ISCCM News Headlines

ISCCM is growing at fast and healthy rate with > 4700 members, 40 branches, 61 IDCC centers and 16 FICC centers

Dynamic Dr. Rajesh Chawla takes over as New President of the Society

Criticare 2010 Hyderabad’s grand success - Great academic feast, thanks to Dr. Shyamsunder and Dr. P. Gopal

Dr. Subhash Todi delivers ISCCM oration

Dr. F. Udwadia and Dr. Manimala Rao honoured with Life time Achievement Awards

Dr. Pravin Amin delivers Past President Oration

Outgoing President Dr. Divatia decorates first recipients of FISCCM (Fellows of Indian Society of Critical Care Medicine)

Dr. Jigi Divatia awarded Jaipur oration on Critical Care Medicine

IJCCM indexed – kudos Dr. Shirish Prayag and Dr. Sandhya Talekar

Dr. Pravin Amin elected to World Federation of Intensive Care Societies with highest number of votes

Jaipur conference of Critical Care Medicine – a grand success

ISCCM website launched in its new shape and format

ISCCM elections round the corner

Delhi getting ready for Criticare 2011 "Chalo Dilli" – register now

Pune will host Criticare 2012.

ISCCM to observe 7th October (foundation day) as ISCCM day every year

Guidelines on planning and designing of ICUs in India put on ISCCM website

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Bldg. No.3, No.12, 5th Floor,
Navjivan Commercial Premises Co-op. Society Ltd.,
Dr. D. Bhadkamkar Road, Mumbai Central,
Mumbai 400 008.
Tel.: (022) 6526 8504 • Telefax: (022) 2305 4843

EDITORIAL OFFICE
Dr Narendra Rungta
Head, Critical Care, Rungta Hospital Jaipur
Phone: (R) 0141-2520171, 2522389 • (O) 01414039999
emails : drmrungta@gmail.com

General Secretary : Dr. Atul Kulkarni
kaivalyaak@yahoo.co.in
Dear Reader,

I take this opportunity to thank, all members of ISCCM for unanimously electing me the President-Elect of this esteemed organisation. This gives me the opportunity to be the editor of Critical Care Communications (CCC) – the official mouth piece of Indian Society of Critical Care Medicine.

I feel honored and privileged to present to you, the first edition of Critical Care Communications edited by my new team. Let me first congratulate Dr. Rajesh Chawla, the pioneer promoter of this bulletin for doing a wonderful job in promoting and establishing this bulletin to its present form inspite of lot of hurdles. Our immediate Past President Dr. J.V. Divatia also deserves mention for ensuring that the Bulletin continued to flourish under his guidance. It will be our endeavor to carry this mission forward and make it more fruitful and reader-attractive. Our first attempt will be to let our readers know more and more about ISCCM in every sector possible. This will include information of its esteemed members, its programmes, activities, education, research, leadership and about membership at large.

ISCCM is one of fastest growing Critical Care Societies in the world. We are in the process of developing closer associations with many international societies in terms of mutual co-operation, education and research and sharing of data. We have a MOU with SCCM, APIICCC and are members of World Federation of Intensive Care Societies.

We are trying to start a few columns in the bulletin as follows:

News Headlines, ISCCM and its branch activities. ISCCM in first years and now (a column to be authored by Past presidents), Journal scan / the recent advances, inputs from Pediatric wing, Nurses Corner, the new members directory, the Readers zone (reactions and letters) and many more. We wish to get contributions about activities of branches and groups from all members across the country. We will be pleased to publish maximum information that is made available to us. I am thankful to the editorial board our contributors and above all EC members for their co-operation.

Please do send us your feedback and critical appraisals to help us in improving the content and quality of the Bulletin and we promise to make it more productive.

Thanks

Dr. Narendra Rungta
Editor-in-Chief, Critical Care Communications

Report of the
General Secretary

It gives me great pleasure to write this report for the ISCCM newsletter; Critical Care Communications. Felicitations and welcome to all newly elected Executive Committee members and warm greetings to all old and new members of ISCCM. It's an honor and privilege to serve ISCCM in any capacity and I feel proud to start my term as general secretary.

The GBM at Hyderabad has allocated the next National Conference of the ISCCM to the Pune branch. ISCCM now has total 4793 Members of which 79 new members (Life Members and Associate Life Member) joined us after last EC meeting in Hyderabad. We have 40 city branches of ISCCM in India.

IDCC Examination 2010: 64 candidates appeared for the written examination during the Hyderabad conference of whom 52 passed. Of these, 48 candidates successfully passed the practical examination held at Bangalore and Pune and the list is now published on our website.

Dr. N. Ramakrishnan, our education co-ordinator has done a fantastic job as the results were declared within a week of examinations getting over. Following candidates have won the awards in the examinations. (1) Dr. Vijayalakshmi Kamat Award for IDCCM Topper: D’Souza Ramsy Thomas, Ruby Hall Clinic, Pune. (2) Anand Memorial Award for IDCCM: Mohankumar G, Christian Medical College, Vellore.

Research: The ISCCM is launching its first ambitious research project called “Indian Intensive Care Case Mix and Practice Patterns Study (INDICAPS)”. It is the first large scale, multicentre survey launched and sponsored by the Indian Society of Critical Care Medicine. The aim is to gather information about types and organization of ICUs, patients in ICUs, the types and severity of illnesses, monitoring and therapeutic modalities used, types of infections and other information. We have no authentic or national data and this is our attempt to generate such data.

Data will be collected on four days of next working year. The dates are: July 14 and October 13, 2010 and January 12 and April 13, 2011. Detailed information is available on the ISCCM website. If you have any queries please contact Dr. Divatia, Chairman ISCCM Research Group.
Dear All,

At the outset, let me once again thank all of you for electing me as the 9th President of the Indian Society of Critical Care Medicine (ISCCM).

The society has reached here because of the contributions and hard work of our previous leaders and all of you. I hope to get similar co-operation from all members and would endeavour to work hard along with all of you in the next two years to make this society an even stronger and more effective organization. I have set the following agenda for the 1st year of my tenure.

1. Indian College of Critical Care Medicine (ICCM): ISCCM is undertaking a plethora of educational activities. Its heartening to know that ISCCM has been a pioneer in assisting budding intensivists for the last many years. The Indian Diploma in Critical Care (iDCC) and the Indian Fellowship in Critical Care (iFCC) are sought after courses. To streamline the educational activities of ISCCM, it is proposed to start an Indian College of Critical Care Medicine. The discussion on this issue has already started and we hope to have the first convocation ceremony of the College in New Delhi in February 2011.

2. Electronic Elections: Since the inception of the society, we have been conducting the elections with ballot papers. It is however sad that not many members participate in this process, so much so, that only 370 members participated this year. A larger participation is not only desirable but also necessary to make the Office Bearers more representative. We therefore plan to make the election process electronic. The software is ready and will be tested during the next one year. After everyone’s satisfaction, the first electronic election will be conducted in 2011. With the ease of participation, I am sure there will be a much larger “turnout”. But to make this endeavour successful I need both, your support and participation. Please be a part of this historic change by helping our representative in updating our database.

3. Website: The ISCCM website has become very popular and is being visited by more and more people now. I propose to make the website more user-friendly and more interactive. In the near future we also plan to post more educational material such as lectures on important subjects on our website. The new website will be launched by end April 2010.

4. Constitution: The ISCCM constitution was written 17 years ago and with changing times a few amendments have been made. We propose to simplify the constitution and incorporate into it all new activities launched in the last few years. If the general body agrees to the amendments, this new constitution will be passed in the next general body meeting to be held in Delhi 2011.

5. Research: With the new Chairman of the Research Committee, Dr. J. V. Divatia taking over, research activities are going to be our prime focus this year. Two studies have been planned - Indian Intensive Care Case Mix and Practice Patterns Study (INDICAPS) and the MOSER study. Already, more than 250 ICU’s have registered for the INDICAP study. I hope that the first data entry will start as planned in July. If you have any ideas, ISCCM will facilitate you in your project.

6. Building: The Society has a small space of around 200 sq. ft. in south Mumbai. With so many activities being conducted the whole year round, the society needs larger space. So we propose to buy bigger space, somewhere near the airport. Dr. C. K. Jani and Dr. Atul Kulkarni are working on this project and we expect to complete it by the year end.

7. Publications: With the incessant efforts of Dr. Sandhya Talekar, IJCCM is now listed on PubMed. Dr. Shirish Prayag is the new editor and his commitment and enthusiasm will ensure that not only does the journal get a new look with more enriching content, but also be listed on other search engines. The Critical Care Communications will continue to be published bi-monthly with Dr. Narendra Rungta as its editor. We also propose to publish a book of protocols in the near future.

Friends! These are exciting times of both change and continuity. All our activities will remain incomplete without your new ideas, support and participation. We therefore request all members to please come forward and be a part of the growth of ISCCM!
Dear Colleagues & Friends

This is my last message to you as the general secretary of ISCCM.

It has been my pleasure and privilege to have worked with you all the last six years in this journey of being ISCCM's General Secretary. Over the years our organisation has expanded consistently with approximately 400 new members being added every year. Six years ago ISCCM had approximately 2000 members and today I am proud to say that our society has 4700 members. It is also heart warming to note that ISCCM now has international representation. This would not have been possible without your support, contribution and hard work.

Our society as you are aware has focused in the areas of certification, education and conferences in order to increase awareness and dialogue of critical care practices across the country.

Certificate courses of ISCCM have also become popular with 67 institutes accredited for conducting the same. Currently ISCCM is conducting two courses, Diploma and Fellowship. Every year approximately 100 students are registered for these courses. From this year onwards the society has introduced fellowship of ISCCM for senior consultants practicing critical care and to honor them for their contribution to critical care.

I am also pleased to inform you that the quality of our national conferences has improved with each passing. We are also planning for increased participation of the centre in the management of annual conferences including scientific programmes.

The critical care practice is like a double edged sword. There is a very narrow margin between benefit received and harm done. Anything excess is harmful like keeping the patient in ICU for longer time, giving excessive ionotropes and excessive antiarythemic drugs to name a few. It is therefore our responsibility to tread with caution while managing critically ill patients. Today critical care has become very expensive and it is therefore our responsibility to tread with caution while managing critically ill patients. Today critical care has become very expensive and it is therefore our responsibility to tread with caution while managing critically ill patients. Today critical care has become very expensive and it is therefore our responsibility to tread with caution while managing critically ill patients. Today critical care has become very expensive and it is therefore our responsibility to tread with caution while managing critically ill patients.

The role of ongoing research is also a very important factor. Last year we launched an online research module and today we have a unique ICU registry for undertaking any research. A total of 300 ICUs are registered with us, we also have a plan to conduct an original study to collect our own Indian data in coming years by INDICAP study. ISCCM has also participated in International Observational Studies and in the coming years we want to continue on our hi-tech journey.

Among our other significant achievements is centralization of our society's administrative activities. Today ISCCM has a fully functional head office with professional staff available to help our members at any time with issues about membership, certificate courses, conferences and programmes.

During the past 6 years we concentrated our efforts was to centralise all ISCCM affairs of Finance and to a certain extent we have been able to achieve the same.

We have used technology to help us in these new and ambitious endeavors. With the creative use of technology we have developed complete online membership applications, membership communications, journal, education, surveys and research material to name a few. We re-launched our website in 2007 when Dr. R.K. Mani was president. The transformation to become technologically oriented was a challenging task and I wish to thank all members for their continuous feedback to improve our website. Today our website is the primary means of communication with our members and other stakeholders. Management of all our IDCCM and fellowship courses, membership management, journal & newsletters are conducted online.

Of our various guidelines, the conference guideline has been revised by our President, Dr. Rajesh Chawla. The Guidelines for ICU Designing has been prepared by Dr. Narendra Rungta has team, while Quality Indicators in ICU are completed by Dr. Subhash Todi, Dr. Banambar Ray and their team. All these guidelines will be posted on our website shortly.

Our newsletter has completed five years of successful publication due to the sole efforts of our President Dr. Rajesh Chawla. Our journal is indexed in PUB Med due to the hard work and effort of Dr. Sandhya Talekar

I would like to thank all presidents, executive members and my colleagues for their help, support and motivation as without their support it would not have been possible to accomplish all of this.

I have tried my level best to contribute in the growth of ISCCM and in the process, have gained tremendous experience. I believe there are still more ambitious goals to be achieved. I am confident that the new President Dr. Rajesh Chawla and General Secretary Dr. Atul Kulkarni, President Elect Dr. Narendra Rungta, and their team will continue the progress with great success. ISCCM has achieved rapid growth in a short span of time and now it is the responsibility of all of us to sustain this growth in the present and for the future.

I wish ISCCM great success for its future.

Thank You

Dr. Charu Jani
Know your President

Dr. Rajesh Chawla
MD, FCCM, FCCP
European Diploma in Intensive Care (EDIC),
European Diploma in Adult Respiratory Medicine (EDARM)
drchawla@hotmail.com

PERSONAL

Present Titles
• Academic co-ordinator and Senior Consultant Department of Respiratory and Critical Care Medicine, Indraprastha Apollo Hospitals, Sarita Vihar, New Delhi – 76, India

EDUCATION
• MBBS, (1980) Maulana Azad Medical College, Delhi University New Delhi
• MD (Respiratory Medicine), Delhi University (1985)

Past
• Consultant, Respiratory and Critical Care Medicine, Batra Hospitals, New Delhi (Oct 1988 - Nov 1996)
• Recognized teacher for Diploma in Critical Care Medicine & Fellowship in Critical Care of Indian Society of Critical Care Medicine since 2002
• Certified instructor for:
  1. Advanced Cardiac Life Support (ACLS), USA
  2. Fundamental Critical Care Support Course (FCCS), USA
  3. Primary Trauma Course (PTC)

PROFESSIONAL SOCIETY MEMBERSHIPS

Active member of the following societies-

NATIONAL
1. Indian Society of Critical Care Medicine
2. National College of Chest Physicians
3. Indian College of Allergy and Applied Immunology
4. Association of Physicians of India
5. Indian Association of Clinical Medicine

INTERNATIONAL
1. Society of Critical Care Medicine (USA) since Nov. 2005
2. European Society of Intensive Care Medicine
3. American College of Chest Physicians

Organizational positions held in Indian Society of Critical Care Medicine (ISCCM)
• President 2010 onwards
• Vice President (2007).
• Secretary (2005-2007).
• Executive Member, ISCCM (2001-2005).
• Founder Editor, “The Critical Care Communications”, the official monthly bulletin of the society for the last 4 YEARS.
• Chairperson, Guidelines Committee on Non-invasive Ventilation in Acute Respiratory Failure 2006.
• Member, Guidelines Committee on limiting life-prolonging interventions and providing palliative care towards the end-of-life in Indian Intensive Care Units.
• Member, Guidelines Committee on Critical Care Delivery in Intensive Care Units in India: Defining the functions, roles and responsibilities of a Consultant role of the Intensivist.
• Founder Chairman, ISCCM, Delhi Chapter.
• Have been organizing Annual Critical Care Conference of ISCCM Delhi Chapter, Delhi Critical Symposium, for the last 8 years.
• Organizing Secretary, 1st International Critical Care Congress and 8th Annual National Conference of Indian Society of Critical Care Medicine held in Delhi in Feb 2002

Organizational positions held other than in Indian Society of Critical Care Medicine
• President, Delhi Medical Association (more than 20000 members) (1998)
• President, Lung Care Foundation (1992-2000)
• President, Delhi Chest Forum (1996-1999)
• Executive Counsellor, National College of Chest Physicians of India
• Joint. Secretary, Indian Association of Bronchoscopy (1999)
• President, Doctors Club (1988-1990)
• Executive Members, Medicos Club South Delhi 1994-1999
• Member, Steering Committee on Tuberculosis Research of Govt. of India (1999-2000)
• Member, Disciplinary Committee Delhi Medical Council (1999- 2000)
• Internal Medicine Section, Emergency Medicine Section and Respiratory Care section member of Society of Critical Care Medicine (SCCM)
• ARF section and Infection section member of European Society of Intensive Care Medicine (ESICM)

EDITORIAL AND REVIEW ACTIVITIES

Editorial Activities
• The Critical Care Communications (A bi-monthly news bulletin of Indian Society of Critical Care Medicine)
• Editorial Advisor for Indian edition of “Critical Care Medicine” (the official journal of SCCM)

Peer Review Experience
• Reviewer for –
  Indian Journal of Critical Care Medicine
  Intensive Care Medicine

HONORS
• Fellow of American College of Critical Care Medicine (FCCM)
• Fellow of American College of Chest Physicians, USA (FCCP)
• Fellow of National College of Chest Physicians of India
• Fellow of National College of Allergy and Allied Immunology of India

BOOKS
**THE CRITICAL CARE COMMUNICATIONS**
**A Bi-Monthly Newsletter of Indian Society of Critical Care Medicine**

### NATIONAL EXECUTIVE COMMITTEE MEMBERS

**2009-2010**

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<tr>
<th>Position</th>
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<tr>
<td>President</td>
<td>Dr. Rajesh Chawla</td>
<td>New Delhi</td>
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<td>Past President</td>
<td>Dr. J.V. Divatia</td>
<td>Mumbai</td>
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<td>President Elect</td>
<td>Dr. Narendra Rungta</td>
<td>Jalpur</td>
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<td>Vice Presidents</td>
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<td>Dr. Prasad Rajhans</td>
<td>Pune</td>
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<td>Dr. Shivakumar Iyer</td>
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<td>Dr. C. K. Jani</td>
<td>Mumbai</td>
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<td>Dr. N. Ramkrishnan</td>
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<td>General Secretary</td>
<td>Dr. Atul Kulkarni</td>
<td>Mumbai</td>
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<td>Secretary</td>
<td>Dr. Manish Munjal</td>
<td>Jalpur</td>
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<td>Joint Secretary</td>
<td>Dr. Suninder S. Arora</td>
<td>New Delhi</td>
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<td>Chairperson Pediatric</td>
<td>Dr. Krishan Chugh</td>
<td>New Delhi</td>
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<td>Treasurer</td>
<td>Dr. Sheila Nainan Myatra</td>
<td>Mumbai</td>
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<td>Dr. Pradip Bhattacharyya</td>
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<td>Dr. Prakash Shastri</td>
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<td>Dr. Palepu Gopal</td>
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<td>Dr. Yatin Mehta</td>
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<td>Dr. T. Shyam Sunder</td>
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<td>Dr. G. C. Khilnani</td>
<td>New Delhi</td>
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<td>Dr. Dhruva Chaudhry</td>
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### ZONAL MEMBERS

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<tr>
<td>North</td>
<td>Dr. Y. P. Singh</td>
<td>Meerut</td>
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<td>Dr. Vijaya Patil</td>
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<td>Dr. Prakash Shastri</td>
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<td>Dr. S. Chandrasekaran</td>
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### CO-OPTED MEMBERS

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<tbody>
<tr>
<td>Editor IJCCM</td>
<td>Dr. Shirish Prayag</td>
<td>Pune</td>
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<tr>
<td>Organising Secretary XVI</td>
<td>Dr. B. N. Palepu Gopal</td>
<td>Hyderabad</td>
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<td>National Conference 2010</td>
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<tr>
<td>Organizing Secretary XVII</td>
<td>Dr. Deepak Govil</td>
<td>New Delhi</td>
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<td>National Conference 2011</td>
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<tr>
<td>Chairperson Clinical Research</td>
<td>Dr. J.V. Divatia</td>
<td>Mumbai</td>
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The ISCCM was started in 1993 when a small group of like-minded people met at a hotel in Mumbai (earlier called as Bombay) and decided to organize themselves to further the field of Intensive Care in the city. With some bravado, they decided to initiate a National Society and choose to call themselves the Indian Society of Critical Care Medicine. Initial administrative activity included the formation of an Executive Committee and a constitution, and academic activity was limited to clinical meetings in Bombay and Pune only.

The first major undertaking was holding the First National Conference in Critical Care at the modern conference centre at the Tata Memorial Cancer Hospital. The massive response in terms of registrations was unexpected and gratifying. Equally encouraging was the enthusiastic participation of delegates. A second hall had to be opened for video projections and later, further video projections were set up in the lobby to accommodate those who wanted to hear the talks but could not find place in either of the halls. Spot registrations were accepted with the understanding that they could only attend the talks as the catering services had reached their limit. The first oration by Dr. F. E. Udwadia, on fulminant tropical illness in ICU set a very high standard for the rest of the conference, and laid out the road map for what could be achieved in terms of good outcomes in Indian ICUs. International faculty noted that they had rarely if ever seen such enthusiastic participation in a conference and in the valedictory session. Our major sponsor stated that this was the most successful conference he had ever sponsored in terms of large numbers of people in the lecture halls and almost complete absence of people attending the conference but not the lectures.

This immensely successful conference laid the foundation for the growth of the ISCCM which soon included the previously active Pune group as the first of its many branches, the annual conference, the journal, and most gratifyingly the creation of a formal structured training program in Critical Care. There was little or no prior national precedent for such a program outside the umbrella of a University or the National Boards. Despite this, the program has grown from strength to strength in terms of numbers and scope and it was years later that it was followed as an example by similar programmes from the National Board and some select universities.
Date: 19.03.2010

The Society of Critical Care Medicine, Kolhapur Branch successfully organized “CRITICARE UPDATE 2010 & WORKSHOP ON BASIC MECHANICAL VENTILATION” on 14th March 2010 at Dr. D.Y. Patil Medical College, Kolhapur. The oration faculty included eminent persons from the Medical Fraternity such as Dr. Shirish Prayag, Dr. Amit Maydeo and Dr. Sameer Jog. Lecture topics included –

1. Sepsis 2010 and Beyond by Dr. Shirish Prayag
2. Acute Pancreatitis Controversies and Pit Falls by Dr. Amit Maydeo.
3. Haemodynamic Monitoring by Dr. Sameer Jog.

Hon. MLA from Kolhapur Mr. Satej Patil and Prof. Dr. S.N. Pawar, Vice Chancellor, Dr. D.Y. Patil University were present as Chief Guests.

About 225 critical care specialists from western Maharashtra benefitted from the CME. A special oration award was presented to Dr. Shirish Prayag for his immense contribution to the field of Critical Care Medicine.

A workshop on Basic Mechanical Ventilation was conducted for which Dr. Kapil Jirpe, Ruby Hall Clinic, Pune was the Scientific Advisor. The faculty members included Dr. Mohan Potdar, Dr. Ajit Kulkarni, Dr. Pralhad Kelavkar, Dr. (Mrs.) Krishna Kelavkar, Dr. Niranjn Rathod, Dr. Sayi Prasad and Dr. S. L. Kulkarni.

The workshop was conducted in 4 stations with demonstration and hands on training on –
1. Initiation & Modes of Mechanical Ventilation.
3. NIV & Weaning from Mechanical Ventilation.

The response to the workshop was overwhelming. About 120 doctors of various faculties practicing Critical Care Medicine attended this workshop.

Dr. Sayi Prasad
Honorary Secretary, ISCCM

FCCS course group Ludhiana. This Course was held at DMC Ludhiana on 20th and 21st March under the banner of ISCCM.
Jaipur Conference 2010 was sixth in the series of conference organized by Jaipur Chapter of the Indian Society of Critical Care Medicine. The main conference was held at Hotel Clarks Amer, J.L.N. Marg, Jaipur on 10-11 April, 2010. Pre-conference courses and workshops were also organized on 9-10 April, 2010.

The conference brought over 200 specialists comprising of Intensivists, Anaesthetists, Pediatricians, Physicians, Surgeons and PG students from all over the country along with 60 Nurses from a wide range of disciplines.

The conference offered a good blend of plenary sessions, workshops and panel discussions. It also provided a platform for sharing views, research findings and expertise on a wide variety in the field of Critical Care Medicine.

Jaipur Oration was delivered by Dr. J.V. Divatia, Past President Indian Society of Critical Care Medicine. The topic of his talk was “Haemodynamic Monitoring”.

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

a. Fundamental Critical Care Support (FCCS) Course – FCCS
   This course was prepared under the auspices of the Society of Critical Care Medicine, USA. The Course is a standardized two-day course providing Critical Care information to Non-Critical Care specialists. The course consists of standardized lectures referenced to syllabus material plus interactive skill stations. Individuals who successfully complete the required provider will receive a certificate of successful completion.
   i. FCCS Instructor Course – 5 candidates participated in the Course.
   ii. FCCS Provider Course – 40 candidates participated in the Course.

b. Mechanical Ventilation Workshop – 26 candidates participated in the workshop.

c. Workshop in Critical Care Medicine for Nurses – 60 candidates participated in this workshop from various parts of the country including Rohtak, Meerut, Vapi, Jodhpur, Bikaner, Kota, Alwar and Ajmer. Dr. Prakash Shastri of New Delhi was the Workshop Director.

Following were the resource persons for this conference -

- Dr. Anupam Sharma
- Dr. Atul Kulrani
- Dr. G.C. Khilnani
- Dr. Shirish Prayag
- Dr. Prakash Shastri
- Dr. Kundan Mittal
- Dr. Narendra Rungta
- Dr. Pradeep Bhatia
- Dr. Rajiv Lochan Tiwari
- Dr. Deepak Yaduvanshi
- Dr. Sudhir Khunteta
- Dr. Suresh Bhargava
- Dr. Neena Rungta

All the participants were fully satisfied with the academic session and enjoyed other activities a lot.

Dr. Manish Munjal
Secretary, ISCCM • Organising Secretary, Jaipur Conference
drmmunjal@hotmail.com

Jaipur Branch activity - Jaipur Conference - a grand success

Critical care must reach rural areas, says Rungta

The objective is to provide forum for sharing knowledge in the field of critical care. Critical Care Medicine and Pre-Conference Workshops at Jaipur from Fiving to Saturday. "The objective of the national conference on critical care is to provide a forum for the sharing and dissemination of knowledge acquired in the field of critical care at the national and international levels."

The main aim can be achieved by holding sessions covering the various areas of critical care by the team of experts from across the country. The sessions will be facilitated by Dr. J.V. Divatia, former President, Indian Society of Critical Care Medicine, who added: "More than 100 critical care specialists participated in the sessions. They include intensivists, anaesthetists, pediatricians, nephrologists and postgraduate medical students from across the country."

‘Train doctors at grassroots level in critical care’

Experts say proper treatment at first referral point is crucial for survival.
Highlights from International Symposium on Intensive Care and Emergency Medicine, Brussels, March 2010

Prof. Vincent in his opening remarks highlighted the lessons learnt from past, such as the realization that for many interventions, like fluids, transfusions and sedation, less may often be better.

Dr. Didier Payen suggested in the session on controversies that outcome from sepsis was pre-determined by innate and acquired factors which cannot be changed. He also suggested that this may in part explain why some studies show improvements in morbidity outcomes but not in mortality. Moreover, even when a patient survives the acute episode of septic shock, their mortality rate remains elevated for many months if not years.

Dr. John Marshall spoke about critical illness as an iatrogenic disorder. He noted that 100 years ago, critical illness did not exist as patients either died or recovered rapidly with no treatment. With advances in mechanical support systems, patients started to survive previously unsurvivable conditions and “critical illness” was born along with a new range of iatrogenic diseases, including ARDS, septic shock and multiple organ failure.

He also stressed the role of the doctor in shaping disease phenotype as all therapies can be detrimental if used inappropriately.

Dr. Paul Pepe encouraged the use of estrogens in ICU. He elaborated on studies demonstrating that premenopausal women have better outcomes after cardiac arrest and that patients with better neurological outcomes after traumatic brain injury have higher CSF estradiol levels and discussed some animal studies using estrogens in stroke.

Dr. Michael Niederman chose the difficult topic of futile care in the elderly, starting by highlighting international differences in our approach to the elderly ICU patients. He then suggested that better scoring systems are needed to define futility and that physicians need to be better trained to evaluate the potential effects of continuing futile care not only on the patient in question but on the wider community.

Dr. Marco Ranieri proposed that improved strategies for preventing the development of acute respiratory failure, including stem cell techniques, and new extracorporeal strategies to remove CO2 which would reduce the need for invasive mechanical ventilation.

In a session on procalcitonin guided VAP therapy, the role of this biomarker to shorten the duration of antibiotic therapy was discussed. A recent multicenter randomized controlled study suggested a role for procalcitonin to guide antibiotic therapy in patients with VAP. In the study, 101 patients with clinically diagnosed VAP were randomized after 72 hours of antibiotic therapy, to have their antibiotic therapy discontinued according to guidelines or to absolute or changes in serum procalcitonin concentrations which were measured from days 2-10. Patients in whom antibiotics were stopped according to procalcitonin levels had a significant 27% increase in the number of antibiotic-free days alive compared to the guideline-group.

The number of mechanical ventilation-free days alive, intensive care unit-free days alive, length of hospital stay and mortality rate on day 28 for the two groups were similar.

Alkaline Phosphatase: A New Treatment for Sepsis induced Kidney Failure?

Dr Peter Pickkers presented the results of a phase II double-blind, randomized, placebo-controlled study on the safety and efficacy of alkaline phosphatase as a treatment in patients with sepsis-related acute kidney injury. 36 adult patients with sepsis and acute renal failure were included in the study; 16 were randomized to receive intravenous bovine alkaline phosphatase for 48 hours and 19 received placebo. The results demonstrated that treatment with alkaline phosphatase was associated with faster improvement and normalization of creatinine clearance, and effect that was sustained over the study period, and reduced need for dialysis or shorter duration of dialysis when needed.

Although the exact mechanisms of action are unclear, Dr. Pickkers mentioned several possibilities including the ability of this endogenous enzyme to detoxify lipopolysaccharide. In addition, although no studies have evaluated the effects of this on outcomes, renal alkaline phosphatase levels decreased in patients with sepsis, making it possible that simple restoration to normal levels may be in part responsible for its beneficial effects.

RCT: Friend or Foe?

Dr. Michael Matthay and Prof Jean-Louis Vincent presented opposing views on the role the RCT has played in transforming critical care medicine. Both speakers agreed that the majority of RCTs in intensive medicine have given neutral results and shown no outcome benefit of the intervention being tested. Dr. Matthay believed that these negative results had benefited the field by preventing useless interventions from being pursued and by demonstrating that our understanding of underlying mechanisms was incorrect thus stimulating research and leading the way to the discovery of new therapies. He also noted that many negative trials have led to major changes in clinical practice, citing the recent SOAP dopamine versus norepinephrine trial as an example of a negative trial which is likely to impact daily practice.

Prof Vincent, however, felt that negative randomized trials could result in an important concept being dismissed as useless, citing tight glucose control as an example. He discussed the possible reasons for the negative results, including issues of inadequate power and problems with study design. He also highlighted the problem of heterogeneity noting that it is not surprising to see a neutral result if all critically ill patients are randomized to an intervention, as it will inevitably result in benefit for some and harm in others. He concluded by emphasizing that not all interventions can or should be tested by randomized trial and that other study types should be used instead of randomized trials wherever possible.

Extracorporeal Gas Exchange to Replace Invasive Mechanical Ventilation?

Extracorporeal gas exchange refers to techniques that perform the gas exchange functions of the lung, thus potentially removing the need for invasive mechanical ventilation in patients with acute respiratory failure. Various techniques have been developed including extracorporeal membrane oxygenation and extracorporeal CO2 removal, generally used in combination with non-invasive mechanical ventilator techniques.

By avoiding tracheal intubation and mechanical ventilation, Dr. Antonio Pesenti suggested that these techniques could prevent the three ‘evils’ of mechanical ventilation: ventilator-associated pneumonia, ventilator-induced lung injury, and the heavy sedation often given to such patients. He presented some data supporting the feasibility of these techniques in patients with ARDS.

Dr. Nausherwan Burki then presented very preliminary data from a pilot study using extracorporeal CO2 removal in patients with hypercapnic respiratory failure due to acute exacerbation of COPD supporting its efficacy in these patients. The conclusions of this session were that extracorporeal gas exchange technology has undergone huge progress in the past 30 years, and holds huge promise for the future management of patients with acute respiratory failure.

Sepsis Biomarkers: Methodological Limitations

Sepsis can be difficult to diagnose, particularly in ICU patients who often have multiple ongoing disease processes and many of whom are already receiving antimicrobial therapy. Yet, rapid diagnosis is crucial so that appropriate therapy can be started at an early stage of disease when it is likely to bring maximum benefit. Multiple compounds have been proposed as biomarkers, including acute phase proteins, cytokine levels, and others.

However, as highlighted by Derek Angus in a session dedicated to sepsis biomarkers, there are many methodological problems that need to be considered when developing and using biomarkers. Although there are multiple biomarker candidates, most have undergone only rudimentary analysis. Most importantly, different biomarkers will have different uses in different situations, such as diagnosis, prognosis, therapeutic decision making and there is unlikely to be a single biomarker that works in all these situations. The purpose for which any biomarker is to be used therefore needs to be taken into consideration when assessing its value.
What is being “marked” also needs to be determined, for e.g., infection versus sepsis versus organ failure versus death, as does the target population. When biomarker data and clinical data seem discordant, the biomarker should not necessarily be discarded as of no use but the two aspects could be combined, as is currently being done in trials of cancer therapeutics. Finally, Dr. Angus stressed the importance of a theragnostic approach, as biomarker development is to evaluate any biomarker in terms of its likely clinical application and ability to change clinical practice for the better.

**CPR Guidelines:** What will change in 2010?

The International Liaison Committee on Resuscitation (ILCOR) is presently in the process of revising its guidelines on CPR, the last set of which were published in 2005. At an interactive Round Table session, five experts in the field of resuscitative medicine who are actively involved in this process spoke about the areas of controversy within this field. The panel started with the controversy related to hands-only CPR. The panel felt that hands-only CPR may be easier to apply, particularly for the layperson. Dr. Hirasawa noted that the importance of spinal stabilization should not be forgotten, and that while hands-only CPR may be adequate initially in a young patient with a cardiac etiology rapid response arrest, in other patients with hypoxic etiology or longer response times, it may not be appropriate. Teaching laypersons to distinguish between such patients would be difficult, and there were also concerns that if the hands-only approach was taught, rescue breathing techniques would rapidly be forgotten, and it would be a shame if new techniques were lost.

The panel then moved on to issues of intubation and while some felt indeed that endotracheal intubation could be delayed and other techniques used for airway management, others stressed again the importance of considering the individual patient and the skills and training of the attending personnel. All the panel members stressed the need to limit any interruption in chest compressions as much as possible. The need for debrillation was also discussed with an emphasis on careful timing and a more individualized approach. The question of when and how to use hypothermia was raised by the audience with the panel suggesting that this would be a one area where some flexibility could be incorporated into the new guidelines, but that all post-arrest centers should have facilities to offer hypothermia. Finally, the confusion between different algorithms for the pediatric and adult populations was raised with a suggestion that for simplicity and where possible these would be brought into alignment. Some important points made about these guidelines had not yet been finalized and data was still being reviewed and discussed, but that for many aspects the levels of evidence was still limited so that only low grade recommendations would be offered. In principle, the aim is to keep things as simple as possible and limit changes as much as possible.

**Extracorporeal Mediator Removal in Sepsis**

Sepsis is a complex condition involving the release and interaction of multiple mediators. Hypercytokinemia has been demonstrated to be correlated with blood lactate levels, HLA-DR expression, organ dysfunction, and outcomes. In contrast to many pharmacological strategies aiming to target specific cytokines, extracorporeal techniques can remove multiple chemical mediators, thus modifying the “hostile” environment in which the cells find themselves. Various techniques have been designed and differ in terms of permeability, convection, and adsorption properties. Dr. Hiroyuki Hirasa discussed the results from small studies demonstrating that continuous hemodiafiltration using a poly-lactic acid (PLA) poly-methymethacrylate membrane was associated with reduced pro-inflammatory cytokine levels, increased HLA-DR monocyte expression, improved mean arterial pressure, reduced vasopressor requirements and improved outcomes.

Dr. Claudio Ronco focused on a different technique specifically aimed at removing endotoxin with a polymyxin B filter. He cited the results of a meta-analysis in which this strategy had been shown to be associated with favorable results in terms of reducing endotoxin levels, increasing mean arterial pressure and improving outcomes. Because the studies were overall of poor quality, however, his group performed a randomized trial in which 64 patients with severe sepsis or septic shock due to abdominal infection were assigned to receive standard care or polymyxin B hemofiltration within 6 hours of their abdominal surgery. Patients in the hemofiltration group had greater mean arterial pressure, decreased vasopressor requirements, improved organ function, and possibly increased survival compared to the control group. However, this study had several limitations, including its unblinded nature and the fact that it was stopped early because of the decreased mortality, and Dr. Ronco stressed that these findings need confirmation in larger studies.

**Glucose Control in 2010**

The importance of variability in blood glucose levels rather than hyperglycemia per se was highlighted by several speakers. Dr. Dhilli Annane discussed the results of a recent randomized study showing that although corticosteroids are associated with increased blood glucose levels, intensive insulin therapy (to maintain blood glucose levels between 80 and 110 mg/dl) in these patients seemed to have no benefit over standard of care glucose control (blood glucose maintained according to the stable controlled guidelines).

Dr. Mauro Oddo then discussed the potentially detrimental effects of tight blood glucose control in patients with neurological injury and suggested that brain glucose monitoring with cerebral microdialysis may be useful in these patients. Dr. James Kinsley then tried to summarize how he felt we should be managing blood glucose today. He stressed the difficult nature of glucose control with resource intensive, complex protocols, and emphasized the need to assess the performance of the investigators when interpreting study data as the learning curve for this intervention may be an important factor. He concluded with the message that in 2010 we should be avoiding hypo and hyperglycemia and variability in blood glucose levels but that the exact protocols and blood glucose limits need to be determined according to the ability of each unit to achieve those targets according to the available staff, technology, and resources.

**Sedation Guidelines:** Where are We?

In a session on sedation, Dr. Michael Grounds started by reminding us that the word sedation comes from the Latin word “sedare” meaning to soothe, settle, calm, and not to put to sleep or make unconscious! Sedation is often needed in the ICU patient especially during mechanical ventilation, but also for relief of anxiety, fear or agitation, to assist with sleep, and to help limit discomfort during procedures. Dr. Grounds reminded us of the various nonpharmacological means of alleviating anxiety including good communication, control of environmental factors, and touch/massage. He commented briefly on short-term sedation, noting that here the choice of agent was largely down to individual preference. He then reviewed the various guidelines available for more prolonged sedation, noting that surprisingly few have been published. All the guidelines advice control of pain before sedation, and when sedation infusion is needed most recommended fentanyl, midazolam, or lorazepam. All recommend repeated reassessment of sedation, but this varies from daily to every three or four hours. Dr. Grounds suggested some factors he felt were important in developing new guidelines for sedation. He acknowledged that pain and anxiety are contraindicated to sedation, but for patients who have sustained a critical injury or who may have suffered cerebrovascular accident. He noted that it was important to be able to adjust sedative levels relatively rapidly and that drugs with short context-specific half-lives should be used, commenting that perhaps fentanyl and lorazepam were not ideal choices in this respect. Finally, Dr. Grounds stressed the need for sedation to be adapted to the individual patient and encouraged a more frequent, at least hourly, reassessment of sedation.

Reference: Newsletters distributed during ISICEM Congress.
ISCCM rolls out Intensivits for Future

**IFCCM Exam April 2010**
1. Dr. Kavita Kamineni
2. Dr. Mehul Shah
3. Dr. Shalini Nair
4. Dr. Vinoda Gonchikar

**IFCCM Exam May 2009**
1. Dr. Harshal Pravinchandra Thaker
2. Dr. Chavda Mitul Pushottam
3. Dr. Rajat Agrawal

**Indian Diploma in Critical Care Medicine (IDCCM) February 2009**
1. Dr. K. Gunavathy
2. Dr. R. Ebenezer
3. Dr. Kavita Kamineni
4. Dr. C. Ragunath
5. Dr. Saurabh Saigal
6. Dr. Keyur S. Acharya
7. Dr. Mathew Pulicken
8. Dr. Nagaraj Athal G.R.
9. Dr. Praveen Bajaj
10. Dr. R. S. Senthilkumar
11. Dr. Srilatha Dwaram
12. Dr. Suneel Kumar Garg
13. Dr. T. Mohan Sankarji Maharaj
14. Dr. Vijay Kumar Agrawal
15. Dr. Ashish K. Ganjare

**IDCCM Exam February / March 2010**
1. Dr. Amit Kumar Verma
2. Dr. Anamika Ganju
3. Dr. Anish M Joshi
4. Dr. Akhilesh Tandekar
5. Dr. Ashok Kumar Mogugesan
6. Dr. Ashish Kumar Gupta
7. Dr. Bhagyashri Bhurke
8. Dr. Bharat Agrawal
9. Dr. Bhagyesh Shah
10. Dr. Chakravarthi Alapati
11. Dr. Chanchalani Gunjan P.
12. Dr. Chetan C. Pande
13. Dr. D’Souza Ramsy Thomas
14. Dr. Deepandra Choudhari
15. Dr. Deepom Sharma
16. Dr. Himanshu Dewan
17. Dr. Jacob Mathews
18. Dr. Kiran Birari
19. Dr. Kuntal Gunvantal Shah
20. Dr. Milind D. Mane
21. Dr. Minal Jariwala
22. Dr. Mohan Kumar
23. Dr. Niraj Kumar Kalotia
24. Dr. Padmaja Badbade
25. Dr. Prasanth Ranjan
26. Dr. Pravin Gare
27. Dr. Rahul Amte
28. Dr. Rahul Tambade
29. Dr. Rajkumar Manna
30. Dr. Rajkumar Ghumare
31. Dr. Rakesh Bhasare
32. Dr. Ravendra Patil
33. Dr. Ruchira Khasne
34. Dr. Sachin Gupta
35. Dr. Saroj Kumar Patnaik
36. Dr. Shahnawaz Ahmed Siddiqui
37. Dr. Shantanu
38. Dr. Siddharta Verma
39. Dr. Sreevassanan
40. Dr. Sudarshan Reddy B
41. Dr. Sweta Patel
42. Dr. Vatsyapa Hresh Kumar Amarchibhi
43. Dr. Vijay Chandrappa Byranahalli
44. Dr. Vijay Kumar Channamchetty
45. Dr. Vikas Srivastava
46. Dr. Vinod Jaiswal
47. Dr. Virasheevee Vilas Shaha
48. Dr. Vishal Khanwalkar

**Indian Diploma in Critical Care Medicine (IDCCM) July 2009**
1. Dr. Archita Joshi
2. Dr. Bharat Jagiasi
3. Dr. Bhavik Shahi
4. Dr. Elizabeth C. Sada
5. Dr. Harish Chaffe
6. Dr. Kapil O Rathi
7. Dr. Nitin Tarale
8. Dr. Prashant Walse
9. Dr. Puneet Pulak
10. Dr. Ranjit Patil
11. Dr. Rishi Kumar
12. Dr. Sachin Suryakant Joshi
13. Dr. Supriya Patil
14. Dr. Sushma Gurav
15. Dr. Ashutosh Bhardwaj
16. Dr. Pradeep Reddy
17. Dr. Pradyut Bag
18. Dr. Ramanathan Moordhy
19. Dr. Ramanathan Ramkumar
20. Dr. Sanjeev Singla
21. Dr. Shubhakaran Sharma
22. Dr. Tushar Nemmanivar
23. Dr. Vikas Arora
24. Dr. Dinesh Makkar
25. Dr. Gijoe George Jacob
26. Dr. Jyoti Goyal
27. Dr. Kamaraj Parmar
28. Dr. Mohit Mathur
29. Dr. Naveen Manchal
30. Dr. V.S. Hemamala
31. Dr. Amit Madaan
Purpose of review: The aims of this paper are to examine the physiological rationale for noninvasive respiratory support (NRS) in children older than 1 month with acute respiratory failure, to review clinical available data and to give some practical recommendations for the safe application of NRS.

Recent findings: NRS is the delivery of ventilatory support without the need for an invasive airway. Two types of NRS are commonly used in the pediatric population: (1) noninvasive continuous positive airway pressure and (2) noninvasive positive pressure ventilation. In general, the evidence to support the use of NRS in children with acute respiratory failure is scarce. However, two randomized studies have been recently published suggesting that noninvasive positive pressure ventilation ameliorates clinical signs and gas exchange while reducing the need for endotracheal intubation. Moreover, noninvasive continuous positive airway pressure and heliox may improve clinical scores and carbon dioxide washout in infants with severe bronchiolitis, without major complications. Data from noncontrolled studies show that NRS unloads the respiratory muscles and that the helmet can be a valid alternative to a facial and/or nasal mask when noninvasive continuous positive airway pressure is administered to children in the early stage of acute respiratory failure.

Summary: Preliminary clinical data show that NRS is safe and effective in children with acute respiratory failure.

Predictors of failure of Noninvasive Ventilation in patients with severe community-acquired pneumonia

Michele Carrona, Ulderico Freoa, Manuel Pelosi, Paolo Pelosi

Journal of Critical Care, May, 11, 2010

The study aimed to investigate cardiorespiratory parameters potentially predictive of failure of Noninvasive Ventilation (NIV) in severe Community-Acquired Pneumonia (CAP).

Patients and Methods

64 consecutive patients with severe CAP entered the study and underwent NIV with a helmet. Arterial blood gases, PaO2/FiO2 and oxygenation index (OI; mean airway pressure × FiO2 × 100/PaO2) were determined before and after a one-hour trial of NIV.

Results

Noninvasive ventilation succeeded in 28 patients (43%) and failed in 36 patients (56%). Patients who avoided intubation had significantly (P < .05) shorter stays in ICU and lower rates of mortality in ICU and in hospital. Patients who failed NIV had higher Simplified Acute Physiology Score II at ICU admission (33 ± 11 versus 29 ± 9) and lower pH before NIV trial (7.37 versus 7.44). Furthermore, patients who required intubation failed to improve or worsened arterial blood gases during NIV trial and by the end of the trial, had lower (P < .05) pH (7.34 versus 7.44) and PaO2/FiO2 (177 versus 228) and higher OI (8.6 versus 5.0) and respiratory rate (28 versus 23 breaths/min). In a multivariate analysis, post-NIV to pre-NIV deltas of PaO2/FiO2 and of OI were independent predictors of NIV failure, with OI delta being significantly more accurate.

Conclusions

Noninvasive ventilation failed in approximately half patients with severe CAP. Posttrial to pretrial deltas of PaO2/FiO2 and OI may help to guide decision about endotracheal intubation.

Prophylactic intravenous magnesium sulfate for treatment of Aneurysmal Subarachnoid Hemorrhage: A randomized, placebo-controlled, clinical study*

Westermoier, Thomas MD; Stetter, Christian MD; Vince, Giles H. MD, PhD; Pham, Mirko MD; Tejon, Jose Perez MD; Eriskat, Jörg MD; Kunze, Ekkehard MD; Matthies, Cordula MD, PhD; Ernestus, Ralfingo MD, PhD; Salymoni, Laszlo MD, PhD; Roosen, Klaus MD, PhD

Critical Care Medicine: May 2010 - Volume 38 - Issue 5 - pp 1284-1290

Objective: To examine whether the maintenance of elevated magnesium serum concentrations by intravenous administration of magnesium sulfate can reduce the occurrence of cerebral ischemic events after aneurysmal subarachnoid hemorrhage.

Design: Prospective, randomized, placebo-controlled study.

Setting: Neurosurgical Intensive Care Unit of a University hospital.

Interventions: I10 patients were randomized to receive intravenous magnesium sulfate or to serve as controls. Magnesium treatment was started with a bolus of 16 mmol, followed by continuous infusion of 8 mmol/hr. Serum concentrations were measured every 8 hrs, and infusion rates were adjusted to maintain target levels of 2.0–2.5 mmol/L. Intravenous administration was continued for 10 days or until signs of vasospasm had resolved. Thereafter, magnesium was administered orally and tapered over 12 days.

Measurements and Main Results: Delayed ischemic infarction (primary end point) was assessed by analyzing serial computed tomography scans. Transcranial Doppler sonography and digital subtraction angiography were used to detect vasospasm. Delayed ischemic neurologic deficit was determined by continuous detailed neurologic examinations; clinical outcome after 6 months was assessed using the Glasgow outcome scale. Good outcome was defined as Glasgow outcome scale score 4 and 5.

The incidence of delayed ischemic infarction was significantly lower in magnesium-treated patients (22% vs. 51%; p = .002); 34 of 54 magnesium patients and 27 of 53 control patients reached good outcome (p = .209). Delayed ischemic neurologic deficit was nonsignificantly reduced (9 of 54 vs. 15 of 53 patients; p = .149) and transcranial Doppler-detected angiographic vasospasm was significantly reduced in the magnesium group (36 of 54 vs. 45 of 53 patients; p = .028). Fewer patients with signs of vasospasm had delayed cerebral infarction.

Conclusion: These data indicate that high-dose intravenous magnesium can reduce cerebral ischemic events after aneurysmal subarachnoid hemorrhage by attenuating vasospasm and increasing the ischemic tolerance during critical hypoperfusion.

What are the current indications for noninvasive ventilation in children?

Calderini, Edoardo; Chiidini, Giovanna; Pelosi, Paolo

Current Opinion in Anaesthesiology: June 2010 - Volume 23 - Issue 3 - p 368–374

Dr. Deepak Govil
Dr. Sachin Gupta

Journal Scan

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

13
Disasters, their management and medical professionals have been closely associated for a very long time. Many path-breaking medical procedures, discoveries and protocols were born on the battlefields during wars, which are man-made disasters of the greatest level. Involvement of medical professionals in disaster management has benefited not only the victims but also enriched the science and its practitioners with valuable experience. Even in today's world of super-specializations and niche practice, medical professionals must be in the forefront when disaster strikes. But they should be adequately prepared for it.

World Health Day is celebrated each April 7 to mark the founding of the World Health Organization. In 2009, World Health Day’s theme was When Disasters Strike: Safe Hospitals Save Lives. It focuses on three important messages: (1) All health facilities must be able to withstand the physical impact of disasters; (2) Critical health services must continue to function in all emergency situations; and (3) The health workforce must be trained and ready (prepared) to deal with the particular challenges these situations impose.

Dr. Saurabh Kole
Kolkata
saurabh_kole@yahoo.com

this document, the criteria for high, moderate, and low probability are:

- **High Probability**: once a year
- **Moderate Probability**: once every two to ten years
- **Low Probability**: once every ten to fifty years

A **Medical disaster** occurs when the destructive effects of natural or man-made forces overwhelm the ability of a given area or community to meet the demand for health care

**Disaster preparedness**

Country or state specific details, like disaster proneness, previous history of disasters, geography and topography, distances between capital city and disaster-prone areas, national and local disaster response and management capacity, security, maps, existence of early warning and other alarm systems, existence of relief agencies and disaster capacity of sister agencies, as well as local customs and norms and other information about common and possible natural hazards can be obtained to form a plan.

The Humanitarian Early Warning Service website (www.HEWSweb.org) is a global one-stop shop for early warning information. It has dedicated pages for drought, floods, topical storms, locust infestation, El Nino, earthquakes and volcanic activity, including additional references and resources. The site, whose homepage displays a natural hazard map of the world with the various risks facing specific countries and regions, rationalizes and brings together under one platform the vast amount of information now available on the internet from multiple specialized institutions.

**Why Critical Care Society**

In common parlance, Critical Care implies addressing sudden acute health crisis by a range of Health Specialists. In disaster situations and particularly in terms of preparedness, Critical Care gives a feeling of emergency response rather than preparedness. But to respond in highly demanding situations, the response team must be clear in mind what their expected roles are and what they need to do given the situation. The element of 'preparedness' comes into play here. Unless a team of Critical Care Professionals are prepared how to face the horrible ground realities that may warrant imminent variety of medical and surgical actions with expectations often differing in realities, the outcome of interventions may not yield desired goals. In this perspective Disaster Preparedness is equally important for Critical Care professionals though slightly different from preparedness activities prescribed for professionals from other fields.

As a discipline, Critical Care personnel are used to rapid response, teamwork, working against odds, working round the clock and doing all these almost by reflex, thereby saving crucial time and preventing delay.

A huge variety of medical problems and complications can be encountered in a disaster-affected area. Not only that, a trivial illness or injury tends to a huge variety of medical problems and complications can be encountered in a disaster-affected area. Not only that, a trivial illness or injury tends to

**Perspectives in Disaster Management**

"A serious disruption of the functioning of the community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources" United Nations

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<th>Natural</th>
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<td>Earthquake, cyclone, floods, volcanic eruptions, wild fire, draught, tornado</td>
<td>War, biological warfare, chemical warfare, fire, nuclear hazards, gas and chemical poisoning</td>
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The boundary between natural and man-made disasters is often blurred. Hazards can range from an earthquake, which is of natural origin; to a landslide, which can be caused by a combination of deforestation, heavy rains and light earth tremors; to a chemical spill, which is man-made. Climate change is increasingly blurring the distinction between man-made and natural hazards. Although climatic hazard, such as droughts and floods, would occur regardless, global warming may increasingly accelerate these types of hazards.

**Hazard Identification and Vulnerability Assessment (HIVA)**

The first step toward a mitigation program is the identification of the hazards a community may face. Large, local hazards can be categorized as either natural or technological/man-made events. While the local climate changes rather slowly, our man-made environment can change rapidly, especially in terms of the local economic base.

Hazards are assessed comparing the experienced frequency of the event versus the potential impact that may result.

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Planning begins with events that are expected to occur often and have potentially high impacts on life and property, followed by those with more moderate probabilities or moderate impacts. Jurisdictional strategies are dependant on the philosophy and experiences of local officials. Largely, the priorities addressed in HIVA-years one through five are a reflection of this assessment and local philosophical priorities. For the purpose of rendering service in disaster situations. The entire health system in Bhuj,
Gujarat, collapsed after a massive earthquake. A team of 10 doctors and Paramedics (Ten) from Kolkata visited the ravaged area after about a week of the incident. The experiences varied from multifarious fractures inflicted by the earthquake to delivery of a newborn in makeshift medical camp. A doctor of local hospital was admitted in that camp following an acute myocardial infarction and treated by the Critical Care team within limitations of infrastructure and subsequently cured to possible extent. A Disaster Management Committee was formed by the Critical Care Society following the Gujarat experience. The objective was to provide limited but prompt and critical medical support to local institutions in the wake of events with high degree of severity and damage. Following the devastating tsunami incident in 2004, the Tsunami Critical Care Society provided service to the community by its committed presence at Nagapattinum and Kadalur situated in coastal Tamil Nadu which was worst hit by the event and also in Port Blair, Andaman and Nicobar Island.

A mother running to escape tsunami waves in Andaman Islands in 2004 December with four children and gradually losing all of them finally, received a fracture in neck femur with multiple injuries by being smashed against a tree by lashing waves and had to be treated by the Critical Care Unit as a traumatized patient. The priority in this case varied from trauma counseling to fixing her broken leg along with prevention of infection and sepsis.

Gaining valuable experience in Gujarat, we from Indian Society of Critical Care Medicine thought of spreading our initiatives in other countries as well. In the recent experience of Bangladesh Cyclone (Sidr) and Myanmar cyclone (Nargis), with the help of Rotary Club Dist. 3290 Critical Care Society worked as support unit in two hospitals, one at Sarankhola of Bangladesh (most affected area) and the other at Dala of Myanmar.

A relief team was sent to the affected areas of Bangladesh consisting of doctors of different disciplines, logisticians, technicians and para medics. The target area was Sarankhola in the District Bagerhat at the bank of Dholeswari. The cyclone massacred not only human lives but also property and the animal husbandry. The worst affected area was the core of Sunderban, causing massive loss in ecology and wildlife. The journey itself showed the massive devastation, which were scattered beside the roads leading towards Sarankhola. More than 1000 patients visited the medical camp, most of who were mainly suffering from high fever, gastroenteritis and orthopedic trauma.

A medical team was sent to Myanmar on August 2008 when the Government of Myanmar decided to open up the doors to the foreign aid teams to the areas affected by the Cyclone Nargis. Our team was allotted Dale, a village that was affected by the cyclone at the bank of Yangon River. The team organized a five full day medical camp in the PHC of Dale. Where more than 1500 patients visited the camp.

Since our first experience of offering medical care to disaster victims in 2001, we from the Society have realized and expressed that Disaster Management should be an integral part of critical care. Our relentless service, research and toil were recognized in 2009, when I was invited to present our views and present a talk on “Guidelines and Perspectives of Disaster Management at the World Critical Care Conference in Florence, Italy 2009” as “Invited Speaker”.

“In disasters, hospitals should not be allowed to become victims too,” said PAHO (Pan American Health Organization) Director Dr. Mirta Roses. “The cost is lower than what one might expect and far less than the price paid when health facilities fail at the time when people need them most.”

In Geneva recently, the World Health Organization (WHO) called on its member countries to undertake six core actions to make their health facilities safe during emergencies:

1. Assess the safety of hospitals
2. Protect and train health workers for emergencies
3. Plan for emergency response
4. Design and build resilient hospitals
5. Adopt national policies and programmes for safe hospitals
6. Protect equipment, medicines, and supplies.

Need of the hour

I suggest that critical care societies from each region have a Rapid Response Team and protocol ready. A makeshift hospital with equipment and facilities to provide adequate service should be planned and be ready on demand. Proper education for doctors and health-workers to tackle disasters most effectively must be an essential and on-going feature of our society.

Conclusion

Once you choose hope, anything’s possible. It’s this message that rang out, loud and clear, from the rubble of earthquake to the devastation caused by the Tsunami.

Critical Care Experts, in different parts of the world, have played a crucial part in responding to the health emergencies arising out of disasters. A network among such societies would also help to co-ordinate the activities and exchange of experts in different fields on the basis of felt needs. The system can be institutionalized and gradually built to rise to the demands created during emergencies by providing proper medical care to the disaster victims. We need to accept that Critical Care is now on its move out of the secured zone of intensive care to broader horizons where scores of people are in need of medical attention following a disaster which could save their lives and limbs. Let us organize ourselves with determination to stand by the people who are in distress and look up to us with utmost expectations.

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Team of Disaster Management Committee: Dr. Sumit Poddar, Dr. Bimal Roy, Dr. Jyotsna Paranjape, Dr. M. M. Roy, Dr. Asitendu Dutta, Dr. K. Saha, Dr. Amit Roy, Dr. Debasis Sarbadhikari, Dr. Saurabh Kole, Mr. Goutam Roy, Mr. Joy Roy Chowdhury, Mrs. Dipali Poddar, M. Kasim, Ms. Anndhi Sha, Mr. Kaustuv Chatterjee, Dr. Gautam Saha and Many Others.
Welcome To Delhi

The Scientific Committee is planning an exciting and varied scientific program that will include plenary and thematic sessions, presentation of research papers, workshops and Meet the Expert sessions. The program is currently evolving through collaboration between local and international experts and is expected to be very creative. The content will be international in scope with a blend of national, regional and international speakers recognized for achievements in their respective fields. We are confident that the 2011 Critical Care Congress will provide a rich educational forum with multiple programs, special events and activities for all of you that will enhance your practice of Critical Care.

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Criticare 2011 Secretariat
Room No 4162, 1st Floor, General OPD, Gate no.10, Indraprastha Apollo Hospital, Sarita Vihar, Delhi - Mathura Road, New Delhi - 110076, India.
Ph: +91 11 26925858, 26925801 Ext. 4162, Telefax: +91 11 26825586
E-Mail: congress@criticare2011.org, info@criticare2011.org