ISCCM News Headlines

- Online electronic elections of ISCCM conducted successfully - the first Indian society of medical professionals to do so.
- New office of ISCCM in Dadar (Mumbai) becomes functional. Please use the new address for communication.
- ISCCM day will be celebrated on 8th October. Dr. Sunit Singhi and Dr. M Munjal doing their best to sensitize everyone to the importance of sepsis.
- ISCCM growth continues - more than 100 new members added during last quarter.
- Kanpur and Rajamundhry city branches come into existence. Congratulations!
- Conferences of regional branches drawing tremendous attention.
- 'Chalo Pune' - CRITICARE 2012 calling you to the cultural capital of Maharashtra.
- Update your email ID and mobile numbers now - don’t miss the ISCCM election bus next time. Join the voter bandgown of ISCCM.

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We request our esteemed readers to send their valued feedback, suggestions & views at drnrungta@gmail.com
The growth of the society in terms of membership, number of branches, education and research programmes, innovations and infrastructure creation has been remarkable during the last few years. Successful organization of online electronic elections of the ISCCM executive has been a satisfying exercise indeed. Reduction of backroom work stress, maximum utilisation of voting powers, lesser formal meetings and reduced expenditure in the future are a few net gains of the programme. I am sure future election commissioners will breathe easier. Also, this may pave way for other societies of medical specialities to adopt this modality of online elections and ISCCM can boast of being a pioneer in the field.

Moser study has been started. Congratulations to Dr Ramesh Venkatraman for having done the hard work and touching every investigator and monitoring the progress of the programme. That speaks about the bench strength of the society. Indicas followed by back to back Moser study will generate greater interest among the members towards their participation in research programmes. This strength needs to be tapped for future growth and direction to the society. We are a democratic nation so well known for our ‘united living in diversity’. We need to exploit both this unity and diversity in terms of methods and approaches to the best results for our intensive care specialists.

We have lots of feed back of members from various parts of the country seeking to study and follow some programmes in which other societies have been pioneers. Mass indemnity insurance and welfare programmes for the members may be initiated. It will be great if members could send their views and ideas on such issues to the editor. Not only this, members should also feel free to convey their basic views about other programmes which they think the society should undertake in moving forward. This will establish a greater dialogue between members and the society leadership.

I take this opportunity to congratulate the organisers of the DCCS and Bhopal branch for successfully organising meetings and keeping the branch active and flag of ISCCM flying high. More branches and regions are now becoming active. This is reflected by the calendar events of various activities related to Critical Care and ISCCM across the country.

Let us encourage the organizers by maximum participation in such events. Last but not the least, ‘Chalo Pune’ is the call of this issue of The Critical Care Communications.

Thanks.

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

The Critical Care Communications
A Bi-Monthly Newsletter of Indian Society of Critical Care Medicine
Dear Friends,

First and foremost, I must thank all of you who have worked very hard to make the first e-elections of the Indian Society of Critical Care Medicine a great success. This historic change would not have been possible without your support. Please join me in congratulating and welcoming all those members who have been elected to be a part of the Executive Committee for the year 2012-2013. In spite of repeated reminders, many of you have still not updated your email addresses in the society database. Please do so now. You can download the form from the society website, isccm.org, and send it to the new official address in Dadar.

The new office of the society at Dadar was inaugurated on 7th August 2011. We have appointed an Executive Manager who will supervise all the activities of the office. Different people have been appointed to look after various activities of the society such as education, research and membership. The address of the new office has been mentioned at the end of the page.

The Indian College of Critical Care Medicine was launched at Vigyan Bhawan, New Delhi, after its constitution was approved in the AGM. The main aim of the college is to streamline the educational activities of the ISCCM and plan for its future.

The college will award the Fellowship of Indian College of Critical Care Medicine (FICCM). A physician who has been a member of the society for the last five years and fulfils the eligibility criteria can apply for this fellowship. His/her application will be scrutinized by the Credential Committee. The first convocation ceremony will be held during the annual conference in Pune. The application form is available on the website. All other details about the college have also been put up on the ISCCM website.

Last year the Executive Committee of the society decided to celebrate the ISCCM Foundation Day every year. Last year we celebrated this day for the first time and its theme was “Early CPR saves lives”. This year it has been decided to celebrate the ISCCM Foundation Day on 9th October 2011 all over India. The theme of the ISCCM Day this year is “War Against Sepsis”, sepsis being a leading cause of mortality and morbidity worldwide, more so in India. The foundation day activities will bring the focus on this disease among physicians and public at large. This activity is being coordinated by Dr Sunit Singh and Dr Manish Munjal. We plan to hold press conferences and organize webinar on sepsis. We are trying to organize interactive sessions, skill testing and lectures on the subject for general physicians. We are requesting all the branches of the ISCCM to organize similar IEC activities for physicians and media to bring the attention of the public towards sepsis. We also plan a quiz competition on this subject during that period. These and other details can be found on the website.

Your contribution to this campaign or towards other activities of the society is valuable to us. Please feel free to call or write to me. Together we can move faster and further.

From the Desk of the President

Dr. Rajesh Chawla
President, ISCCM
drchawla@hotmail.com

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Form for Change of Authorised Residential Address, Email ID and Mobile Number

To,
Indian Society of Critical Care Medicine

I would like to request you to change residential address / email / mobile number in ISCCM database.

ISCCM Membership Number : ________________________________

Name : ..............................................................................................................

Residential Address : ...........................................................................................

New Email Address : ...........................................................................................

New Mobile Number : ...........................................................................................

Signature : ...........................................................................................................

(Please note that any form without signature will not be accepted)

Please sign above and post a copy to:

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
Did you know?

- Tens of millions of people die from sepsis each year worldwide
- Sepsis cause more deaths per year than cancer and AIDS combined
- Sepsis may lead to multiple organ failure very rapidly and be fatal
- Early and appropriate medical treatment can improve outcome.
- “Time is Life” and awareness on early care during the ‘golden hour’ can save lives.

Delay in diagnosis and management is mainly responsible for high death rate of children and adults suffering from severe sepsis.

What is Sepsis

Sepsis is defined as the body’s response to an infection. An infection is caused by microorganisms or “germs” (usually bacteria) and can be limited to a particular body region (e.g., wound infection, throat infection) or generalized (e.g., typhoid fever and Malaria). The body response can be mild or overwhelming.

Who is at Risk?

Everybody is at potential risk of developing minor sepsis from infections (e.g., ‘flu, urinary tract infections, gastroenteritis, etc.). However, severe sepsis is more likely to develop in:
- Children and elderly.
- Those with poor immunity to genetic factors.
- Those who have a weakened (“Compromised”) immune systems due to diabetes, treatments such as cancer chemotherapy, steroids or after transplantation.
- Individuals addicted to alcohol, nicotine or other ‘drugs’.
- Hospitalized patients who have external catheters and drains.

What is the difference between “Community Acquired” and “Hospital Acquired” Infections?

The infection leading to sepsis can be acquired outside the hospital (known as “community-acquired”) or in the hospital (known as “hospital-acquired infections”). Hospital-acquired infections are generally more difficult to manage because:
- The bacteria causing infections may be drug resistant due to prior use of antibiotics.
- The patient is often already sick and has a lower immunity than when healthy.

Are There Many Forms Of Sepsis?

Sepsis occurs in three different forms of severity:
- Uncomplicated sepsis
- Severe sepsis
- Septic shock

The disease progresses in some people through all three stages or may directly present in severe form. Despite optimal (best or most favorable) care, some patients may not respond to treatment, and may develop multiple organ disease and eventually die.

Uncomplicated sepsis: such as that caused by “flu” and other viral infections, gastroenteritis, or dental abscesses, is very common and is experienced by millions. The majority may not need hospital treatment.

Severe sepsis: when sepsis occurs in combination with problems in one or more of the vital organs, such as the heart, kidneys, lungs, or liver. People with severe sepsis are likely to be very ill and 30-35% may even die despite best care.

Septic shock: when sepsis is complicated by low blood pressure that does not respond to standard treatment, it affects one or more vital organs and the body tissue does not receive enough oxygen. Septic shock patients are very ill and need rapid emergency admission to the hospital Intensive Care Unit (“ICU”). Despite best possible therapy, the death rate in this condition may be 50-60%.

How do we recognize Sepsis?

Sepsis patients generally have the following symptoms:
- Fever or low body temperature
- Difficulty with breathing or rapid breathing
- Warm / cold skin, sometimes associated with a skin rash
- Rapid heart beat
- General weakness

In addition patients with sepsis may have specific symptoms based on the site that is causing the sepsis (Ex: Headache in infections involving brain or its covering meninges, abdominal pain in appendicitis).

Signs of organ Dysfunction in Severe Sepsis and Septic Shock

- The respiratory system: Sepsis may lead to lung injury. Many patients require oxygen, some require insertion of tube into their windpipe and need support from breathing machines (“ventilator”).
- The kidney: The amount of urine can reduce and the kidneys may fail to excrete waste products, thereby necessitating dialysis temporarily.
- The blood flow and blood clotting: Patient may start bleeding from any site.
- The central nervous system: The patient may be disoriented, confused, or have decreased alertness.
- Liver function: Alterations in the liver may result in jaundice.
- Alteration in blood sugar may require insulin administration even in non-diabetic patients.

People with problems in more than one of their organs are said to have “multiple organ dysfunction or failure”.

How Is Sepsis Treated?

People with severe sepsis are very sick and typically require ICU treatment. The treatment of severe sepsis and septic shock includes:
- Large amount of fluids through the intravenous or IV catheter (“drip”) particularly when the blood pressure (BP) is very low. In addition sometimes drugs may be required to improve BP and heart function.
- Early & Appropriate Antibiotic therapy is essential to kill the infective bacteria. For severe infections, antibiotics must be administered directly into the vein (intravenously).
- Organ support, such as artificial ventilation for the lungs (“ventilators”), kidney support (“dialysis machine”) as appropriate.
- Eradication of source of infection (if identified) by a local procedure (drainage of pus collection) or surgery may be essential.

The process of identifying the source of the infection requires:
- Careful clinical examination.
- Procedures such as chest X-rays, Ultrasound and other imaging procedures (CT Scan/MRI).
- Collection of specimens from infected area (Ex: Wound swabs, urine) and also blood test (Culture). Of note, reports of cultures may take up to 5 days for final reporting since the bacteria grow over a period of time and treatment cannot be held for that purpose.

In addition to above medical experts may determine the appropriateness of additional therapies based on current knowledge.

Suggested Key messages in Individual Boxes

- Sepsis is the body’s life-threatening response to infection.
- Sepsis may lead to shock, multiple organ failure and death, especially if not recognized early and treated promptly.
- Sepsis remains the primary cause of death from infection despite advances in modern medicine.
- Recognize sepsis as a medical emergency which requires rapid administration of fluids, antibiotics and other appropriate treatments of infection within one hour of suspicion of sepsis. Recognize early and be vigilant. Delay in starting antibiotics increases the risk of poor outcome and death.
- Sepsis occurs more frequently in the young and the elderly, and in many hospitalized patients. In addition, anti-cancer medications and other drugs that reduce immunity frequently render patients susceptible to infection.
- As many as 50% of septic patients who would otherwise die might be saved if their condition is recognized early and treated with fluids and antibiotics within the first hour of detection.

ISCCM Foundation Day  -
Action Plan to improve awareness on Sepsis

Dr. Sunit Singh, MBBS, MD, FIAP, FAMS, FICCM, FCCM
Professor & Head, Dept. of Pediatrics, PGIMER, Chandigarh and Vice President, Indian Society of Critical Care Medicine
The ISCCM Foundation Day under the guidance and leadership of President Dr. Rajesh Chawla, has decided to declare war against Sepsis. The chosen theme “War Against Sepsis” is based on the society’s conviction that sepsis is one of the leading cause of death and an enormous public health problem worldwide, and more so in India where there are so few ICUs and intensivists. It should therefore be declared as a public health medical emergency.

The foundation day activities will be directed to bring to focus to the above facts and increase awareness of sepsis among healthcare professionals and policy makers as well as lay people and patients. Several activities are planned by the central office and suggestions are made for individual members and city branches. They are as follows:

1. Spread the message through the media- press release for print media, radio and TV interviews. President Dr Chawla will be addressing the press in Delhi on behalf of the society and will give a national call for action in “War Against Sepsis”. Other key members of the society will undertake similar activities in their own cities.

2. A lecture on the new frontiers in war on sepsis by an eminent expert in the subject for web-casting to as many centres in the country as possible is being planned for the members of the society. Dr Chawla is already contacting experts for this activity.

3. Organise interactive sessions, skill testing and CMEs for health professionals and general practitioners to help the medical community, particularly, general practitioners to “recognize Sepsis as the body’s life-threatening response to infection, and treat it as a medical emergency requiring the administration of fluids, antibiotics and other appropriate treatments of infection within one hour of suspicion of sepsis.”

   The society is developing a set 3-4 talks to help with this activity, which will be made freely available to all the branches for local use

4. Organize educational activities for the common public - in form of public lectures, press release for news papers, TV/radio interviews (taking advantage of contacts in local press)

The important message for the common public should include:

1. A simple definition for public: “Sepsis is a life-threatening condition that arises when the body’s response to an infection damages its own tissues and organs. Sepsis may lead to shock, multiple organ failure and death, especially if not recognized early and treated promptly.”

2. Millions of people die of sepsis every year worldwide despite advances in modern medicine, including vaccines, antibiotics and acute care.

3. Available interventions such as fluids, antibiotics and other appropriate treatments of infection can dramatically alter the course of sepsis and improve survival if administered within the first hour of suspicion of sepsis.

   A small booklet for public education is in the process of being finalized. It will be made available through the central office to all the branches for public education.

5. Organize various programmes among residents and medical students

   a. Quiz competitions on sepsis related facts.

   b. Poster making competition on the theme “Sepsis-a public health emergency” or “War Against Sepsis”

   c. If we can find sponsors, simple T-shirts with printed messages may be distributed with help of key opinion makers.

6. We could also have some kind of online competition among the ISCCM members on sepsis related knowledge - with prizes!

      City branches and members are urged to organize as many of these activities as possible in their city, to help in achieving our society’s objectives.

Looking forward to hearing from you, your ideas and views, with best wishes and kind regards

For ISCCM Foundation Day - 2011 Celebration Committee

Coming together is a beginning. Keeping together is progress
Working together is success

- Henry Ford

There is no breakdown or breakthrough without a commitment.
Successful people ask them selves
"whether I am committed to my goal or what ever is getting in way of achieving these goals"

Carol mcall - The founder of world listening course
Management of severe sepsis in patients admitted to Asian intensive care units: prospective cohort study

Author: Phua J, Koh Y, Du B et al.
Reference: BMJ 2011; 342:3245

The objective of this prospective cohort study was to assess the compliance of Asian ICUs and hospitals to the Surviving Sepsis Campaign’s resuscitation and management bundles. Secondary objectives were to evaluate the impact of compliance on mortality and the organizational characteristics of hospitals that were associated with higher compliance. It was conducted in 150 ICUs in 16 Asian countries and included 1285 adult patients with severe sepsis admitted in July 2009. Main outcome measure was compliance with the Surviving Sepsis Campaign’s resuscitation (six hours) and management (24 hours) bundles.

The hospital mortality was 44.3% and the compliance rates for the resuscitation and management bundles were 7.6% and 3.5% respectively. On logistic regression analysis, compliance with following bundle targets independently predicted decreased mortality: blood cultures (62.5%), broad-spectrum antibiotics (79.2%), and central venous pressure (39.7%). High-income countries, university hospitals, ICUs with an accredited fellowship programme, and surgical ICUs were more likely to be compliant with the resuscitation bundle.

The study concluded that mortality from severe sepsis is high; compliance with resuscitation and management bundles is generally poor in much of Asia. Achievement of targets for blood cultures, antibiotics, and central venous pressure was independently associated with improved survival.

Procalcitonin-guided interventions against infections to increase early appropriate antibiotics and improve survival in the intensive care unit: A randomized trial

Author: Jensen JL, Hein L, Bettina Lundgren et al.

The objective of this randomized controlled open-label trial was to determine whether a strategy of antimicrobial spectrum escalation, guided by daily measurements of the biomarker procalcitonin, could reduce the time to appropriate therapy, thus improving survival. The study was done in nine multidisciplinary ICUs across Denmark and included a total of 1,200 critically ill patients. The patients were randomized either to the “standard-of-care-only arm,” receiving treatment according to the current international guidelines and blinded to procalcitonin levels, or to the “procalcitonin arm,” in which current guidelines were supplemented with a drug-escalation algorithm and intensified diagnostics based on daily procalcitonin measurements. The primary end point was death from any cause at day 28 (31.5% in the procalcitonin arm and 32.0% in the standard-of-care-only arm). Length of stay in the ICU was increased by one day (p=0.004) in the procalcitonin arm, the rate of mechanical ventilation per day in the ICU increased by 4.9%, and the relative risk of days with estimated glomerular filtration rate <60 ml/min/1.73 m² was 1.21. The study concluded that procalcitonin-guided antimicrobial escalation in the ICU did not improve survival and did lead to organ-related harm and prolonged admission to the ICU and the procalcitonin strategy used in this trial cannot be recommended.

Use of weaning protocols for reducing duration of mechanical ventilation in critically ill adult patients: Cochrane systematic review and meta-analysis

Author: Blackwood B, Alderidge F, Burns K et al.
Reference: BMJ 2011; 342:c7237

This systematic review looked at the effects of weaning protocols on the duration of mechanical ventilation, mortality, adverse events, quality of life, weaning duration, and length of stay in the intensive care unit and hospital. Data sources included Cochrane Central Register of Controlled Trials, Medline, Embase, CANMHL, LILACS, ISI Web of Science, ISCI Conference Proceedings, and Cambridge Scientific Abstracts with no language restrictions. The authors included randomised and quasi-randomised controlled trials of weaning from mechanical ventilation with and without protocols in critically ill adults. Eleven trials that included 1971 patients met the inclusion criteria. The geometric mean duration of mechanical ventilation in the weaning protocol group was lower by 25% when compared with the control group (P=0.006; 10 trials): the duration of weaning was reduced by 78% (P=0.009; six trials); and stay in the ICU length by 10% (P=0.02; eight trials). There was significant heterogeneity among studies for total duration of mechanical ventilation (I²=76%, P<0.01) and duration of weaning (I²=97%, P<0.01), which could not be explained by subgroup analyses based on type of unit or type of approach. The authors concluded that there is evidence of a reduction in the duration of mechanical ventilation, weaning, and stay in ICU when standardised weaning protocols are used, but there is significant heterogeneity among studies and an insufficient number of studies to investigate the source of this heterogeneity.

Subglottic secretion drainage for the prevention of ventilator-associated pneumonia: A systematic review and meta-analysis

Author: Muscedere J, Rewa O, Mckechnie K et al.

Endotracheal tubes with subglottic secretion drainage can potentially reduce the aspiration of secretions containing bacterial pathogens into the lower respiratory tract and, therefore, the incidence of ventilator-associated pneumonia (VAP). The authors conducted an updated systematic review and meta-analysis by including randomized clinical trials of mechanically ventilated patients comparing standard endotracheal tubes to those with subglottic secretion drainage and reporting on the occurrence of VAP. Studies were meta-analyzed for the primary outcomes of VAP and secondary clinical outcomes. 13 randomized clinical trials that met the inclusion criteria with a total of 2442 randomized patients were analyzed. Of the 13 studies reported a reduction in VAP rates in the subglottic secretion drainage arm. In the meta-analysis, the overall risk ratio for VAP was 0.55 (p < 0.0001) with no heterogeneity (I² =0%). The use of subglottic secretion drainage was associated with reduced ICU length of stay (-1.52 days; p = .03); decreased duration of mechanically ventilated (-1.08 days; p = .03), and increased time to first episode of ventilator-associated pneumonia (2.66 days; p = .001). There was no effect on adverse events or on hospital or intensive care unit mortality. The meta-analysis that in those at risk for VAP, the use of endotracheal tubes with subglottic secretion drainage is effective for the prevention of VAP and may be associated with reduced duration of mechanical ventilation and ICU length of stay.

On Being a Doctor- On Being Observed

Author: Holt GE

An interesting letter, which highlights the impact of our statements spoken aloud in the ICU. The author recalls when he was young resident performing CPR in a code (cardiac arrest) victim, he uttered aloud his opinion about poor prognosis for the patient, given the length of the code. A grey haired senior cardiologist who was watching the CPR gave him two suggestions: one that the in-house ventricular fibrillation arrest had a better prognosis, and second - to be careful of his spoken words, as you never know who might be watching. To the surprise of the young resident, this patient survived and recovered. The author recalls this incident much later when he has turned into a grey haired senior cardiologist and is involved in a CPR code. He directs his team to perform a prolonged resuscitation and the patient survives. The author does not know the final outcome as he was only moonlighting as a critical care physician in that hospital. He was surprised when he got a letter from one of the hospital nurses informing him that the patient was in the ICU and undergoing a rehabilitation program and had personally thanked him for not giving up on her. The key phrase in the letter was “She said she was watching us work on her.” Further discussions with the nurse revealed that the patient had had two out-of-body experiences during the code. She recalled floating around the ceiling during the first, and she hung on to the same IV pole I was standing the second. The author ends the letter with the words: “I smiled as I thought, Two for two, grey-haired cardiologist. You never know who might be watching.”

Impact of previous antibiotic therapy on outcome of Gram-negative septic shock

Author: Michael T. Johnson MT, Reichley R, Bauer JH et al.

This retrospective cohort study tried to determine whether exposure to antimicrobial agents in the previous 90 days resulted in decreased bacterial susceptibility and increased hospital mortality in patients with severe sepsis or septic shock due to
Gram-negative bacteria. Study included seven hundred fifty-four consecutive patients with Gram-negative bacteremia complicated by severe sepsis or septic shock admitted in a 1,000-bed urban teaching hospital from January 2002 to December 2007. The data was abstracted from computerized medical records. The most common isolates from blood cultures were Escherichia coli (30.8%), Klebsiella pneumoniae (23.2%), and Pseudomonas aeruginosa (17.6%). Among the 2,000 patients (41.1%) that had recent antibiotic exposure. Cefepime was the most common agent with previous exposure (50.0%) followed by ciprofloxacin (32.6%) and imipenem or meropenem (28.7%). Patients with prior antibiotic exposure had significantly higher rates of resistance to cefepime (29.0% vs. 7.0%), piperacillin/tazobactam (31.9% vs. 11.5%), carbapenem (20.0% vs. 2.5%), ciprofloxacin (39.7% vs. 17.6%), and gentamicin (26.1% vs. 7.9%) (p < .001 for all comparisons).

Patients with recent antibiotic exposure had greater inappropriate initial antimicrobial therapy (45.4% vs. 21.3% < .001) and hospital mortality (51.3% vs. 34.0% < .001) compared with patients without recent antibiotic exposure. Multivariate logistic regression analysis demonstrated that recent antibiotic exposure was independently associated with hospital mortality (p = .005). Other variables independently associated with hospital mortality included use of vasopressors, infection resulting from P. aeruginosa, inappropriate initial antimicrobial therapy, increasing Acute Physiology and Chronic Health Evaluation II scores, and the number of acquired organ failures. Study concluded that recent antibiotic exposure was independently associated with hospital mortality (p = .005).

The CriTiC al Care CommuniC aTions

Believe that the development of a “bundle” of preventive strategies will help identify patients who are at increased risk of postoperative pulmonary complications, and also to recommend strategies to reduce the deleterious impact on clinical outcomes and healthcare costs, and establish an algorithm that will help identify patients who are at increased risk for postoperative pulmonary complications. They convened a patient safety summit to discuss ways to enhance physical awareness of postoperative pulmonary complications (PPCs), a major contributor to the overall risk of surgery and also to recommend strategies to reduce their deleterious impact on clinical outcomes and healthcare costs, and establish an algorithm that will help identify patients who are at increased risk for postoperative pulmonary complications. They conducted PubMed searches for postoperative pulmonary complications in addition to the summit participants’ experience in the management of patients with PPC and postoperative pulmonary complications. The article looks at the problem and highlights the independent predictors of postoperative complications. The authors suggest that reduction of the incidence of PPCs will require a multifaceted approach involving many clinical disciplines. The approach includes strategies such as proper patient positioning, optimal care of the endotracheal tube, development of endotracheal tubes that minimize microaspiration, consideration of noninvasive ventilation, and the establishment of algorithms. They believe that the development of a “bundle” of protocols and interventions will optimize our ability to address this important public health issue. They conclude that the most practicable marker that identifies patients at highest risk for postoperative pulmonary complications is the need for postoperative mechanical ventilation of a cumulative duration > 48 hrs.

Clinical and economic burden of postoperative pulmonary complications: Patient safety summit on definition, risk-reducing interventions, and preventive strategies

Author Stander A, Fleisher LA, Bigatello LM et al.
Reference Cric Care Med 2011; 39:2163–2172.

The criteria that define acute lung injury and the acute respiratory distress syndrome include PaO2/FIO2 < 300, where FIO2 is the fraction of inspired oxygen. Authors performed a randomized trial to determine whether azithromycin decreased the frequency of exacerbations in participants with COPD who had an increased risk of exacerbations but no hearing impairment, rest tachycardia, or apparent risk of progression on a given CT interval. A total of 1577 subjects were screened and 1,142 (72%) were randomly assigned to receive azithromycin, at a dose of 250 mg daily (570 participants), or placebo (572 participants) for 1 year in addition to their usual care. The rate of 1-year follow-up was 89% in the azithromycin group and 90% in the placebo group. The median time to the first exacerbation was 266 days in participants receiving azithromycin, as compared with 174 days among participants receiving placebo (P < 0.001). The frequency of exacerbations was 1.48 exacerbations per patient-year in the azithromycin group, as compared with 1.83 per patient-year in the placebo group (P = 0.001), and the hazard ratio for having an acute exacerbation of COPD per patient-year in the azithromycin group was 0.73 (95% CI, 0.63 to 0.84; P < 0.001). The scores on the St. George’s Respiratory Questionnaire (on a scale of 0 to 100, with lower scores indicating better functioning) improved more in the azithromycin group than in the placebo group (a mean ± SD decrease of 2.8±12.8 vs. 0.6±11.4, P = 0.004); the percentage of participants with more than the minimal clinically important difference of 4 units was 43% in the azithromycin group, as compared with 36% in the placebo group (P = 0.03). Hearing decrements were more common in the azithromycin group than in the placebo group (25% vs. 20%, P = 0.04). Among selected subjects with COPD, azithromycin taken daily for 1 year, when added to standard treatment of end-stage pulmonary exacerbations and improved quality of life but caused hearing decrements in a small percentage of subjects. Although this intervention could cause microbial resistance patterns, the effect of this change is not known.

Prevention of Intraoperative Awareness in a High-Risk Surgical Population

Author Avidan MS, Jacobsen E, Blick D et al.

Unintended intraoperative awareness, which occurs when general anesthesia is not achieved or maintained, affects up to 1% of patients. This prospective, randomized, evaluator-blinded study tested the hypothesis that a protocol incorporating the electroencephalogram derived bispectral index (BIS) is superior to a protocol incorporating standard monitoring of end-tidal anesthetic agent concentration (ETAC) for the prevention of awareness. This trial was conducted at three medical centers and 6041 patients at high risk for awareness were randomly assigned to BIS-guided anesthesia or ETAC-guided anesthesia. Superiority of the BIS protocol was assessed with the use of a one-sided Fisher exact test. A total of 7 of 2865 patients (0.24%) in the BIS group compared with 2 of 2852 (0.07%) in the ETAC group, who were interviewed postoperatively had definite intraoperative awareness (a difference of 0.17 percentage points; 95% confidence interval 0.03 to 0.38; P = 0.98). Thus, the superiority of the BIS protocol was not demonstrated. A total of 19 cases of definite or possible intraoperative awareness (0.66%) occurred in the BIS group, as compared with 8 (0.28%) in the ETAC group (p = 0.08). None of the patients in the BIS group had awareness compared with 95% CI, 0.03 to 0.74; P = 0.99), with the superiority of the BIS protocol again not demonstrated. There was no difference between the groups with respect to the amount of anesthesia administered or the rate of major postoperative adverse outcomes. The superiority of the BIS protocol was not established; contrary to expectations, fewer patients in the ETAC group than in the BIS group experienced awareness.

The value of positive end-expiratory pressure and FIO2 criteria in the definition of the acute respiratory distress syndrome

Author Britos M, Smoot E, Liu KD et al.

Azithromycin for Prevention of Exacerbations of COPD

Author Albert RK, Bailey WC, Casaburi R et al.
A Glimpses - Inauguration of New ISCCM Office
Chennai Branch

1. ISCCM meet January 2011
   Topic: Delirium in ICU by Dr Raghavan, Intensivist, USA
   Topic: Antiseptic lock in vascular catheters
   Topic: DECRA trial
4. ISCCM meet August, 2011
   Topic: TO BE DECIDED
5. Mechanical ventilation workshop, August 20, 21, 22
   Basic & advanced

New office bearers will take over from August 2011

ISCCM Chennai Branch elects new Office Bearers (August 2011-July 2013)

Dr. R. Senthilkumar, Secretary of ISCCM Chennai branch invited nominations for new office bearers for the term August 2011 – 2013 and after the appropriate process the following office bearers were elected unopposed:

1. Advisor: Dr. Ram E Rajagopalan (Sundaram Medical Foundation)
2. Chairman: Dr. N. Ramakrishnan (Apollo Hospitals, Chennai)
3. Secretary: Dr. Ramesh Venkataraman (Apollo Hospitals, Chennai)
4. Treasurer: Dr. S. Mahendran (Apollo Hospitals, Chennai)
5. Executive Committee Members
   • Dr. Arun Kumar Menon (Sri Ramachandra University)
   • Dr. Bala Ramachandran (Child Trust Hospital)
   • Dr. O. Sivathanu Pillai (Velammal Hospital)
   • Dr. Shakeer (Sundaram Medical Foundation)
   • Dr. R. Thirumavasalan (SRM University)
   • Dr. Vijil Rahulan (Global Hospitals)

This was announced during the branch meeting held on August 11, 2011 when cases were presented by teams from Apollo Children hospital, Sri Ramachandra University & Apollo Main Hospitals.

Future programs planned:
1. Principles and Practice of Mechanical Ventilation (Basic & Advanced) – August 21-23, 2011
2. Hemodynamic monitoring (Basic & Advanced with a specific focus on use of bedside ultrasound) – October 2011 (Dates to be decided)
3. 6th Annual Chennai Refresher Course – December 2-4, 2011.

In addition, routine journal clubs and monthly activities would be planned.

Bhopal Branch

ISCCM
Chennai Branch Meeting
- August 2011

AP CRITICON 2011

1st State Conference of Critical Care Medicine
September 17th & 18th, 2011
The Gateway Hotel, Beach Road, Visakhapatnam
Theme: Today’s knowledge for today’s ICU practice
Website: www.apcriticon.com

Chairman Organising Committee
Dr G Ravindra Babu | 9848189289

Organising Secretary
Dr T Mohan S Maharaj | 9949844414

Chairman Scientific Committee
Dr V Kuchela Babu | 7799133666

ORGANIZED BY:
Indian Society of Critical Care Medicine - Visakhapatnam Chapter

SECRETARIAT:
Care Hospital, Ramnagar, Visakhapatnam - 530 002.
E-mail id: apcriticon2011@gmail.com
The 9th Delhi Critical Care Symposium (DCCS 2011) was held from August 19th- 21st, 2011 at Hotel Le Meridien, New Delhi. It was attended by 400 delegates from all over the country. Pre-conference courses were also organized on 19th & 20th April, 2011.

During Pre-conference courses, Fellowship Preparatory Course was held for the first time in India.

Following Courses / workshops as a part of Pre-Conference Programme were also held:

a. Fundamental Critical Care Support (FCCS) Course –
   Course Director: Dr Narendra Rungta, Co-ordinator: Dr M Munjal
   i. FCCS Instructor Course – 45 candidates participated in the Course.
   ii. FCCS Provider Course – 4 candidates participated in the Course.

b. Haemodynamic Monitoring
   Course Director: Dr Rajesh Chawla, Dr Atul Kulkarni.

c. Bronchoscopy
   Course Director: Dr Manoj Goel

d. Critical Care Workshop for Nurses –
   Dr. Prakash Shastri, New Delhi was the Workshop Director.

e. Ultrasound in ICU (WINFOCUS)

The main conference was on 21st August, 2011. The theme of the Conference was to achieve Critical Excellence and ensuring uniformity of care in the treatment of the critically ill and injured patients for the first 24 hours.

Delhi Oration was delivered by Dr. Abhijit Bhattacharya, a legend in the field of Anaesthesia and Critical Care. His topic of talk was “Human Errors in Critical Care”.

There was also a good participation by pharma companies as sponsors, advertisers and exhibitors of the conference. All the participants were fully satisfied with the academic session and enjoyed other activities as well.

Dr. Prakash Shastri
Gurgaon • prakashshastri@live.in

Indian Diploma in Critical Care Medicine
List of Successful Candidates - July 2011

1. Amol Bansode
2. Apurba Borah
3. Arpan Jain
4. Anoop Kumar A.S
5. Anil Kumar.K
6. Apurva Mulay
7. Ashutosh Jaiswal
8. Balaji V
9. Biyyapu Ramakrishna
10. Dnyaneshwar Munde
11. Gaurishankar Sharma
12. Girish Agrawal
13. Hitesh Patel
14. Ketan Vijay Kargirwar
15. Lakshmi Patil
16. Lawni Goswami
17. Krishna Baradol
18. K.C. Misra
19. Mrinal M
20. Narayana Swamy Moola
21. Narendranath K
22. Parmez A R
23. Praveen Chabukswar
24. Rahul Kumar
25. Rajnikanth S. Malapur
26. Ramakumar J
27. Sachin Goyal
28. Sachin Pralhad Sasane
29. Sailendra Sharma
30. Salil Patil
31. Sanjay Kumar Sogani
32. Subrata Datta
33. Swarup Dey
34. Swastikita
35. Tasmia Asad
36. Umesh Dryandeo Salunkhe
37. Varaprasad. D
38. Vikram Amale
39. Vinath Paritala
40. Vishal Aryan
41. Vinodh M. P
42. Yogesh Deogirikar
## Welcome New Members to the ISCCM family

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Location</th>
</tr>
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<tr>
<td>1</td>
<td>Vipul Parekh</td>
<td>Bhopal</td>
</tr>
<tr>
<td>2</td>
<td>Archana Agarwal, Agra</td>
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<tr>
<td>3</td>
<td>Soni Jasuja</td>
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<td>4</td>
<td>Preema Gomes, Mumbai</td>
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<td>6</td>
<td>Deepak Verma, Haryana</td>
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<td>7</td>
<td>Venkata Ramana, Vijaywada</td>
<td>ALCM-11/R-335</td>
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<td>8</td>
<td>Sanjay Muragod, Maholingsapur</td>
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<td>Manoj Kumar, Patna</td>
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<td>Ramchandra Sharma, Siliguri</td>
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<td>Manoj Yadav, Vadodara</td>
<td>L.M-11/Y-27</td>
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<td>Sonia Dalal, Baroda</td>
<td>L.M-11/D-325</td>
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<td>Summa Joy, Vadodara</td>
<td>L.M-11/J-265</td>
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<td>Vishnu Mangal, Gondal</td>
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<td>Harpal Singh, Guntur</td>
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<td>Jagadisha Chikkegowda, Bangalore</td>
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<td>Sudhanshu Rai, Senapat</td>
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<td>Sunjay Pathak, Gurgaon</td>
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<td>Tushar Parmar, Mumbai</td>
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<td>Shamit Gupta, Gurgaon</td>
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<td>Rohit Sing, Ludhiana</td>
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<td>Nitesh Bargiye, Pune</td>
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<td>Sai Praveen Haranath, Hyderabad</td>
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<td>Promod K.B, Kanyakulam</td>
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<td>Prashant Jedge, Pune</td>
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<td>Santosh Thakur, Thane</td>
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<td>Nimala Jayaraman, Chennai</td>
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<td>Rajesh Jain, Shahado</td>
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<td>Ripenmeet Salhotra, Mumbai</td>
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<td>Ajit Thakur, New Delhi</td>
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<td>Cihahi Sharma, Varanasi</td>
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<td>Murali T, Coimbatore</td>
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<td>Hiranthanavanlal Vijayakumar, Banglore</td>
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<td>Dilip Kairrisagar, Nagpur</td>
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<td>Leeladhar Mandaknalli, Pune</td>
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<td>Sambhunath Mukherjee, Kolkata</td>
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<td>Sujiit Pal, Medinipore</td>
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<td>Satish Junjiala, Banglore</td>
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<td>Rahul Kumar, New Delhi</td>
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<td>Tandra Biswas, Delhi</td>
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<td>Kishore Mangal, New Delhi</td>
<td>L.M-11/M-449</td>
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</tbody>
</table>

### Contributing Members

- Juvvala Radha, Trupati
- Alai Taggi, Chennai
- Sonia Saini, Nawan Shah
- Vivudh Singh, Lucknow
- Dhyaneshwar Shinde, Mumbai
- Narendra Ramana, Guntur
- Notu Reddy, Guntur
- Bikas Saurabh, Patna
- Ashish Jain, Bharatpur
- Chanchal singh, New Delhi
- Trilok Chand, Sikar
- Jyotishka Pal, Kolkata
- Mahesh Sarda, Nagpur
- Ansuman Mukhopadhyay, Kolkata
- Anand Srivastava, Varanasi
- Sumit Sengupta, Kolkata
- Russhikesh Garde, Pune
- Vaibhav Bhargava, Mumbai
- Ritesh Borkar, Nagpur
- Vijaya Vohra, Secunderabad
- Lokesh Garg, Faridabad
- Dilip Bhai Patel, Oshalampur
- Nilanq Yasavada, Rajkot
- Udegeeth Thaker, Akota
- Lakshminarathcharan S, Chennai
- Trishila Bankar, Mumbai
- Aswathy S, Trivandrum
- Dip Mukherjee, Serampur
- Natarajan Rajagopalan, Banglore
- Vipparthi Kumar, Vishakhapatnam
- Usha Namballa, Vishakhapatnam
- Parampreet Singh, Chandigarh
- George Mathew, Thrissur
- Pramod Jares, Shimla
- Sunil Jain, Rajpur
- Adithya Bharadwaj, Chennai
- Fazl Aabubakar, Thrissur
- Aapoorn Krishna, Chennai
- Akol Ashok Shah, Mumbai
- Swapnil Patharekar, Mumbai
- Zakir Hussain Shaik, Vijaywada
- Madhu Nainiwal, Vadodara
- Mohan Kamaraju, Bangalore
- Saptarshi Banerjee, Kolkata
- Janhavi Deshpande, Loni
- Vaibhav Vaishnav, New Delhi
- Manish Gupta, Jajpur
- Shyam Goyal, Jajpur
- Ashish Patel, Hyderabad
- Jitendra Srivastava, Agra
- Aniket Inamdar, Akly
- Nagar Redkar, Sindhudurga
- Mugdha Mule, Pune
- Digamber Munde, Ambojogai
- Dedeepiya Dvapravad, Chennai
- Sanjay Warude, Pune
- Ashok Bансode, Pune
<table>
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<th>DATE (2011-2012)</th>
<th>CONFERENCE NAME</th>
<th>CONTACT DETAILS</th>
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<tr>
<td>10th-11th September 2011</td>
<td>AP CRITICON 2011, ISCCM AP</td>
<td>Dr G Ravindra Babu</td>
</tr>
<tr>
<td></td>
<td>Visakhapatnam, AP, India</td>
<td>Dr T Mohan S Maharaj</td>
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<td>Dr V Kuchela Babu</td>
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<tr>
<td></td>
<td>Secretariat: Care Hospital, Ramnagar, Visakhapatnam - 530 002.</td>
<td>Email: <a href="mailto:apcriticon2011@gmail.com">apcriticon2011@gmail.com</a> • <a href="http://www.apcriticon.com">www.apcriticon.com</a></td>
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<tr>
<td>24th-25th September, 2011</td>
<td>Fundamental Critical Care support Course (FCCS), ISCCM, Nagpur Chapter</td>
<td>Dr. Rajan Barokar</td>
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<td>1st-5th October 2011</td>
<td>24th ESICM Lives Annual Congress</td>
<td>ESICM Registration Department, c/o K.I.T. Group GmbH</td>
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<td></td>
<td>Berlin, Germany</td>
<td>Secretariat: Care Hospital, Ramnagar, Visakhapatnam - 530 002.</td>
</tr>
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<td>22nd-23rd October 2011</td>
<td>Fundamental Critical Care support Course (FCCS), Amritsar, Punjab</td>
<td>Dr. Raman Chaitrath</td>
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<td>27th-28th October 2011</td>
<td>Sepsis-2011, Beijing, China</td>
<td>ISF, 7024 Palmetto Pines Ln</td>
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<td>Secretariat: Care Hospital, Ramnagar, Visakhapatnam - 530 002.</td>
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<td>19th-20th November 2011</td>
<td>3rd EZZCCON 2011</td>
<td>Dr. Samir Sahu</td>
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<td></td>
<td>3rd Eastern Zonal Critical Care Conference</td>
<td>Mr. Subrat Mohanty</td>
</tr>
<tr>
<td></td>
<td>Hotel The Crown, Bhubaneswar</td>
<td>Email: <a href="mailto:samirsahu_kal@yahoo.co.in">samirsahu_kal@yahoo.co.in</a></td>
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<tr>
<td>18th-20th November 2011</td>
<td>National Conference on Paediatric Critical Care</td>
<td>Dr. VSV Prasad &amp; Dr. Dinesh Chirla</td>
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<td></td>
<td>Indian Academy of Paediatrics, Paediatric Critical care</td>
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<tr>
<td>26th-27th November, 2011</td>
<td>Fundamental Critical Care support Course (FCCS), Hyderabad</td>
<td>Dr. Suhashini</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mobile no.: +91 9848512668</td>
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<tr>
<td>9th-10th December 2011</td>
<td>Fundamental Critical Care support Course (FCCS), New Delhi</td>
<td>Dr. Maitree Pande &amp; Dr. Rajesh Pande</td>
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<tr>
<td>12th-14th December 2011</td>
<td>The Intensive Care Society Annual State of the Art Meeting 2011, London, ICS (Intensive Care Society) UK</td>
<td>ICC London, East ExCel, Royal Victoria Dock, London</td>
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<tr>
<td>4th-8th February 2012</td>
<td>SCCM Congress 2012, George R. Brown Convention Center, Houston, Texas, USA</td>
<td>George R. Brown Convention Center &amp; Society of Critical Care Medicine Headquarters (Map), 500 Midway Drive, Mount Prospect, Illinois 60056 USA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Web site: <a href="http://www.sccm.org">www.sccm.org</a> • Email: <a href="mailto:info@sccm.org">info@sccm.org</a></td>
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<tr>
<td>15th-19th February 2012</td>
<td>CRITICARE 2012: 18th National conference of Indian Society of Critical Care Medicine, Pune</td>
<td>Dr. Kapil Zirpe, Organizing Secretary,</td>
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<td>16th-17th February 2012</td>
<td>Fundamental Critical Care support Course (FCCS), Criticare 2012, Crystal Hall, Hotel Mariott, Pune</td>
<td>Dr. Kapil Zirpe</td>
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<tr>
<td>15-17, March 2012</td>
<td>10th European Postgraduate Course in Neonatal and Pediatric Intensive Care Medicine</td>
<td>Course Chairman: Dr. Fachira P. Wagner</td>
</tr>
<tr>
<td></td>
<td>University Children’s Hospital, Berne, Switzerland</td>
<td>Phone: +41 31 632 9739 • Fax: +41 31 632 0784</td>
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<tr>
<td></td>
<td>University Children’s Hospital, Inselspital, CH-3010 Berne, Switzerland</td>
<td>E-mail: <a href="mailto:daniela.gruetter@insel.ch">daniela.gruetter@insel.ch</a></td>
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<td>Administrative Secretary: BBS Congress GmbH</td>
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<tr>
<td></td>
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<td>Phone: +41 31 331 8275 • Fax: +41 31 332 9879</td>
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### 17th APACCM - Japan

**The 17th Congress of Asia Pacific Association of Critical Care Medicine**  
February 27th (Mon) - March 1st (Thu), 2012  
Makuhari Messe, Chiba, Japan  
**Theme**: QUALITY and SAFETY in CRITICAL CARE  
http://www.jsicm2012.com/  

**President**  
Nobuo Fuke, M.D., Ph.D.

**ORGANIZED BY:**  
Teikyo University Chiba Medical Center, Japan  
Tel : +81-436-62-1211 Fax : +81-436-62-1327  
E-mail : jicm39@med.teikyo-u.ac.jp

**CONGRESS SECRETARIAT:**  
c/o Japan Convention Services, Inc.,  
18F Daido Seimei Kasumigaseki Bldg., 1-4-2, Kasumigaseki, Chiyoda-ku, Tokyo, 100-0013, Japan  
Tel : +81-3-3508-1214 Fax : +81-3-3508-1302  
E-mail : 39icm@convention.co.jp

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### Reader's Feedback

**Dear Dr. Rungta,**  
I am a regular reader of the Critical Care Communication as well as the ISCCM journal. I also follow the CCP group closely. I have received the Critical Care Communication on email as a link. I have also received it as a hard copy by normal post. For me personally, I do not need to get a hard copy if I can read it on the internet as an attachment or link or even as an emagazine. It will save the cost of printing and postage. So I suggest that you ask members if they would like to receive Critical Care Communication by email. Only those who request for a hard copy can be sent one by post. Now a days everyone is using an Ipad or some ebook reader so it will be good to start cutting down on hard copies. Also making ISCCM paperless is more eco friendly.

**Thank you and all the best.**

**Dr. Madhurita Singh Bhanu**  
MD, DA  
Anaesthesiologist, Padhar Hospital  
PO Padhar, Dist Betul 460005, MP  
madhuritasinghbanu@hotmail.com

**Dear Dr. Rungta**  
Ref.: Training of MBBS doctors  

**Dr. Ashok Panagariya**  
Member Planning Board, Govt of Rajasthan  
Former Principal and Controller, SMS Medical College, Jaipur
I regret to inform you with deep sadness that Dr Max H Weil passed away over the weekend in Palm Springs, California. He was 84 and was ailing from carcinoma prostate.

Dr. Weil can be truly labelled as the father of Modern Era of Critical Care Medicine, proposing the term critical care, and leading the Society of Critical Care Medicine as its first president from 1970 to 1972. A true visionary, he co-founded the Weil Institute of Critical Care Medicine, where he was active until his death.

His research focused on the mechanism of shock, the hemodynamic effects of endotoxin, and the relationship of endotoxic shock with other types of shock. His contributions are too numerous to name. He established the first “shock ward” to provide continuous monitoring of seriously ill cardiology and postsurgical patients. He also developed a cardiac catheterization laboratory and monitoring facility for surgical patients, as well as a clinical physiology unit for hemodynamic and metabolic patient studies. The bedside shock carts and critical care units that now fit so seamlessly into hospitals, saving countless lives each day, would not be there but for the sharp intellect and passionate persistence of this one man.

He established the first critical care unit; introduced computerized patient monitors; and took defibrillators into stores, restaurants and country clubs across the Coachella Valley. During a career that continued well into his final days, Dr. Weil wrote more than 1,300 peer-reviewed articles and books and has U.S. patents on 25 inventions.

He also trained legions of doctors, nurses and health care professionals in the around-the-clock monitoring of a patient’s vital signs, saving an incalculable number of lives. Many giants in the field of Critical Care including Dr. Jean Louis Vincent, and others were trained in his unit.

It can be easily said that the things that we are doing right now are quite significantly because of him.

In September 2009, the World Federation of Societies of Intensive and Critical Care Medicine presented him with the Lifetime Achievement Award in a ceremony in Florence, Italy.

The best homage that we can pay him would be to continue to strive to save lives in our ICUs.

Dr. Shirish Prayag
Editor, IJCCM • Organizing Chairman, CRITICARE 2012
critical@vsnl.com
Pune
On behalf of ISCCM Pune Branch, & the Organising Committee of CRITICARE Congress 2012, it is a pleasure & privilege to invite you all to the “18th Annual Conference of the Indian Society of Critical Care Medicine & International Critical Care Congress 2012”, being held at Marriott Hotel’s & Convention Centre, Pune from February 15th to 19th, 2012. Over the last decade critical care in India has grown by leaps & bounds and hence the theme of this year’s conference is, ‘Critical Care in India - Coming of Age’. We have invited some of the world’s most renowned faculties who are pioneers in their respective fields with original work in critical care.

### CONFIRMED INTERNATIONAL FACULTY

**Dr. Andrew M. Naidich, MD/MSPH**  
Associate Professor in Ken and Ruth Davis Department of Neurology, Anesthesiology and Neurological Surgery  
**Interests**  
Neurocysticercosis, Brain aneurysm, Cerebral Hemorrhage, Critical Care. Critical Care Outcome, Dyspnea, Ethics of Research with Human Subjects, Hip joint: Non Critical Care: Neurology, Stroke, Subarachnoid Hemorrhage

**Dr. Vincent Pellegrino**  
Senior Intensive Care Specialist at the Alfred Hospital & Heart of the ECMO Clinical Service  
**Interests**  
Anesthesiology and physiology and control of the circulation.

**Dr. Andrew Hillion**  
Consultant Critical Care Physician (RCSI, FRCA, FICCF)  
Senior Intensivist and Supervisor of Intensive Care Training at the Alfred Hospital, Intensive Care Unit in Melbourne, Critical Care mentor for the Certificate in Physicin Ultrason (CCPU)

**Prof Charles Gomersall**  
Associate Professor, Dept of Anaesthesia & Intensive Care. The Chinese University of Hong Kong  
**Interests**  
Thromboembolic disease, sepsis and respiratory protection and an enhanced interest in respiratory epidemiology.

**Dr. Edgar J Jimenez, MD**  
Anesthesiologist, Critical Care Practitioner, Internist  
Florida State University School of Medicine, Clinical Associate Professor, University of Florida College of Medicine  
**Specialty**  
Internal Medicine  
Subspecialty: Critical Care Medicine Anesthesiology

**Dr. Emanuel P. Rivers, MD, MPH**  
Vice Chair and Director of Research, Department of Emergency Medicine and Critical Care at Henry Ford Hospital  
**Interests**  
His interests include the examination and treatment of critical illnesses or the critically ill in the earliest stages of hospitalization, which includes the Emergency Department and Intensive Care Unit.

**Dr. Jean-Jacques Rouby, MD, PhD**  
Director of the Surgical Intensive Care Unit of Hospital Pitie-Salpêtrière, Université Paris 11, France  
**Interests**  
Intensive Mechanical Ventilation and New Technologies

**Prof. Ken Hillman**  
Director of The Simpson Centre for Health Services Research  
**Research Interests**  
Professor Hillman’s research involves actively re-engineering health services, with close clinician involvement, and evaluating complex interventions.

**Prof. Dr. Neil MacIntyre, MD**  
Chief, Critical Services  
**Interests**  
Pulmonary-function testing, pulmonary rehabilitation, mechanical ventilation

**Dr. Mitchell Levy, MD, FCCM, FCCP**  
Interim chief of the division of pulmonary, critical care and sleep medicine at Rhode Island Hospital  
**Interests**  
Clinical and Research Interests

**Dr. Kalpana K. Guntupalli, M.D.**  
Chief of Pulmonary, Critical Care and Sleep Medicine  
**Interests**  
Clinical and Research Interests

**Dr. Dan Witzberg**  
**Interests**  
Invasive Fungal Infections, Infections in Hematology and Oncology, Fever of unknown origin, Abdominal infection

**Dr. Patrick Murray, MD**  
Professor of Critical Care Medicine, UCD  
**Interests**  
Clinical, Anaesthesiology & Critical Care Medicine, Mater-Meanorstown University Hospital Dublin, Ireland
Scientific Highlights

- Neurology
- Infection
- Respiratory
- Gastroenterology
- Cardiology
- New Technology
- Nephrology
- Airways
- Diagnostics
- Ethics
- Organization
- Administration
- Ventilation

Welcome to Pune

ISCCM Pune branch was the first city Branch of ISCCM, formed in 1993 and has been at the forefront in the ISCCM in various activities. The 4th National Congress held in Pune in 1998 is still remembered by the attending delegates as one of the most outstanding ones. We in Pune look forward to welcoming you once again for CRITICARE 2012. Pune is known as the ‘Oxford of the East’, and is home to famous educational institutions like the University of Pune, Fergusson College, National Defence Academy, Armed Forces Medical College, B J Medical College, National Chemical Laboratory, National Insurance Academy, College of Military Engineering, The College of Engineering, etc. We now also boast of newer institutions like Symbiosis, Bharti Vidyapeeth, D. Y. Patil College and the Sinhgad Institutes. Pune known for its salubrious weather and historic places to see, it offers an ideal place to unwind from hectic schedules. You can meet colleagues and exchange ideas on the sidelines of the conference. We look forward to your active participation.

Criticare 2012 Secretariat:

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For Registration & Workshop Details Login to www.criticare2012.org

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