College of Surgeons - Committee on Trauma**

**Awards & Honors:**

- **Best Branch Award - 2013 at Kolkata conference ISCCM.**
- **Presidential Citation Awardee 2013 in the category of Emergency and Trauma Care.**
- **Fellow Critical Care, IDCC**
- **ISCCM recognized Teacher and IDCC Course Coordinator for Fortis Hospital, Jaipur**
- **Society for Emergency Medicine, India (SEMI) - Teacher for Masters and Diploma in Emergency Medicine**
- **BASIC course, BASIC Patient Safety Course, Beyond Basic - Intensive Care Nephrology**
- **Patient Safety Course, Beyond Basic - Intensive Care Nephrology**
- **Executive Member Jaipur ISCCM Chapter and Faculty ISCCM annual conference and workshop**
- **Co-founder and Coordinator for Acute Care and Emergency (ACE) Forum, a pure academic forum with regular bimonthly meetings for all doctors in Jaipur.**
- **Organized numerous courses, talks, seminars, symposium and workshops on Trauma, MDR Infections, Antibiotics, Infection Control, Patient Safety, Quality and Performance Improvement in ICU, Critical Care Nursing, Hemodynamic Monitoring, ICU Procedures, etc.**
- **Started the first Code Blue CPR Team in Rajasthan**
- **Started the first Masters and Diploma Emergency Medicine Course in Rajasthan**

**Publications:**

- **Publications in many journals of repute on varied critical care subjects.**
- **Conducted workshops on infection control, FCCS, Sepsis, Toxicology and ICU procedures, Reviewer for many national and international journals.**
- **Developed and implemented Checklist for Shock, Sepsis, Trauma, MDR Infections, Antibiotics, Infection Control, Patient Safety, Quality and Performance Improvement in ICU, Critical Care Nursing, Hemodynamic Monitoring, ICU Procedures, etc.**
- **Presently writing a book titled Basics of Critical Care Nursing.**

**Present Role:**

- **Consultant providing a range of specialized administrative and clinical services to the patients. Active role in training critical care nurses, emergency medicine / critical care fellows.**

**Academic:**

- **Invited faculty for various national conferences ISCCM, ITACCS, ISA & Traumacon, APICON.**
- **Conducted workshops on infection control, FCCS, Sepsis, Toxicology and ICU procedures, Reviewer for many national and international journals.**
- **Publications in many journals of repute on varied critical care subjects.**

**Presently writing a book titled Basics of Critical Care Nursing.**

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- **Started the first Code Blue CPR Team in Rajasthan**
- **Started the first Masters and Diploma Emergency Medicine Course in Rajasthan**
Dr. Rajesh Chandra Mishra

MD (Internal Medicine), FNB (Fellow), Critical Care Medicine, EDIC, FCCP. ACLS Instructor, FCCS Instructor. Free lance Intensivist, Visiting consultant intensivist, The GCRI, Ahmedabad

Personal Detail:

Name: Rajesh Chandra Mishra
Address: C 301, Indraprasth-B-Frangipani, Surthara Circle, Nr-Tulip Banglow, Thaltej, Ahmedabad, Gujarat 380054
E-mail: mishr_c@hotmail.com • Mobile: +91-9825013983

Education:
FNB (fellow) critical care medicine, [Manipal Hospital Bangalore]
1 year fellowship course, recognised by National Board of Examinations New Delhi.

Post Graduation Internal Medicine (MD-Internal Medicine)
• BRD Medical College, Gorakhpur University, UP,
• MBBS (KG’s Medical College Lucknow).

Professional Experience:
I believe, practice, and encourage closed ICU system.
I am organising regular CME and trying to take critical care medicine at peripheral centre.
I am being invited as a faculty in critical care conferences organised by ISCCM, in National as well as Regional chapter.

Membership- ISCCM
• API
• ESI
• ATS
• SCCM
• ACCP

Principal Investigator - Phase 2 & 3 trails.

CME
• ISCCM Kolkata, Pune, Delhi- Faculty
• International conference in bronchoscopy cleveland, Merselle, Athens
• ECMO Paris.
• ESI, Barcelona, Veinna, Berlin

Dr. Rajesh Chandra Mishra

Dr. Rajesh Pande

MD, PDCC, FCCM, FCCM
Trained in Anaesthesiology & Critical Care at SGPGI, Lucknow, short advanced training from Erasme Hospital, Brussels. Currently Director of Critical Care & Emergency Medicine at BLK Super specialty Hospital, practicing intensive care for the last 25 years.

I am an active member of the ISCCM and currently serving as an Executive Member at the centre besides being the Secretary of the vibrant Delhi-NCR branch. I am a national faculty & a recognized teacher for FCCS, Advanced BTLS, IDCCM & FNB in Critical Care. I am a member of a number of professional bodies, including the ESI, SCCM, ISA, IMA, RSACP, SEMI & ITACC.

I was awarded the Fellowship of the Indian College of Critical Care Medicine in 2012, and the Fellowship of American College of Critical Care Medicine in 2013. I was awarded the Presidential citation for outstanding contribution in 2013. Contributed to research & have been on the editorial board of the CCC. I was actively involved with the ISCCM day & World Sepsis Day activities for 2012 and have been involved in the organization of major events like Criticare 2011, DCCS 2011, 2012 & 2013 besides many workshops on Mechanical Ventilation at national Level.

Dr. Rajesh Pande

Dr. Sauren Panja

Professional Qualifications:
• MBBS (Calcutta University) - 1993
• MD (Internal Medicine): UCM - Calcutta University - 1999
• FNB (Critical Care) - National Board of Examination -2005
• EDIC (European Diploma in Critical Care) - 2008

Present Position:
• Senior Consultant & ICU Coordinator, Medica Institute of Critical Care, Medica Super Speciality Hospital
• Head of the Department, Internal Medicine, Medica Super Speciality Hospital
• Member, Hospital Infection Control Committee

Past position:
• Consultant : Dept. of Critical Care & Emergency Medicine, Sir Ganga Ram Hospital, New Delhi (since November 2005)
• Teaching coordinator : FNB & IDCC since 2009-2011 (Sir Ganga Ram Hospital, New Delhi)
• In charge Infection Control : Dept. of Critical Care, Sir Ganga Ram Hospital, New Delhi (since November 2005)

Research and Publications:
• Have several national and international publications

Deliberation:
• Has frequently presented in national, regional & local conferences and CMEs over the past 5 years

Dr. Sauren Panja

Dr. Rakesh Kumar Tyagi

Senior Consultant Critical Care, Medicine Pushpanjali Hospital, Agra
Dr. Rakesh Kumar Tyagi is graduated from S.N. Medical college, Agra and Post Graduation in Anaesthesia from J.N. Medical College, AMU, Aligarh. He served for tribals in Arunachal Pradesh for two years through a N.G.O. on Honorary basis. He worked as Senior resident Anaesthesia and Critical Care in different Hospitals in New Delhi. Since 2002 He is working as Consultant Critical Care at Agra. Presently he is Director of OXIM Anaesthesia, critical care and pain Associate. He is also Senior Consultant Critical Care at Pushpanjali Hospital, Agra. He is also a recognized Teacher for IDCC.

He is conducting BTC3 (Basic Trauma Critical Care Course) for Nurses and Doctors and FAR Course (First Aid and Resuscitation Course) for the general public for last 8 years.

He has also played key role in organizing National and State Conferences of ISCCM as Treasurer and Organizing Secretary. He also served as organizing secretary for National Conferences of Trauma Care (ITCCS). Currently he is Secretary of Agra Branch of ISCCM.
Zonal Member - Central Zone -
Number of Post - 1

Dr. Mohan Gurjar
Present Employment:
• Associate Professor of Critical Care Medicine, SGPGIMS, Lucknow
Education:
• MBBS (1998, SN Medical College, Agra); MD Anaesthesiology (2003, GSVM Medical College, Kanpur); Senior Residency (AIIMS, N. Delhi); PDCC Critical Care Medicine (2006, SGPGIMS, Lucknow).
Honour:
• Honorary Fellowship of Indian College of Critical Care Medicine (FICCM) [Feb 2012]
Publication:
• More than 50 published articles.
Reviewer of Journals:
• More than 13 Journals (including Respiratory Care, Journal of Critical Care, JICCM, Clinical Toxicology, PLoS ONE, JAPI)
Editorial Board Member:
• World Journal of Critical Care Medicine
Membership of Societies:
• ISCCM, ESICM, SCCM, ISA, IAB, CIDS
Organizational Activity:
• Contribution in preparing a document (By Professor A K. Baronia, HOD, Critical Care Medicine, SGPGIMS) in support of Critical Care medicine specialty, that was sent to MCI to get recognition, The request of the Department and Institute for recognition of ‘Critical Care Medicine’ as a super specialty subject for 3 year DM training course and 1 year PDCC course has been accepted by MCI in 2010.
• In organizing committee of 1st & 3rd State chapter (UP-Uttrakhand) Annual conference and many ‘CMEs’ conducted by the department.

Dr. Shabbar H K Joad
MD (Medicine) DNB - Fellow Critical Care, IDCC
• Head of Department, Critical Care and Emergency, Fortis Escorts Hospital, Jaipur
• Senior Consultant Medicine
• Hospital Committee member for -
  • ISCCM recognized Teacher and IDCC Course Coordinator for Fortis Hospital, Jaipur
  • Society for Emergency Medicine, India (SEMI) - Teacher for Masters and Diploma in Emergency Medicine
  • Instructor - ACLS (AHA), ATLS, BASIC, FCCS, Ultrasound in Critical care and Emergency, Palliative Medicine (Indian Association of Palliative Medicine), PALS
  • Instructor - (Chinese University of Hong Kong) BASIC course, BASIC Patient Safety Course, Beyond Basic - Intensive Care Nephrology
  • Executive Member Jaipur ISCCM Chapter and Faculty ISCCM annual conference and workshop
  • Society for Emergency Medicine, India - Vice President - Central Zone
  • Society for Emergency Medicine, India - Founder President Rajasthan Chapter
  • Co-founder and Coordinator for Acute Care and Emergency (ACE) Forum, a pure academic forum with regular bimonthly meetings for all doctors in Jaipur.
  • Organized numerous courses, talks, seminars, symposium and workshops on, Trauma, MDR Infections, Antibiotics, Infection Control, Patient Safety, Quality and Performance Improvement in ICU, Critical Care Nursing, Hemodynamic Monitoring, ICU Procedures, etc.
• Started the first Code Blue/ CPR Team in Rajasthan

Dr. Ranvir Singh Tyagi
MD from S M S Medical College, Jaipur
Professional Experience
• Core team member of Oxim Anaesthesia & Critical Care Associates.
• Senior Consultant department of Anaesthesia & Critical Care, Pushpanjali Hospital, Agra.
Academic Achievements
• One of the pioneers in the field of Critical Care medicine in the city.
• National Faculty in Trauma & Critical Care Conference.
• Post Graduate Teacher & Trainer for DNB students: Anaesthesiology.
• Organizing Secretary of 9th National Conference of ITC2006.
• Co-organising Secretary 14th National Conference of ISCCM held at Agra in Feb. 2009.
• Running BTC3 Course (Basic Trauma & Critical Care Course) for Nurses.
• Running F.A.R. (First Aid Resuscitation Course) for general public since 2005.
• Organizing Secretary of 2nd Annual Conference of U.P. & UK. Chapter ISCCM held on September 2011 at Agra.
Updated academic achievements
• Received “Best branch award - Agra” as chairman in national conference at Pune in Feb’12.
• National ISCCM-zonal (central) member (2012-14).
• General secretary UP & UK state chapter ISCCM from oct. 2012-14.
• Approved Teacher for IDCC from 2012.

Dr. Ranvir Singh Tyagi
Address : Pushpanjali Hospital, Agra • drranvirstyagi@gmail.com

APPEAL TO ALL ISCCM BRANCHES

Celebrate
9th OCTOBER 2013

ISCCM

ISCCM FOUNDATION DAY

Theme : “CRITICAL ILLNESS IN TROPICAL FEVER”

ISCCM plans to celebrate ISCCM DAY by creating an awareness regarding tropical diseases among health professionals and the lay public.

Branches are requested to hold CME & public awareness programme along with poster presentation on same day. Detailed program with standard powerpoint presentations, posters and information leaflets is being prepared.

Please send your suggestions asap to andydongre@hotmail.com

ISCCM DAY Committee
Dr. Anand Dongre • Dr. Anand Nikalje
Dr. Manish Munjal • Dr. Palep Gopal
The recent judgment by a bench of the Supreme Court of India, denying a patent, to Novartis, on the active pharmaceutical ingredient of Imatinib mesylate (Gleevec) which is an oral medication used for CML, has brought the focus on Generic drugs right on to the centre stage. A patent for the free base had already been granted in 1995. The story of Imatinib has been followed by both Big Pharma and organizations working for people’s right to healthcare and access to medicines, with great interest. This story brings with it all the arguments about the need for generic drugs, the idea that healthcare and access to drugs is a fundamental human right and posits it against the laws on patents, the debate on the control of the process of innovation and the fundamental basis of the right to profit for big corporations. We shall come back to the story later.

### What is a generic drug?

A generic drug has been defined by the Centre for Drug Evaluation and Research and the Food and Drug Administration of the US as, “A generic drug is defined as a drug product that is comparable to brand / reference listed drug product in dosage form, strength, route of administration, quality and performance characteristics and intended use.” It has also been defined as a term referring to any drug marketed under its chemical name without advertising. So, by its very definition, one of the main arguments against generic drugs vis-a-vis branded/research molecules is destroyed, as it has to be “a product comparable to brand/refere- ence listed drug products.” What opponents of generic drugs tend to mix up are spurious vis-a-vis generic drugs. Any intelligent human being, particularly a physician will op- pose spurious drugs. Without any doubt, there is a need to regulate and penalize producers of spurious medications. Supposedly, improper/ inadequate quality control in some segments of the indigenous pharma industry cannot be an excuse against generic drugs. The detractors seem to forget that a large number of multi- national pharmaceutical companies source a large proportion of the base drug from the very same Indian and Chinese companies, who pro- duce the generics. So, is it the packaging with the name of a large MNC, which makes them “purer”?

#### Equivalence of Brand v/s Generic:

Those of us who are still not convinced about the non-superiority of branded drugs vis-a-vis generic, need to look at two major studies. The first published in JAMA 2008 by Kesselheim et al was a meta-analysis and systematic review of 47 articles covering 9 sub-classes of cardiovascular medication. Table 1 below has their results.

#### Table 1:

<table>
<thead>
<tr>
<th>Class</th>
<th>Number of RCTs (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>β- blockers</td>
<td>7 of 7 RCTs (100%)</td>
</tr>
<tr>
<td>Diuretics</td>
<td>10 of 11 RCTs (91%)</td>
</tr>
<tr>
<td>Ca + Channel blockers</td>
<td>5 of 7 RCTs (71%)</td>
</tr>
</tbody>
</table>

#### Table 2: Big Pharma Big Fraud-Major Fines paid by Big Pharma for violating laws.

<table>
<thead>
<tr>
<th>Company</th>
<th>Settlement</th>
<th>Violation(s)</th>
<th>Year</th>
<th>Product(s)</th>
<th>Laws violated</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSK</td>
<td>$3 billion</td>
<td>Off-label promotion/failure to disclose safety data</td>
<td>2012</td>
<td>Rosiglitazone, Bupropion, Paroxetine</td>
<td>False Claims Act/FDCA</td>
</tr>
<tr>
<td>Pfizer</td>
<td>$2.3 billion</td>
<td>Off-label promotion/kickbacks</td>
<td>2009</td>
<td>Pre-gabapentin, Valdecoxb, Ziprasidone, Linezolid</td>
<td>False Claims Act/FDCA</td>
</tr>
<tr>
<td>Abbott</td>
<td>$1.5 billion</td>
<td>Off-label promotion</td>
<td>2012</td>
<td>Valproic acid</td>
<td>False Claims Act/FDCA</td>
</tr>
<tr>
<td>Eli Lilly</td>
<td>$1.4 billion</td>
<td>Off-label promotion</td>
<td>2009</td>
<td>Olanzapine</td>
<td>False Claims Act/FDCA</td>
</tr>
</tbody>
</table>

When you defraud more, you have to bribe more. So, pharmaceutical industry spent $855 million for lobbying (which is legalized bribing for all practical purposes) between 1998 and 2006, in the US. Again they were the champion spenders among all industries.

#### THE RESEARCH COST MYTH – The $800 million pill!

One of the major reasons that Big Pharma gives for the high cost of Research/branded molecules is the huge cost of research for these drugs. The cost for developing a new molecule was pegged at $800 million in 2003. This was based on an article by Dimasi et al published in 2003 in the Journal of Health Economics. Dimasi et al did this analysis at the Tufts Center for the Study of Drug Development, Boston, USA. They got data from 12 of the 24 companies they had invited for data, of which 10 gave only confidential data. They estimated the mean sample size to be $530 patients / study and the cost per patient at $23,572. They arrived at a figure of $403 million. To this they added the cost of capital, i.e. the cost of returns, if they had invested the money in the stock market, rather than in research. They calculated returns at 11%, over a period of 90 months. 90 months was the mean time period required for clinical trials and FDA approval. Adding all this together, they arrived at the final cost of $802 million in 2003.

Big Pharma has now extrapolated that figure to $1.3 billion for the present.

This study by DiMasi was challenged by many experts. Three works particularly standout. One by Merrill Goozner in his book, “The $800 million pill: The truth behind the cost of new drugs”. The second by Dr. Marcia Angell (ex-Editor in Chief of NEJM) in her book, “The truth about drug companies”. The third and probably the most detailed by Light and Warburton, in “The London School of Economics and Political Science, Biosocieties 2011.”

Their criticism was as follows:
1. The Tufts Center and the study was heavily industry funded.
2. No other researcher has been given access to analyze the complete data.
3. No effort was made to verify the costs provided by the companies.
4. The average number of patients per trial, as calculated by FDA is 2667 and not 5303.
5. The average cost per patient as calculated by NIH is $3861, not $23,572.
6. The return on the cost of capital during that period, as calculated by the US Govt. is between 3-7%, not 11%.
7. The mean trial and approval time calculated by the US govt. and FDA during that period was 48 months, not 90 months.
8. They also did not calculate the 39-50% tax subsidy on research that companies get.

Taking into consideration all these changes, they arrived at a more reliable calculation of $200-400 million per molecule.

A study published in JAMA 2010, by Donsey et al, on funding of US Biomedical Research between 2003-2008, showed that Pharma funding of research was 36% of the total spending on research, while Public funding was 38%. They also found that 84.2% of all basic research for drugs was funded by public money. While pharmaceutical companies spent most of their money in Phase II and Phase III trials. This had also been shown by another study by the US National Science Foundation in 2003.

Fortune 500 reports show that Pharma revenues for 2009 was $540 billion, while their R & D spending was $653.3 billion, approx 12.5% of which only 18%, i.e. 2.4% of revenue was on basic research. I analyzed the annual reports of the Big 3, Pharma companies – Pfizer, Johnson & Johnson and Novartis between 2009 and 2012.

According to their own reports, their R & D costs were 11.1-16.2% of revenue (after tax subsidies) of which only 18%, i.e. 2.4% of revenue was on basic research. I analyzed the annual reports of the Big 3, Pharma companies – Pfizer, Johnson & Johnson and Novartis between 2009 and 2012.

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Table 3: Most profitable industries in the world (2011-2012)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Industry</th>
<th>Profit (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crude oil &amp; mining</td>
<td>19.8</td>
</tr>
<tr>
<td>2</td>
<td>Pharmaceuticals</td>
<td>19.1</td>
</tr>
<tr>
<td>3</td>
<td>Tobacco</td>
<td>12.3</td>
</tr>
<tr>
<td>4</td>
<td>Food consumer products</td>
<td>11.9</td>
</tr>
<tr>
<td>5</td>
<td>Household and Personal Products</td>
<td>9.9 Products</td>
</tr>
<tr>
<td>6</td>
<td>Telecommunications</td>
<td>7.5</td>
</tr>
<tr>
<td>7</td>
<td>Industrial Machinery</td>
<td>7.1</td>
</tr>
<tr>
<td>8</td>
<td>Building Materials and Glass</td>
<td>6.5 Glass</td>
</tr>
<tr>
<td>9</td>
<td>Defense and Aerospace</td>
<td>6.2</td>
</tr>
<tr>
<td>10</td>
<td>Shipping</td>
<td>6.1</td>
</tr>
</tbody>
</table>

Median Profits of Industries have been calculated at 4.6% of Revenue.

According to a US pharmaceutical industry body –PhARMA (which represents the interests of the biggest pharmaceutical companies), the cost of producing an original drug has gone up 80-fold from 1950 to 2008.

Annual Reports of top 12 Pharma majors in the Fortune 500 list reveal that in the same period, profits increased from $61.8 million to $63.1 billion. A 1000 fold increase! Adjusting for inflation, profits have still grown 125 fold!

**PATIENTS vs PATENTS**

Coming back to the story of Imatinib’s patent extension, which was rejected by the Supreme Court of India, in April 2013, it raises two major issues.

One, is the efforts of pharma companies to extend their patents by “evergreening” molecules and the second, is the issue of the rights of people to have access to healthcare and medication and the “rights” of industry to their patents.

“Evergreening” is an effort by pharmaceutical industry to extend their patents for longer periods of time, by tweeting the basic molecule and getting a new patent on that molecule.²

Going into a little bit of the history of Imatinib (Gleevac) -- It was developed in the 1990’s, primarily by the works of Dr. Brian Drucker, of Oregon Health & Science University (OHSU), along with scientists from University of Milan, Italy, Hammer Smith Hospital, London, Memorial Sloan-Kettering, New York, (all public funded institutions) and Novartis. Novartis got a patent for the base drug in 1996 and FDA approval for clinical use in 2001. In 2001, it was priced at $30,000/year and Novartis would have recouped development costs in 2 years.

After becoming a blockbuster drug, Novartis increased the price to $92,000/year, with annual earnings in 2012 of $4.7billion! Novartis wanted to extend its patent beyond 2015 and applied for a separate patent for its active ingredients.

In 2009, the Indian government did not accept this, as the cost of Gleevac was prohibitive, and allowed compulsory licensing for the production of a cheaper generic version by Natco Pharma. This brought down the cost of ARV therapy from $615 in 2003, to $74 per patient

A similar battle was fought in South Africa in 1997-1998, on anti-retrovirals (ARVs). Almost 3 million patients were dying of AIDS in South Africa, without access to ARVs. The South African government under public pressure started importing generic ARVs. 39MNC’s took the South Africa government to court, to stop import of ARVs. There was huge international support for the South African government, and Big Pharma withdrew their case in 2001. It made it obvious that Big Pharma was interested only in profiteering and did not care for patients lives. Big Pharma considers this, as their biggest PR disaster. Since then, many countries like Brazil, Thailand etc. depend on generic medication primarily for their successful public health and HIV programmes. Even the US public health system is dependent on generics.

Large volume generic supplies have been able to save millions of lives. India has had a huge role to play. We supply almost 87% of generic ARV’s to developing countries, as shown in a study published in Journal of International AIDS Society 2010.³

It has brought down the cost of ARV therapy from $615 in 2003, to $74 per patient

Not only that, India is the highest source of supplying generic medication to the UNICEF ($467 million / year). Edwin de Goood, the Managing Director of International Dispen-

sary Association (one of the largest non-profit organizations, supplying essential medicines in low and middle income countries) in an interview to Times of India (April 07, 2013)⁴ said that 70-90% of their purchases are from India, which includes ARV’s, anti-TB, antibi-

otics etc. He states that generics from India are of a very high quality, and “we have not blacklisted any company in India as a result of sub-standard medicines…..”

Table 4: Big Pharma – Revenues of Top 12 Pharma (2011-12)

<table>
<thead>
<tr>
<th>Company</th>
<th>Revenue (SBIL)</th>
<th>Profits (SBIL)</th>
<th>Profits as % Revenue</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pfizer</td>
<td>67.9</td>
<td>10</td>
<td>14.8</td>
<td>USA</td>
</tr>
<tr>
<td>J &amp; J</td>
<td>65.1</td>
<td>9.7</td>
<td>14.9</td>
<td>USA</td>
</tr>
<tr>
<td>Novartis</td>
<td>58.6</td>
<td>9.1</td>
<td>15.5</td>
<td>Switzerland</td>
</tr>
<tr>
<td>Bayer</td>
<td>50.7</td>
<td>3.4</td>
<td>6.7</td>
<td>Germany</td>
</tr>
<tr>
<td>Hoffman-Roche</td>
<td>48</td>
<td>17.4</td>
<td>36.3</td>
<td>Switzerland</td>
</tr>
<tr>
<td>Merck &amp; Co</td>
<td>48</td>
<td>6.3</td>
<td>13.1</td>
<td>USA</td>
</tr>
<tr>
<td>Sanofi Aventis</td>
<td>43.2</td>
<td>7.4</td>
<td>17.1</td>
<td>France</td>
</tr>
<tr>
<td>GSK</td>
<td>42.5</td>
<td>8.2</td>
<td>19.3</td>
<td>UK</td>
</tr>
<tr>
<td>Abbott</td>
<td>38.9</td>
<td>4.7</td>
<td>12.2</td>
<td>USA</td>
</tr>
<tr>
<td>Astra-Zeneca</td>
<td>32.4</td>
<td>9.6</td>
<td>29.6</td>
<td>UK</td>
</tr>
<tr>
<td>Eli-Lilly</td>
<td>24.3</td>
<td>4.3</td>
<td>17.9</td>
<td>USA</td>
</tr>
<tr>
<td>BMS</td>
<td>21.3</td>
<td>3.7</td>
<td>17.5</td>
<td>USA</td>
</tr>
</tbody>
</table>

Profitability of PHARMA 19.1%! Second only to Oil! (19.8%)
Patents versus Patients - the case of ARV's

control over the production process and profit from drugs), is that, innovations will flow only in situations where these laws are strong. But, history tells us a different story. Many of the great innovators like Thomas Alva Edison borrowed heavily from other scientists’ ideas and became great innovators! The United States which is for strong patent laws, was one of the biggest “borrowers” of technology and ideas from the rest of the world, particularly Germany & Great Britain till the Second World War! Even now there is debate on the whether “open source” method of sharing technology and ideas may be a better way of hastening innovation, rather than strong patent laws. The jury is still out on it.

When John Maynard Keynes the brilliant British macro-economist, proposed the idea of the “Welfare state”, one of the most important aspects of that “welfare state” was the fundamental right to health, for all its people. This fundamental right can only be provided, when there is access to inexpensive, quality medicines, which generics provide. It is an essential part of access to health. Before you reject him as a socialist/communist, he was a member of the British Liberal Party. In 1999, The Time magazine had him in the 100 most important and influential people of the 20th century. Commenting that: “His radical idea…..may have saved capitalism.” Thus, the basis of the welfare state and our democratic fundamental right to healthcare is dependent on large volumes of inexpensive drugs, which can only be provided by generics.

Figure 2 : Price trends for generic 3TC/NVP/d4T30 (fixed dose combination) and innovator 3TC+NVP+d4T30 (3 individual tablets), 2003-2008. **2003 price is for three individual ARVs (1st FDC purchase reported in 2004).

One of the major arguments that are given to make strong patent laws, (which allow Pharmaceutical companies to have prolonged

Figure 3 : Spread of Indian Generics across the world. **

The views expressed in this article are the author’s own views and do not necessarily represent the views of the editorial board or ISCCM.

References
2. Donahue et al, NEJM 2012;366:530-538
5. Truth About Drug Companies (2004), Marcio Angell, Random house
8. Hitchings et al, BMJ (2012);345.e7941
9. Annual report, Novartis India 2010-2011

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- develop multiple organ failure and die?

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Sodium Bicarbonate Infusion to Reduce Cardiac Surgery-Associated Acute Kidney Injury: A Phase II Multicenter Double-Blind Randomized Controlled Trial
Michael Ried, Thomas Bein, et al.
Critical Care 2013, 17:R110
Severe trauma with concomitant chest injury is frequently associated with Acute Lung Failure (ALF). This study reports our experience with Extracorporeal Lung Support (ELS) in thoracic trauma patients treated at the University Medical Center Regensburg.
A retrospective observational analysis of prospectively collected data (Regensburg ECMO-Registry database) on all consecutive trauma patients with acute pulmonary failure requiring ELS in a 10-year interval was performed. Between April 2002 and April 2012, 52 patients (49 male, 3 female) with severe thoracic trauma and ALF refractory to conventional therapy required ELS. The mean age was 32 ± 14 years (range, 16 - 72). Major traffic accident (73%) was the most common trauma followed by blast injury (17%), deep fall (8%) and blunt trauma (2%). The mean Injury Severity Score (ISS) was 58.9 ± 10.5. The mean lung injury score (LIS) was 3.3 ± 0.6. and sequential organ failure assessment (SOFA) score was 10.5 ± 3. Twenty-six patients required complex extracorporeal life support (PECLA) and twenty-six patients required veno-venous extracorporeal membrane oxygenation (v-ECMO) for primary post-traumatic respiratory failure. Mean time to ELS support was 5.2 ± 7.7 days (range, <24h - 19 days) and mean ELS duration was 6.9 ± 3.6 days (range, <24h - 19 days). In 24 cases (48%) ELS implantation was performed in an external facility and cannulation was done percutaneously by Seldinger’s technique in 98% of patients. Cannula-related complications occurred in 15% of patients (PECLA 19% (n=5); v-ECMO 12% (n=3)). Surgery was performed in 44 patients with 16 patients under ELS protection. Eight patients (15%) died during ELS-support and three patients (6%) died after ELS weaning. Overall survival rate was 79% compared to proposed ISS-related mortality (59%).
Conclusions
Pumpless and pump-driven ELS systems are an excellent treatment option for thoracic trauma patients with acute lung failure and facilitate survival in an experienced trauma-center with an interdisciplinary treatment approach. We encourage the use of v-ECMO due to reduced complication rates, better oxygenation and best short-term outcome.

Prognostic value of troponins in sepsis: a meta-analysis
Francis Bessière, Safia Khenifer et al.
The role of biomarkers such as troponin in risk stratification of sepsis is still debated. The aim of this meta-analysis is to assess the relation between troponin elevation in septic patients and mortality.
All observational studies from Embase, Medline and those manually searched up to September 2010 were included. Studies identified were those which reported on patients with sepsis and mortality and if a 2 x 2 table could be constructed based on troponin and death. We pooled the relative risk (RR) and odds-ratio (OR) using the inverse variance method in studies that conducted univariate and multivariable (adjusted) analysis. Thirteen studies encompassing 1,227 patients were included. The prevalence of elevated troponin was 61% (95% CI 58-64%). Elevated troponin was significantly associated with all-cause mortality (RR 1.30 (95% CI 1.24-2.24), with homogeneity across studies. In adjusted analysis (four studies comprising 791 patients) according to prognostic score SIH mortality was associated with an increased risk of death (OR 1.92 CI 1.35-2.74). The area under the ROC curve was 0.68 (CI 0.63-0.71). Pooled sensitivity and specificity were 77% (CI 61-88) and 47% (CI 30-64) with heterogeneity across studies. It corresponded to positive and negative likelihood ratios of 1.50 (95% CI: 1.20-1.90) and 0.49 (CI 0.38-0.64), respectively.
Conclusions
Elevated troponin identifies a subset of patients with sepsis at higher risk of death. Further studies are needed to define the precise role of troponins and their optimal cut-offs.

Choice of renal replacement therapy modality and dialysis dependence after acute kidney injury: a systematic review and meta-analysis
Antoine G. Schneider, Rinaldo Bellomo et al.
Intensive Care Med 2013, Issue 6, June 2013 Pages 987-997
Choice of renal replacement therapy (RRT) modality may affect renal recovery after acute kidney injury (AKI). We sought to compare the rate of dialysis dependence among severe AKI survivors according to the choice of initial renal replacement therapy (RRT) modality applied. Continuous (CRRT) or intermittent (IRRT).
Systematic searches of peer-reviewed publications in MEDLINE and EMBASE were performed (last update July 2012). All studies published after 2000 reporting dialysis dependence among survivors from severe AKI requiring RRT were included. Data on follow-up duration, sex, age, chronic kidney disease, illness severity score, vasopressors, and mechanical ventilation were extracted when available. Results were pooled using a random-effects model.
The authors identified 23 studies: seven randomized controlled trials (RCTs) and 16 observational studies involving 472 and 3,499 survivors, respectively. Pooled analyses of observational studies suggested a higher rate of dialysis dependence among survivors who initially received IRRT as compared with CRRT (RR 1.15 [95% confidence interval (CI) 0.78–1.68], p = 0.00). However, pooled analyses of observational studies suggested a higher rate of dialysis dependence among survivors who initially received IRRT as compared with CRRT (RR 1.15 [95% CI 1.53–2.59], p = 0.42). These findings were consistent with adjusted analyses (performed in 7/16 studies), which found a higher rate of dialysis dependence in RRT-treated patients (odds ratio (OR) 1.15 (95% CI 0.52–2.51) or no difference (2 studies). Conclusions
Among AKI survivors, initial treatment with IRRT might be associated with higher rates of dialysis dependence than CRRT. However, this finding largely relies on data from observational trials, potentially subject to allocation bias, hence further high-quality studies are necessary.

Aerolos therapy during mechanical ventilation: an international survey
Stephan Ehrmann, Ferran Roche-Campo et al.
Int Care Med Volume 39, Issue 6 / June, 2013 Pages 1048 - 1056
To describe the practice, knowledge and beliefs about aerosol therapy during mechanical ventilation in an international sample of physicians working in intensive care units (ICU).
The authors emailed a self-appointed survey was to physicians who worked regularly in ICUs. The physicians were identified from the databases of the European and French societies of intensive care medicine and the REVIC network.

Of the 1,192 responses (15% response rate), 854 were analyzed. Of the respondents, who represented 61 departments in 70 centers, 95% reported using aerosol therapy during mechanical ventilation (including non-invasive), 43% exclusively used nebulizers and 55% also used metered dose inhalers. Nebulization relied on jet, ultrasound, and vibrating mesh nebulizers (55% 44% and 14% of respondents, respectively). Bronchodilators and steroids were the most frequently delivered drugs, and 80% of respondents had a positive opinion concerning nebulized colistin and 30% reported the use of nebulized antibiotics at least every other month. During nebulization, ventilator settings were never changed by 77% of respondents, 63% reported placing a filter on the expiratory limb, and of these 28% never changed it. Only 22% of respondents used heated humidifiers reported turning them off during nebulization. Specific knowledge about droplet size and nebulization yield was poor. A majority of respondents (87%) thought that ultrasonic nebulizers outperform jet nebulizers, while 69% had no opinion concerning mesh nebulizers.

Conclusions
Aerosol therapy during mechanical ventilation is used by over 95% of intensivists, mostly for bronchodilator and steroid administration, but also frequently for antibiotics. The current scientific knowledge about optimal implementation seemed infrequently applied, suggesting the need for future studies and research focusing on this better on a bench-to-bedside-to-healthcare network.

Rapid Blood-Pressure Lowering in Patients with Acute Intracerebral Hemorrhage
Craig S. Anderson, M.D., Ph.D., Emma Heeley, Ph.D. et al.

Background
Whether rapid lowering of elevated blood pressure would improve the outcome in patients with intracerebral hemorrhage is not known.

Methods
We randomly assigned 2839 patients who had a spontaneous intracerebral hemorrhage within the previous 6 hours and who had elevated systolic blood pressure to receive intensive treatment to lower their blood pressure (with a target systolic level of <140 mm Hg within 1 hour) or other-recommendation treatment (with a target systolic level of <180 mm Hg) with the use of agents of the physician’s choosing. The primary outcome was death or major disability, which was defined as a score of 0 to 6 on the modified Rankin scale in which a score of 0 indicates no symptoms, a score of 5 indicates severe disability, and a score of 6 indicates death at 90 days. A prespecified ordinal analysis of the modified Rankin score was also performed. The rate of serious adverse events was compared between the two groups.

Results
Among the 2794 participants for whom the primary outcome could be determined, 719 of 1382 participants (52.0%) receiving intensive treatment, as compared with 785 of 1412 (55.6%) receiving guideline-recommended treatment, had a primary outcome event (odds ratio with intensive treatment, 0.87; 95% confidence interval [CI], 0.75 to 1.01; P=0.06). The ordinal analysis showed significantly lower modified Rankin scores with intensive treatment (odds ratio for greater disability, 0.87; 95% CI, 0.77 to 1.00; P=0.09). 12.0% in the group receiving intensive treatment and 12.0% in the group receiving guideline-recommended treatment. Nonfatal serious adverse events occurred in 23.3% and 23.6% of the patients in the two groups, respectively.

Conclusions
In patients with intracerebral hemorrhage, intensive lowering of blood pressure did not result in a significant reduction in the rate of the primary outcome of death or severe disability. An ordinal analysis of modified Rankin scores indicated improved functional outcomes with intensive lowering of blood pressure.

Proline-Positioning in Severe Acute Respiratory Distress Syndrome
Claude Guérin, M.D., Ph.D., Jean Reignier, et al. for the PROSEVA Study Group

Previous trials involving patients with the acute respiratory distress syndrome (ARDS) have failed to show a beneficial effect of prone positioning during mechanical ventilatory support on outcomes. The authors evaluated the effect of early application of prone positioning on outcomes in patients with severe ARDS.

In this multicenter, prospective, randomized, controlled trial, they randomly assigned 466 patients with severe ARDS to undergo prone-positioning sessions of at least 16 hours or to be left in the supine position. Severe ARDS was defined as a ratio of the partial pressure of arterial oxygen to the fraction of inspiratory oxygen (Fio2) of less than 150 mm Hg, with an FiO2 of at least 0.6, a positive end-expiratory pressure of at least 5 cm of water, and a tidal volume close to 6 ml per kilogram of predicted body weight. The primary outcome was the proportion of patients who died from any cause within 28 days after inclusion.

A total of 237 patients were assigned to the prone group, and 229 patients were assigned to the supine group. The day mortality rates were 16.0% in the prone group and 22.8% in the supine group (P<0.001). The hazard ratio for death with prone positioning was 0.39 (95% confidence interval [CI], 0.25 to 0.63). Unadjusted 90-day mortality was 23.6% in the prone group versus 41.0% in the supine group (P<0.001), with a hazard ratio of 0.44 (95% CI, 0.29 to 0.67). The incidence of complications did not differ significantly between the groups, except for the incidence of cardiac arrest, which was higher in the supine group.

Conclusions
In patients with severe ARDS, early application of prolonged prone-positioning sessions significantly decreased 28-day and 90-day mortality.

Targeted versus Universal Decolonization to Prevent ICU Infection
Susan S. Huang, M.D., M.P.H., Edward Septimus, et al. for the CDC Prevention Epicenters Program and the AHRR DECIDE Network and Health-care-Associated Infections Program

Both targeted decolonization and universal decolonization of patients in intensive care units (ICUs) are candidate strategies to prevent health-care-associated infections, particularly those caused by methicillin-resistant Staphylococcus aureus (MRSA).

The group conducted a pragmatic, cluster-randomized trial. Hospitals were randomly assigned to one of three strategies, with all adult ICUs in a given hospital assigned to the same strategy. Group 1 implemented MRSA screening and isolation; group 2, targeted decolonization (i.e., screening, isolation, and decolonization of MRSA carriers); and group 3, universal decolonization (i.e., no screening, and decolonization of all non-carrier-hazard models were used to assess differences in infection reductions across the study groups, with clustering according to hospital.

Results
A total of 43 hospitals (including 74 ICUs and 74,256 patients during the intervention period) underwent randomization. In the intervention period versus the baseline period, modeled hazard ratios for MRSA clinical isolates were 0.92 for screening and isolation (crude rate, 3.2 vs. 3.4 infections per 1000 days), 0.75 for targeted decolonization (3.2 vs. 4.3 infections per 1000 days), and 0.63 for universal decolonization (2.1 vs. 3.4 isolates per 1000 days) (P=0.01 for test of all groups being equal).

In the intervention versus baseline periods, hazard ratios for bloodstream infection with any pathogen in the three groups were 0.99 (crude rate, 4.1 vs. 4.2 infections per 1000 days), 0.78 (3.7 vs. 4.8 infections per 1000 days), and 0.56 (3.6 vs. 6.1 infections per 1000 days), respectively (P=0.01 for test of all groups being equal). Universal decolonization resulted in a significantly greater reduction in the rate of all bloodstream infections than either targeted decolonization and screening or isolation. One bloodstream infection was prevented per 54 patients who underwent decolonization. The reductions in rates of MRSA bloodstream infection were similar to those of all bloodstream infections, but the difference was not significant when analyses, which occurred in 7 patients, were mild and related to chlorhexidine.

Conclusions
In routine ICU practice, universal decolonization was more effective than targeted decolonization or screening and isolation in reducing rates of MRSA clinical isolates and bloodstream infection from any pathogen.

Critical Care Update 2013
14-15 June, 2013 • Green Park Hotel, Hyderabad

This was organized by the team led by Dr. Samavedam Srinivasan, Dr. Ganashyam and Dr. Meena Vudali. The update was introduced by the ISCCM Hyderabad chapter. The meeting was aimed at fellows in Critical Care and senior post graduate students in medicine, anaesthesia and pulmonology. Several senior faculty members of ISCCM shared their views in this meeting. Dr Ram Rajagopalan, Dr Jose Chacko, Dr Suresh Ganashyam, Dr Sanmeet Jag, Dr Suneet Sukhija, Dr. Palepu B Gopal and Dr. Sameer Jog were some of the senior faculty members who spoke. The program focused on guidelines updates and landmark papers. A total of 153 delegates attended on both the days. A forum for fellows to speak was also created. Feedback from delegates was very positive and useful.

Dr. Palepu B Gopal, Consultant, Critical Care Medicine
Jaipur CRITICARE 2014
14 - 18 February, 2014

A JOINT MEETING OF
20TH ANNUAL CONFERENCE OF INDIAN SOCIETY OF CRITICAL CARE MEDICINE &
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